STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT WILLOW	2725 LAKE CIRCLE DR, INDIANAPOLIS, , 46268

(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. This visit included the Investigation of Intakes 469581 and 470060. Intake 469581-No deficiencies related to the allegations are cited. Intake 470060-No deficiencies related to the allegations are cited. Survey dates: June 4, 5 and 8, 2026. Facility number: 010234 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on June 12, 2026	R 0000		

R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect, when a resident with a diagnosis of dementia and a high risk for elopement wandered away from the facility for an undetermined amount of time for 1 of 4 residents reviewed for neglect. (Resident E) This deficient practice resulted in Resident E exiting a secure locked unit and ambulating outside, where he was found lying on the ground and was sent to the hospital. Findings include: During an observation, on 6/4/26 at 11:53 a.m., residents were sitting in the dementia dining room. Qualified Medication Aide (QMA) 2 stood at the medication cart and QMA	R 0052	Submission of this Plan of Correction does not constitute an admission or agreement by the provider... The Plan of Correction is submitted as a credible allegation of compliance. R-052 - Resident E has been assessed and interventions updated - All residents have the potential to be affected. - In an effort to ensure the deficient practice will not recur, all staff are being re-educated on elopement prevention, alarm response, and supervision expectations. Elopement risk assessments and care plans are being reviewed and updated for at-risk residents. - In an effort to ensure continued monitoring, the Executive Director/designee will conduct weekly audits x 4 weeks, and monthly x 5 months. Additional education provided as needed. - Date of Compliance: 07/15/2026	07/15/2026

	3 was standing by the clean dish cart. A very loud alarm sounded and neither QMA responded. After a few seconds, both were asked what the alarm was sounding for and QMA 2 stated it was "just a resident". QMA 3 moved and looked towards the elevator. The alarm was turned off by another staff member. A facility reported incident provided by the Executive Director (ED) indicated, on 5/30/26 at 5:31 p.m., Resident E with a diagnosis of dementia, was reported to be walking outside. The staff went outside to investigate and found Resident E lying in the parking lot of the adjacent building. The clinical record for Resident E was reviewed on 6/4/2 at 12:32 p.m. The diagnoses included, but were not limited to, dementia, hypertension, and diabetes mellitus. A physician's order, dated 3/25/26, indicated Resident E may remain in a locked and secure unit. An elopement risk assessment, dated 4/10/26, indicated Resident E had attempted to leave the community unaccompanied within the past 6 months, demonstrated repeated exit-seeking behavior more than twice in 30 days and			

	persistently expressed the intent to leave and attempted to act on it. Resident E was at high risk for elopement and elopement precautions, and individualized service plans were implemented. A service plan, dated 4/13/26, indicated Resident E needed to be escorted to meals and activities. He used the walker and walked independently. Staff were to provide interventions to manage and reduce sundowning, orientation to person and time, and to support him with orientation, redirection, and wayfinding. He needed redirection due to wandering and exit seeking during the day and night. Resident E tried to go downstairs to check his mailbox. A progress note, dated 4/7/26 at 6:00 p.m., indicated Resident E was exit seeking. The resident made it off the dementia unit and was found on the 1st floor. This was due to a family member not closing the unit door. The resident was easily redirected and escorted back to dementia unit by the staff member. A progress note, dated 4/9/26 at 1:52 p.m., indicated Resident E was exit seeking and the alarm was set off 4 times. A progress note, dated 5/30/26 at 5:30 p.m., indicated another			

	resident reported a male was walking with a walker in the parking lot near the facility dumpsters. A dietary aide and writer immediately exited the building and searched the parking lot and surrounding area. During the search, Resident E was located lying on the ground in the adjacent restaurant's parking lot. The resident stated his hip hurt and 911 was notified. The emergency medical services and fire department arrived and decided to take the resident to the hospital for further evaluation and treatment. A progress note, dated 5/31/26 at 2:08 p.m., indicated Resident E was exit seeking after lunch. The QMA and other dementia staff heard the door alarm sounding and Resident E was attempting to leave through the emergency exit. The resident stated he needed to leave. The resident was redirected to the common area with other peers. The QMA instructed the activity staff to complete one on one activities with Resident E. During an interview, on 6/5/25 at 9:00 a.m., the Executive Director (ED) indicated the facility did not know how Resident E got out of the building. The alarms did not sound at the time the resident exited the building. The resident			

