STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT EAGLE CREEK	5045 W 52ND ST, INDIANAPOLIS, , 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: October 1 and 2, 2025. Facility number: 003915 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 14, 2025.	R 0000		
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the	R 0120	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **To ensure compliance, the Executive Director or designee will provide a minimum of 6 hours of dementia-specific in-service education to associates**	11/21/2025

	needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		**out of compliance. All associates will receive a minimum of 3 hours annually thereafter.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **All** **residents have the potential to be affected by the deficient practice. To** **address this, the Executive Director** **or designee will audit all associate files to verify that they are in** **compliance. Those that are not in compliance will be provided with six hours of dementia-specific in-service education and a minimum of three hours annually thereafter.**	

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to follow an active order to obtain a monthly weight for a Resident (Resident 10) who had a diagnosis of weight loss for 1 of 6 residents sampled. Findings include: On 10/2/25 at 10:50 a.m. Resident 10's medical record was reviewed. She was an assisted living resident residing at the facility whose diagnoses included but was not limited to breast cancer, weight loss, and	R 0216	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Community Wellness Director or designee will review resident records to ensure physician-prescribed orders are being followed as written.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community Wellness Director or designee will conduct an audit of all resident records to ensure compliance with all physician-prescribed orders.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;	10/31/2025

	chronic kidney disease. Resident 10 had an active order, starting on 6/9/25, to be weighed every month. Resident 10 had an admission weight of 112.2 in June, and a weight of 113.2 for August. During an interview on 10/2/25 at 2:15 p.m. Qualified Medication Aide (QMA) 3 indicated they had not gotten a weight for Resident 10 in July or September. Based on interview and record review, the facility failed to follow an active order to obtain a monthly weight for a Resident (Resident 10) who had a diagnosis of weight loss for 1 of 6 residents sampled. Findings include: On 10/2/25 at 10:50 a.m. Resident 10's medical record was reviewed. She was an assisted living resident residing at the facility whose diagnoses included but was not limited to breast cancer, weight loss, and chronic kidney disease. Resident 10 had an active order, starting on 6/9/25, to be weighed every month. Resident 10 had an admission weight of 112.2 in June, and a weight of 113.2 for August.		and **The Community Wellness Director or designee will conduct regular audits of all resident records to ensure compliance with all physician-prescribed orders.** By what date the systemic changes will be completed. **In-service will be completed by 10/31/2025**	

	During an interview on 10/2/25 at 2:15 p.m. Qualified Medication Aide (QMA) 3 indicated they had not gotten a weight for Resident 10 in July or September.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observations and interviews, the facility failed to ensure medications stored in medication carts were properly labeled, dated, and appropriately destroyed after expiration for 2 of 2 medication carts reviewed and 7 residents. Findings include: On 10/2/25 at 12:30 p.m. the 100 hall medication cart and 200 hall medication cart were reviewed. The medications reviewed were as follows: 1. Resident 11 had an albuterol inhaler that had no open date. 2. Resident 12 had a Spiriva	R 0300	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **To ensure compliance, the Community Wellness Director or designee will verify that all medications identified as improperly labeled have been relabeled appropriately. Additionally, all expired medications will be disposed of in accordance with state-approved protocols.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community Wellness Director or designee will complete a medication cart audit**	10/31/2025

	inhaler that had no open date. 3. Resident 13 had a Breo Ellipta inhaler with an open date of 7/14/25 and a Fluticasone inhaler with an open date of 8/7/25. 4. Resident 14 had an albuterol inhaler with an open date of 11/21/24, 5. Resident 15 had a Spiriva inhaler that had no open date. 6. Resident 16 had Latanoprost eye drops with an open date of 7/15/25. 7. Resident 17 had an over-the-counter bottle of Tylenol 8-hour arthritis with no pharmacy label or handwritten label with appropriate information on it. During an interview on 10/2/25 at 12:45 p.m. Licensed Practical Nurse (LPN) 4 indicated when they opened a new inhaler or eye drop the expectation was to put an open date sticker on it with the date the inhaler or eye drops were opened. She indicated they normally throw away inhalers and eye drops after 30 days if they haven't run out before then. On 10/2/25 at 1:30 p.m. the Executive Director (ED) provided a copy of a current facility policy titled, "Medication		**to ensure that all medications are properly labeled and not expired.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The Community Wellness Director or designee will conduct regular medication cart audits to ensure all medications are appropriately labeled and free of expired items, in compliance with state regulations.** By what date the systemic changes will be completed. **In-service will be completed by 10/31/2025**	

