

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 04/25/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38312</p> <p>Based on observation, interview, and record review, the facility failed to ensure care plan fall interventions were in place for a resident who was at risk for falls for 1 of 4 residents reviewed for accidents. (Resident 107)</p> <p>Findings include:</p> <p>On 4/21/25 at 11:37 a.m., Resident 107 was observed to be resting in his bed. The bed was against the wall with no mat observed to be beside his bed.</p> <p>On 4/22/25 at 10:32 a.m., Resident 107 was observed to be resting in his bed. The bed was against the wall with no mat observed to be beside his bed.</p> <p>On 4/23/25 at 2:04 p.m., Resident 107 was observed to be resting in his bed. The bed was against the wall with no mat observed to be beside his bed.</p> <p>On 4/24/25 at 11:20 a.m., Resident 107's clinical record was reviewed. The diagnoses included, but were not limited to, traumatic brain injury, major depressive disorder, muscle weakness, anxiety, glaucoma, and dementia.</p> <p>The quarterly MDS (Minimum Data Set), dated 3/31/25, indicated Resident 107 had moderate cognitive impairment and had 2 or more falls with no injury.</p> <p>A care plan, dated 8/8/24, indicated Resident 107 was at risk for falls. On 3/19/25, the intervention was to place a mat by the bed.</p> <p>During an interview on 4/24/25 at 10:23 a.m., LPN 1 indicated Resident 107 had history of falls. LPN 1 indicated Resident 107 did not have a mat beside his bed.</p> <p>During an interview on 4/24/25 at 11:20 a.m., LPN 2 indicated Resident 107 had history of falls. She was unsure if Resident 107 required a mat beside his bed. When a resident gets a new fall interventions, they would be in the physician orders. She looked in the physician orders and did not see an order for mat beside the bed. She did not look at the Kardex (system used by nurses to quickly assess resident information for their daily care plan) or the care plan.</p> <p>(continued on next page)</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/25 at 2:15 p.m., the Director of Nursing Services (DNS) indicated all nursing staff could find resident's fall interventions in the Kardex or in the care plan.</p> <p>On 4/25/25 at 2:57 p.m., the DNS provided the facility's policy, Fall Prevention Program, undated, and indicated it was the policy being used. A review of the policy indicated, .d. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assisi devices</p> <p>3.1-35(g)(2)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38312</p> <p>Based on interview and record review, the facility failed to provide care per the plan of care for 1 of 5 residents reviewed for unnecessary medications. Insulin was not held per physician's orders. (Resident 107)</p> <p>Findings include:</p> <p>On 4/24/25 at 11:20 a.m., Resident 107's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, traumatic brain injury, and dementia.</p> <p>The April 2025 Medication Administration Record (MAR) indicated to inject Humalog (insulin) 3 units subcutaneous (under the skin) before meals. Hold if the blood sugar is less than 150 mg/dl (milligrams per deciliter), ordered 3/21/25. The MAR indicated the following:</p> <ul style="list-style-type: none"> - On 4/5/25 before breakfast, the Humalog 3 units were administered. The blood sugar was 128 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/5/25 before lunch, the Humalog 3 units were administered. The blood sugar was 121 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/5/25 before dinner, the Humalog 3 units were administered. The blood sugar was 130 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/6/25 before lunch, the Humalog 3 units were administered. The blood sugar was 132 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/6/25 before dinner, the Humalog 3 units were administered. The blood sugar was 130 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/19/25 before dinner, the Humalog 3 units were administered. The blood sugar was 140 which was less than 150. The clinical record lacked documentation the insulin was held. - On 4/20/25 before dinner, the Humalog 3 units were administered. The blood sugar was 147 which was less than 150. The clinical record lacked documentation the insulin was held. <p>A care plan, dated 8/8/24, indicated Resident 107 had diabetes mellitus. On 8/8/24, the intervention was to administer diabetes medication as ordered by the physician.</p> <p>During an interview on 4/25/25 at 2:03 p.m., the Director of Nursing Services (DNS) indicated Resident 107 was administered Humalog 3 units when his blood sugar was less 150.</p> <p>On 4/25/25 at 2:57 p.m., the DNS provided the facility's policy, Medication Administration, undated, and indicated it was the policy 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>(continued on next page)</p>		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-35(g)(2)

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36912</p> <p>Based on observation, interview, and record review, the facility failed to provide a homelike environment free of damage, disrepair, and odor of urine for 1 of 2 secured units and 5 of 7 resident rooms reviewed for environment. (Reflections 2 Unit, room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER])</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 4/23/25 at 1:20 p.m., 4/24/25 at 2:10 p.m., and 4/25/25 at 10:40 a.m., the bathroom off the dining room on the Reflections 2 unit was observed to emit a strong odor of urine and had brown stained substance around the base of the toilet. On 4/25/25 at 10:45 a.m., the 2 shower room stalls in the Reflections 2 unit shower room were observed to have a brown stained substance around the junctions where the walls meet the floors. On 4/25/25 at 10:50 a.m., the base of the bathroom door in the Lounge room [ROOM NUMBER] was observed to have broken wall board. On 4/25/25 at 10:55 a.m., room [ROOM NUMBER] was observed to have damaged drywall a the head of the 2 beds. There was a brown stained substance around the baseboards and closet track. On 4/25/25 at 10:57 a.m., room [ROOM NUMBER] was observed to have holes in the wall by the bathroom, damaged walls and baseboard on both sides of the air conditioning unit, 4 nails and 4 screws protruding from the wall across from both beds, and brown stained substance around the base of the toilet. On 4/25/25 at 11:00 a.m., the shared bathroom of rooms [ROOM NUMBERS] was observed to have brown stained substance around the base of the toilet. On 4/25/25 at 11:05 a.m., room [ROOM NUMBER] was observed to have an oversized thumbtack pressed into the wall next to the clock. The closet door tracks had brown stained substance in them and one of the closet doors was missing. On 4/23/25 at 1:30 p.m., 4/24/25 at 2:20 p.m., and 4/25/25 at 1:45 p.m., the inside of the Reflections 2 entry/exit door was observed to be sticky to the touch. <p>During an interview on 4/25/25 at 1:50 p.m., the Administrator indicated the aforementioned environmental concerns existed and were in need of attention in order to provide a clean, comfortable, homelike environment for the residents.</p> <p>On 4/25/25 at 2:05 p.m., the Director of Admissions provided the Residents Rights, undated, and indicated these were the resident rights currently used by the facility. A review of the Residents Rights indicated, .you have the right to a safe, clean, comfortable, and homelike environment .</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.1-19(f)</p>