	had received his medication around 5:00 p.m., and was found outside around 5:30 p.m., in the neighboring restaurant's parking lot. The resident was lying on his side on the pavement. The facility did not have cameras or a wanderguard system. The stairway door had a very loud alarm and if a resident pushed the door for 15 to 20 seconds the door would open. The day the resident got out no alarms sounded. The facility's "best guess" was another resident let him out at the front door. During an interview, on 6/5/26 at 1:26 p.m., the ED indicated Resident E did not leave the building, on 4/7/26, but he made it on the elevator and would not get off. The staff on the first floor was alerted, and the resident was met at the elevator and returned to the dementia unit. During an interview, on 6/8/26 at 9:06 a.m., Licensed Practical Nurse (LPN) 5 indicated she was the nurse who found Resident E in the restaurant's parking lot. She was notified by a resident on the 2nd floor an older man with a walker passed her window. The nurse and Server 6 went out the side door and did not see anyone. They walked out to the street behind the building and saw the			

	resident lying in the restaurant parking lot. The resident was holding his head and complaining about his head and left hip hurting. The nurse called 911 and the emergency medical staff took the resident to the hospital for an evaluation and treatment. LPN 5 did not hear an alarm. The dementia unit had a door to the stairway and if you pushed on the door for 15 to 20 seconds the door would open. During an interview, on 6/8/26 at 10:03 a.m., QMA 7 indicated she was not at the facility when the resident got out of the building. However, earlier in the day the resident pushed the stairway door trying to exit the dementia unit. The alarm did go off and he was distracted. Resident E would sundown around 5:00 p.m. and would try to exit the dementia unit. He would push the stairway door and make the alarm go off. He often tried to go downstairs to check his mailbox or take out the trash. During an interview, on 6/8/26 at 10:22 a.m., Server 6 indicated during dinner cleanup another resident informed Server 6 an older man walked past her window. Server 6 went to get LPN 5 and they both went outside to check on the man. They did not see anyone at first. Server 6 went out a little further			

	and saw Resident E lying on the ground by the first entrance of the restaurant parking lot. During an interview, on 6/8/26 at 10:43 a.m., QMA 4 indicated he did work the day the resident exited the building. Resident E always tried to get off the unit. QMA 4 had administered Resident E his medication at 5:00 p.m., in the dining room. QMA 4 indicated he was very busy with other residents, and he did not hear or see Resident E leave the unit. A current facility policy, titled "Missing Resident Protocol", dated 6/13/23 and received from the Executive Director on 6/8/26 at 9:41 a.m., indicated "...Time is of the essence when it is suspected that a resident is missing. Each day, the Executive Director, or responsible person, should ensure that the Resident Roster is complete and correct. When an associate suspects that a resident may be missing, the Missing Resident Alert will be issued. Associates will make the following "Missing Resident Protocol" their number one priority barring other resident emergencies ...." A current facility policy, titled "Elopement Drill", undated and received from the Executive Director on 6/5/26 at 2:35 p.m.,			

	indicated " ...The safety of our residents will always be our top priority ...all exit doors in our community have an alarm that is triggered when a door is being pushed opened without the use of the door code. Staff should immediately go to the alarm sound when on Memory Care/Assisted Living. The staff members should investigate the alarm and check behind the door. Please look down the stairwell to ensure that a resident is not traveling down them ...In case of this event please stay calm, we don't want to yell or frighten the resident that could cause the resident to fall or hurt themselves. During an elopement drill the following steps should be followed, even during a mock drill all staff members must conduct a full search ...during a mock elopement drill staff members will do a head count for each resident and one staff member from MC will communicate through their walkie...."			
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:	R 0092	R-092 - No residents were adversely affected. - All residents have the potential to be affected. - In an effort to ensure the deficient practice will not recur,	06/25/2026

	(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure an attempt to hold a fire and disaster drill in conjunction with the local fire department at least every 6 months was documented for 2 of 2 semi-annuals attempts reviewed. Findings include: The facility fire drills were reviewed on 6/4/26 at 1:48 p.m. The facility had no documentation of the fire		the facility implemented a tracking system for fire drill documentation and biannual fire department invitations will be emailed to maintain record. - Monitoring will occur monthly x6 months by the Executive Director/designee. - Date of Compliance: 06/25/2026	

	department being invited to a fire drill for the 2 invites every 6 months. During an interview, on 6/5/26 at 1:35 p.m., the Executive Director (ED) indicated she did not have any documentation other than a handwritten note to indicate she had invited the local fire department to the facility. She could not remember who she spoke with and did not have the documentation. A current facility policy, titled "Fire Drills," dated as issued September 2011 and received from the ED on 6/5/25 at 10:00 a.m., indicated "...Fire Drills should be executed on a monthly basis per the Evacuation Plan. Every shift should participate at least once annually or per State requirements. 1. A designated associate should complete a Fire Drill Report after the fire drill is finished...."			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references	R 0116	R-116 - No residents were adversely affected. - All residents have the potential to be affected. - All employee files were audited and references obtained where possible. Hiring process	07/15/2026

