

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Bloomington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 155 E Burks Dr Bloomington, IN 47401	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>36912</p> <p>Based on observation, interview, and record review, the facility failed to ensure a self medication administration assessment was complete for residents with medications left at bedside for 1 of 1 random observations. (Resident 80)</p> <p>Findings include:</p> <p>On at 6/19/24 at 9:50 a.m., Resident 80 was observed in her room lying in bed next to the bedside table. On the bedside table in a plastic medication cup were 2 tablets of medication identified as 800 mg (milligrams) each of Sevelamer HCL (a medication used for persons on dialysis to lower blood phosphate levels). No facility staff members were present in the room at that time. Resident 80 indicated she took the medication with food, but she did not eat that morning, and the nurse left the medication on her bedside table and left the room.</p> <p>During an interview on 6/19/24 at 9:55 a.m., the Director of Nursing indicated the medication should not have been left with the resident, as medication administration was to be observed by the administering qualified staff unless the resident was assessed to be able to self administer medications.</p> <p>On 6/19/24 at 10:45 a.m., Resident 80's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease and hypertension. The State Optional Minimum Data Set assessment, dated 3/21/24, indicated the resident was cognitively intact.</p> <p>A physician's order with a start date of 1/23/24 indicated the resident was prescribed 2-800 mg tablets of Sevelamer HCL three times a day with meals.</p> <p>The clinical record lacked a self medication administration assessment.</p> <p>3.1-11(a)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>35318</p> <p>Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 2 of 3 residents reviewed for hospitalization . (Resident 54 and Resident 64)</p> <p>Findings include:</p> <p>1. Residents 54's clinical record was reviewed on 6/24/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic kidney disease.</p> <p>Resident 54's progress notes indicated the resident was sent to the hospital on 1/27/24 and 2/15/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident and the resident representative.</p> <p>2. Resident 64's clinical record was reviewed on 6/24/24 at 9:45 a.m. The diagnoses included, but were not limited to, type II diabetes mellitus and chronic kidney disease.</p> <p>Resident 64's progress notes indicated the resident was sent to the hospital on 6/17/24. The clinical record lacked documentation of written Notice of Transfer and Discharge forms having been provided to the resident.</p> <p>During an interview on 6/24/24 at 10:04 a.m., the Director of Nursing Services (DNS) indicated the facility did not provided the resident nor the resident representative the Notice of Transfer and Discharge forms in writing. The facility sent the forms with the resident when they were transferred to another facility.</p> <p>On 6/24/24 at 1:50 p.m., the DNS provided the facility's policy, Transfer and Discharge undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative .</p> <p>3.1-12(a)(6)(A)(i)</p> <p>3.1-12(a)(6)(A)(iii)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>35318</p> <p>Based on interview and record review, the facility failed to ensure the notification of the bed-hold policy required for a resident who transferred to the hospital was provided in writing to the resident or the resident representative for 2 of 3 residents reviewed for hospitalization . (Resident 54 and Resident 64)</p> <p>Findings include:</p> <p>1. Residents 54's clinical record was reviewed on 6/24/24 at 9:55 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic kidney disease.</p> <p>Resident 54's progress notes indicated the resident was sent to the hospital on 1/27/24 and 2/15/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident or the resident representative.</p> <p>2. Resident 64's clinical record was reviewed on 6/24/24 at 9:45 a.m. The diagnoses included, but were not limited to, type II diabetes mellitus and chronic kidney disease.</p> <p>Resident 64's progress notes indicated the resident was sent to the hospital on 6/17/24. The clinical record lacked documentation of written notification which specified the facility's bed-hold policy having been provided to the resident.</p> <p>During an interview on 6/24/24 at 10:04 a.m., the Director of Nursing Services (DNS) indicated the facility did not provided the resident nor the resident representative the notification of Bed-Hold forms in writing. The facility sent the forms with the resident when they were transferred to another facility.</p> <p>On 6/24/24 at 1:50 p.m., the DNS provided the facility's policy, Bed Hold Notice Upon Transfer undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy .</p> <p>3.1-12(a)(25)</p> <p>3.1-12(a)(26)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>38312</p> <p>Based on interview and record review, the facility failed to have an ongoing communication with the dialysis center regarding dialysis care while at dialysis for 1 of 1 residents reviewed for dialysis care. (Resident 63)</p> <p>Findings include:</p> <p>On 6/20/24 at 10:13 a.m., Resident 63's clinical record was reviewed. The diagnoses included, but were not limited to end stage renal disease, hypertension, and dementia.