	Labeling", dated 5/2012. This policy indicated, " ... All medications must be labeled in a container that conforms to state regulations ... 6. The containers of all medications shall bear a label containing all of the following information: a. Name and strength of the medication, b. Quantity in the container, c. Name of the resident d. Directions for use, e. Name of the physician, f. Date the drug was dispensed, g. Name and address of the pharmacy, h. Prescription number, i. Expiration date when applicable ...". During an interview at the time of exit the ED indicated they did not have a policy that spoke to dating and expiration of medication, they follow state regulation. Based on observations and interviews, the facility failed to ensure medications stored in medication carts were properly labeled, dated, and appropriately destroyed after expiration for 2 of 2 medication carts reviewed and 7 residents. Findings include: On 10/2/25 at 12:30 p.m. the 100 hall medication cart and 200 hall medication cart were reviewed. The medications reviewed were as follows: 1. Resident 11 had an albuterol			

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	Executive Director (ED) provided a copy of a current facility policy titled, "Medication Labeling", dated 5/2012. This policy indicated, " ... All medications must be labeled in a container that conforms to state regulations ... 6. The containers of all medications shall bear a label containing all of the following information: a. Name and strength of the medication, b. Quantity in the container, c. Name of the resident d. Directions for use, e. Name of the physician, f. Date the drug was dispensed, g. Name and address of the pharmacy, h. Prescription number, i. Expiration date when applicable ...". During an interview at the time of exit the ED indicated they did not have a policy that spoke to dating and expiration of medication, they follow state regulation.			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug.	R 0301	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **The Community Wellness Director or designee will ensure that all orders in the eMAR match the physician-prescribed orders in the resident's chart to ensure that residents are receiving**	10/31/2025

	(E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observations and interviews the facility failed to ensure ordered medications matched on the Electronic Medication Administration Record (EMAR) and the medication card for 1 of 1 residents (Resident 11) whose medication order needed to be clarified. Findings include: On 10/2/25 at 11:58 a.m. Licensed Practical Nurse (LPN) 4 was observed during a medication pass. When preparing Resident 11's medication it was found that the order in the EMAR indicated the resident should receive acetaminophen 325 milligrams (mg) tablets, 3 tablets three times daily and the medication card indicated the resident should receive acetaminophen 325mg tablets, 3 tablets every 6 hours. There was no change of		**medications as prescribed. Additionally, the Community Wellness Director or designee will verify that medication labels accurately correspond with the prescribed orders and the eMAR.** How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **The Community Wellness Director or designee will complete an audit of residents' prescribed orders in individual health records to verify they match those in the eMAR. Additionally, the Community Wellness Director or designee will verify that medication labels accurately correspond with the prescribed orders and the eMAR.** How	

	order sticker on the card or any indication on which order was the correct order. During an interview on 10/2/25 at 12:05 p.m. LPN 4 indicated she always went by the order in the EMAR because that was the most up to date order. She indicated they had change of order stickers, but they normally just administer the medication according to the order in the EMAR. LPN 4 indicated she would call the pharmacy and the physician to reconcile the discrepancies in the order. On 10/2/25 at 1:30 p.m. the Executive Director (ED) provided a copy of a current facility policy titled, "Medication Labeling", dated 5/2012. This policy indicated, " ...2. When verifying labels, the nurse, or designee, receiving the medication should verify that the directions on the label correspond to the latest physicians' order and that the order is correctly written on the MAR...."		the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The Community Wellness Director or designee will provide in-service education to nursing staff to ensure medications are administered to residents as prescribed by the resident's physician on each shift. Additionally, the community's pharmacy consultant will audit medication carts and orders at least every 60 days.** By what date the systemic changes will be completed. **In-service will be completed by 10/31/2025**	

Based on observations and interviews the facility failed to ensure ordered medications matched on the Electronic Medication Administration Record (EMAR) and the medication card for 1 of 1 residents (Resident 11) whose medication order needed to be clarified.

Findings include:

On 10/2/25 at 11:58 a.m. Licensed Practical Nurse (LPN) 4 was observed during a medication pass. When preparing Resident 11's medication it was found that the order in the EMAR indicated the resident should receive acetaminophen 325 milligrams (mg) tablets, 3 tablets three times daily and the medication card indicated the resident should receive acetaminophen 325mg tablets, 3 tablets every 6 hours. There was no change of order sticker on the card or any indication on which order was the correct order.

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	physician to reconcile the discrepancies in the order. On 10/2/25 at 1:30 p.m. the Executive Director (ED) provided a copy of a current facility policy titled, "Medication Labeling", dated 5/2012. This policy indicated, " ...2. When verifying labels, the nurse, or designee, receiving the medication should verify that the directions on the label correspond to the latest physicians' order and that the order is correctly written on the MAR...."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREScott	TITLEMcCoskey	(X6) DATE10/24/2025