	and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure pre-employment references were completed and documented for 5 of 5 employees reviewed for employee records. (CNA 8, QMA 9, QMA 2, QMA 4, and LPN 10) Findings include: The facility employee records were reviewed on 6/5/26 at 11:30 a.m. The following employees did not have documentation for completed references: 1. CNA 8 was hired on 2/21/25 and did not have complete references on file. 2. QMA 9 was hired on 5/25/26 and did not have complete references on file. 3. QMA 2 was hired on 10/9/25 and did not have complete references on file. 4. QMA 4 was hired on 5/24/21 and did not have complete references on file. 5. LPN 10 was hired on 10/10/25 and did not have complete references on file. During an interview, on 6/8/26 at		updated to require references prior to employment. - Executive Director/Designee will audit new hires weekly x 4 weeks, then monthly x 6 months. - Date of Compliance: 07/15/2026	

	12:03 p.m., the Executive Director (ED) indicated the facility could not locate documentation of completed reference checks for the employees. A facility policy was not provided at the time of exit.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for	R 0117	R-117 - No residents were adversely affected. - All residents have the potential to be affected. - Staff were scheduled to ensure CPR/First Aid coverage on all shifts and certifications updated. - Executive Director/Designee will complete weekly audits of schedules x 4 weeks, then monthly x 6 months. - Date of Compliance: 07/15/2026	07/15/2026

	which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met the requirements of Cardiopulmonary Resuscitation (CPR) and first aid training for 11 of 21 shifts reviewed for CPR and first aid. Findings include: A review of the staffing schedule, on 6/5/23 at 12:30 p.m., indicated the following shifts were not staffed with CPR and first aid certified staff: a. On 5/25/26, there was no CPR or first aid coverage for the first shift. b. On 5/26/26, there was no CPR or first aid coverage for the evening shift and night shift. c. On 5/27/26, there was no CPR or first aid coverage for the day shift and night shift. d. On 5/28/263, there was no CPR or first aid coverage for the day shift and evening shift. e. On 5/29/26, there was no CPR or first aid coverage for the first shift. f. On 5/30/26, there was no CPR or first aid coverage for the			

	day shift and evening shift. g. On 5/31/26, there was no CPR or first aid coverage for the day shift During an interview, on 6/8/26 at 12:03 p.m., the Executive Director indicated they did not have CPR and first aid certified staff on duty for the shifts listed. A facility policy was not provided at time of exit.			
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 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.	R 0120	R-120 - No residents were adversely affected. - All residents have the potential to be affected. - Staff completed required dementia and annual in-service training; tracking system implemented. - Executive Director/Designee will complete monthly audits x 6 months by Executive Director/designee. - Date of Compliance: 07/15/2026	07/15/2026

	(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. Based on interview and record review, the facility failed to ensure employees received annual in-service training for 4 of 5 employees reviewed for annual in-services. (CNA 8, QMA 2, QMA 4, and LPN 10) Findings include: The facility employee records were reviewed on 6/5/26 at 11:30 a.m. The following			

	employees did not have the required annual dementia training: 1. CNA 8 was hired on 2/21/25 and did not have the initial six hours of dementia training or annual three hours of dementia training completed. 2. QMA 2 was hired on 10/9/25 and did not have the initial six hours of dementia training completed. 3. QMA 4 was hired on 5/24/21 and did not have annual resident rights or the three hours of dementia training completed. 4. LPN 10 was hired on 10/10/25 and did not have the initial six hours of dementia training completed. During an interview, on 6/8/26 at 12:03 p.m., the Executive Director (ED) indicated the facility could not locate documentation of the annual in-services for the employees. A facility policy was not provided at the time of exit.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel	R 0123	R-123 - No residents were adversely affected. - All residents have the potential	07/15/2026

	records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure job descriptions and orientation checklists were completed and signed for 4 of 5 employees reviewed for employee files. (CNA 8, QMA 2, QMA 4, and LPN 10)		to be affected. - Personnel files updated with missing documentation and checklist implemented. - Executive Director/Designee will complete monthly audits x 3 months, then quarterly. - Date of Compliance: 07/15/2026	