</p> <p>The physician orders, dated 6/24/24 indicated the following:</p> <ul style="list-style-type: none"> - Dialysis treatment on Monday, Wednesday, and Friday (start date 11/3/23). - Monitor Post Dialysis dressing for bleeding every Monday, Wednesday, and Friday (start date 7/28/23). - Post Dialysis Assessment every Monday, Wednesday, and Friday (start date 7/28/23). - Pre Dialysis Assessment every shift (start date 7/28/23). - Send Dialysis Communication Binder with resident to dialysis on Monday, Wednesday, and Friday (start date 7/31/23). <p>A care plan, dated 7/28/23, indicated Resident 63 received hemodialysis due to end stage renal disease. The care plan lacked any documentation of dialysis facility communicating with the facility.</p> <p>The In-Facility Post Dialysis Form, dated 6/3/24, lacked any documentation of dialysis center communication.</p> <p>The In-Facility Post Dialysis Form, dated 6/5/24, lacked any documentation of dialysis center communication.</p> <p>The Dialysis/Observation Communication Form, dated 6/10/24, lacked documentation of dialysis center communication.</p> <p>The Dialysis/Observation Communication Form, dated 6/12/24, lacked documentation of dialysis center communication.</p> <p>The In-Facility Post Dialysis Form, dated 6/14/24, lacked any documentation of dialysis center communication.</p> <p>The Dialysis/Observation Communication Form, dated 6/17/24, lacked documentation of dialysis center communication.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Dialysis Communication Form, dated 6/19/24, lacked documentation of post-dialysis information.</p> <p>The Dialysis Communication Form, dated 6/21/24 at 9:00 a.m., lacked documentation of the dialysis center information.</p> <p>The Dialysis Communication Form, dated 6/24/24 at 8:48 a.m., lacked documentation of the dialysis center and post-dialysis information.</p> <p>During an interview on 6/21/24 at 10:30 a.m., the Assistant Director of Nursing Services (ADNS) indicated Resident 63 was at the dialysis center with his dialysis communication binder. The dialysis center did not fill out the dialysis center information on the communication forms.</p> <p>During an interview on 6/24/24 at 11:42 a.m., the ADNS indicated when Resident 63 goes to dialysis, they would send his dialysis binder with the top of the dialysis communication fill out. While at dialysis, the dialysis center would fill out the dialysis center information. When he returns from dialysis center, the dialysis center information was blank.</p> <p>On 6/24/24 at 2:00 p.m., the Director of Nursing Services provided the facility policy, Hemodialysis. revised on 2/23, and indicated it was the policy currently being used. A review of the policy indicated, .3. The facility will coordinate and collaborate with dialysis facility to assure that: d. There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialyses staff .</p> <p>3.1-37(a)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>38312</p> <p>Based on interview and record review, the facility failed to ensure medications were administered with adequate indications for use for 1 of 5 residents reviewed for unnecessary medications. Medications were administered outside of physician order parameters. (Resident 88)</p> <p>Findings include:</p> <p>On 6/21/24 at 11:38 a.m., Resident 88's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure, hypertension, and dementia.</p> <p>Resident 88's physician orders dated 6/24/24 indicated the following:</p> <ul style="list-style-type: none"> - Lisinopril (medication used to treat high blood pressure) 20 milligrams (mg) by mouth one time a day for hypertension. Hold medication if the systolic blood pressure was less than 90 or diastolic blood pressure less than 60. If systolic blood pressure was greater than 160 and diastolic blood pressure was greater than 90, administer the medication and notify the MD. Recheck blood pressure in 30 minutes and document blood pressure (start date 4/18/24). - Metoprolol succinate extended release (medication used to treat high blood pressure) 25 mg by mouth one a day for hypertension. Hold medication if the systolic blood pressure was less than 90 or diastolic blood pressure less than 60. If systolic blood pressure was greater than 160 and diastolic blood pressure was greater than 90, administer the medication and notify the MD. Recheck blood pressure in 30 minutes and document blood pressure. Hold medication if pulse was less than 60 (start date 4/18/24). <p>Resident 88's May 2024 Medication Administration Record indicated the following on:</p> <ul style="list-style-type: none"> - On 5/2/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 106/54 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/2/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 108/54 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. - On 5/12/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her pulse was 52. The clinical record lacked documentation of medication being held. - On 5/24/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her pulse was 56. The clinical record lacked documentation of medication being held. - On 5/25/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 110/50 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 5/25/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 110/50 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held.