| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 10/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BLOOM AT KESSLER | 5011 KESSLER BLVD E, INDIANAPOLIS, , 46220 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000 | INITIAL COMMENTS<br><br>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on August 26, 2025. This visit included a PSR to Investigation of Intakes IN00464032 and IN00464245 completed on August 26, 2025.<br><br>Intake IN00464032 - Corrected.<br><br>Intake IN00464245 - Corrected.<br><br>Survey dates: October 8, 2025<br><br>Facility number: 010064<br><br>Residential Census: 57<br><br>Bloom at Kessler was found to be in compliance with 410 IAC 16.2-5 in regards to the PSR to the State Residential Licensure Survey and the PSR to the Investigation of Intakes IN00464032 and IN00464245.<br><br>Quality review completed on October 14, 2025. | R 0000 | | |

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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 SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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