	Findings include: The facility employee records were reviewed on 6/5/26 at 11:30 a.m. The following employees were missing an orientation checklist or signed job descriptions: 1. CNA 8, hired on 2/21/25, did not have a signed job description. 2. QMA 2, hired on 10/9/25, did not have an initial orientation checklist or a signed job description. 3. QMA 4, hired on 5/24/21, did not have an initial orientation checklist. 4. LPN 10, hired on 10/10/25, did not have an initial orientation checklist. During an interview, on 6/8/26 at 12:03 p.m., the Executive Director (ED) indicated the facility could not locate documentation of the orientation checklists or signed job descriptions for the employees. A facility policy was not provided at the time of exit.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1)	R 0297	R-297	07/15/2026

	(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were available without interruption for 1 of 1 resident reviewed for pharmacy services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/4/26 at 11:00 a.m. The diagnoses included, but were not limited to, dementia, depression, hypertension, and chronic kidney disease. A physician's order, dated 2/5/26, indicated to administer lorazepam (a medication used to treat anxiety) 0.5 milligrams (mg) by mouth two times daily.		- Resident B medication issue corrected; no further missed doses. - All residents have the potential to be affected. - Staff re-educated on medication reorder process, physician communication and pharmacy communication. - DON/designee will audit MARs weekly x 4 weeks, and monthly x 6 months. - Date of Compliance: 07/15/2026	

	A service plan, dated 4/25/26, indicated Resident B required assistance with medication management. The objectives included, but were not limited to, receiving medication in a safe and timely manner. A service plan, dated 4/25/26, indicated Resident B needed daily intervention due to disruptive, aggressive, or socially inappropriate behavior. She experienced hallucinations or delusions, sundown's (increased confusion in the evening) daily, and required staff redirection and reassurance. A medication administration record, dated May 2026, indicated 13 doses of lorazepam were not administered due to unavailability, with 9 of those occurring on consecutive days. During an interview, on 6/8/26 at 11:16 a.m., the Director of Nursing (DON) indicated all licensed staff were responsible for reordering medications. When a request was sent, sometimes the pharmacy would not notify the facility a new script was needed for the refill. During an interview, on 6/8/26 at 11:35 a.m., Qualified Medication Assistant (QMA) 11 indicated when a medication refill was needed, a fax was sent to the pharmacy with the medication			

	information. If the medications were not received, staff should follow up with the pharmacy. A refill should be requested when there were about ten administrations left for a resident. During an interview, on 6/8/26 at 11:45 a.m., the Executive Director (ED) indicated Resident B did not receive a refill on her medication in a timely manner due to the pharmacy needing a new script. During an interview, on 6/8/26 at 12:39 p.m., the Pharmacy Representative indicated the physician was notified on 5/8 a new script was needed for the refill of lorazepam. They were able to locate an older script for a ten-day supply until they were able to get the new refill. The new lorazepam script was written on 5/22, and pharmacy delivered the medication on 5/24. The clinical record did not contain documentation the facility had followed up with the physician again after 5/8 for a new lorazepam script for Resident B. A facility policy was not provided at time of exit.			

R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview and record review, the facility failed to ensure medications were dated when opened and the medication cart was free of loose pills for 1 of 3 medication carts reviewed for medication storage. (third floor medication cart) Findings include: The 300-unit medication cart	R 0298	R-298 - Medication cart issues corrected immediately. - All residents have the potential to be affected. - Staff re-educated on medication labeling and cart organization standards. - DON/designee will complete weekly cart audits x 4 weeks, and monthly x 6 months. - Date of Compliance: 07/15/2026	07/15/2026

was reviewed on 6/4/26 at 1100 a.m. The following were observed:

1. In the top left side drawer, there were 2 opened bottles of dorzolamide-timolol eye drops with no opened dates.

2. The top middle drawer of the medication cart had one (1) Novolog insulin pen and 1 Humalog insulin pen with no opened dates.

3. A Lantus Solostar insulin pen had 130 units remaining. The pen had no resident information or opened date.

4. In the second middle drawer, there were 8 loose pills.

5. In the third middle drawer, there were 6 loose pills.

During an interview, on 6/4/26 at 11:18 a.m., QMA 2 indicated there should be open dates on the medications and there should not be any loose pills in the bottom of the medication carts. The nurses were responsible for cleaning out the cart and the night shift nurse organized the carts.

A current facility policy, titled "Storing General Medications," dated May 2012 and received from the ED on 6/4/26 at 11:17 a.m., indicated "...Medications must be stored in a clean and

	neat, locked container or medication cart...."			

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 SIGNATUREKourtney Harvey	TITLEExecutive Director	(X6) DATE06/25/2026