</p> <p>- On 5/28/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 124/56 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held.</p> <p>- On 5/28/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 124/56 (diastolic blood pressure was less than 60). Her pulse was 58. The clinical record lacked documentation of medication being held.</p> <p>Resident 88's June 2024 Medication Administration Record indicated the following on:</p> <p>- On 6/2/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 142/59 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held.</p> <p>- On 6/2/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 142/59 (diastolic blood pressure was less than 60). Her pulse was 53. The clinical record lacked documentation of medication being held.</p> <p>- On 6/9/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 106/58 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held.</p> <p>- On 6/9/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 106/58 (diastolic blood pressure was less than 60).</p> <p>- On 6/17/24 at 9:00 a.m., lisinopril 20 mg was administered. Her blood pressure was 130/48 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held.</p> <p>- On 6/17/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her blood pressure was 130/48 (diastolic blood pressure was less than 60). The clinical record lacked documentation of medication being held.</p> <p>- On 6/18/24 at 9:00 a.m., metoprolol succinate extended release 25 mg was administered. Her pulse was 50. The clinical record lacked documentation of medication being held.</p> <p>A care plan, dated 7/27/23, indicated she had hypertension. Her interventions were to administer medication as ordered; obtain and document her vital signs as ordered; and report abnormalities to the MD.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/24/24 11:12 a.m., Registered Nurse (RN) 1 indicated Resident 88 had hypertension and was on lisinopril and metoprolol. If her systolic blood pressure was less than 90 or her diastolic blood pressure was less than 60, her lisinopril and metoprolol was held and the nurse practitioner would be notified. If her pulse was less than 60, her metoprolol would be held. If the medication was held, they would document the medication being held in the medication administration record.</p> <p>During an interview on 6/24/24 at 11:50 a.m., the Director of Nursing Services (DNS) indicated the lisinopril and metoprolol was administrated to Resident 88. The clinical record lacked documentation of lisinopril and metoprolol being held per physician orders.</p> <p>On 6/24/24 at 1:37 p.m., the DNS provided the facility policy, Medication Administration, undated, and indicated it was the policy currently being used. A review of the policy indicated, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters .</p> <p>3.1-48(a)(4)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34848</p> <p>Based on interview and record review the facility failed to ensure staff documented neurological assessments for 1 of 1 residents reviewed for falls. (Resident 105)</p> <p>Findings include:</p> <p>On 6/24/24 at 10:18 a.m., Resident 105's clinical record was reviewed. The diagnoses included, but were not limited to, morbid (severe) obesity, abnormalities of gait and mobility, and edema.</p> <p>Progress notes indicated the following:</p> <ul style="list-style-type: none"> - On 4/20/24 at 11:10 a.m., the resident was transferring self with a walker to his wheelchair and stepped on barbell weights instead of the floor. The resident complained of left knee pain and a 6 centimeter (cm) by 0.5 cm abrasion was assessed on his left knee. - On 4/20/24 at 2:06 p.m., a telehealth note indicated the resident was found on the floor. He did not know his bed was elevated when he tried to get up and lost his balance. The resident complained of left knee pain, but refused treatment. - On 4/20/24 at 2:30 p.m., the resident was playing game system. The author indicated neuro checks continue and were within normal limits. No documentation was noted in regard to neurological assessment findings. - On 4/20/24 at 3:22 p.m., the resident wanted to see what the x-rays before going to the ER (emergency room). The author indicated neuro checks continue and were within normal limits. PERRLA (pupils are equal, round and reactive to light and accommodation). No additional documentation was noted in regard to neurological assessment findings. <p>A review of the resident's Neuro Checks, documentation, dated 4/20/23 at 3:24 p.m., indicated neurological assessments were performed 15 minutes after the fall, 1 and 1/2 hours the fall, and 4 hours after the fall. The documentation indicated neurological assessments were not completed 30 minutes post fall, 45 minutes post fall, 60 minutes post fall, 2 hours post fall, 2 and 1/2 hours post fall, 3 hours post fall, 5 hours post fall, 6 hours post fall, 7 hours post fall, 11 hours post fall, 15 hours post fall, 19 hours post fall, nor 23 hours post fall.</p> <p>During an interview on 6/24/24 at 1:53 p.m., the Director of Nursing Services (DNS) indicated the neuro check flowsheet was kind of new to them so some nurses would use the form and then others would make a progress note. She indicated there were holes in the resident's Neuro Checks documentation and progress notes, and the standard of care is for staff to perform neuro checks on any unwitnessed falls.</p> <p>3.1-50(a)(2)</p>		