STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00438591. Complaint IN00438591 - State deficiencies related to the allegations are cited at R216 and R349. Survey dates: July 29 and 30, 2024. Facility number: 010234 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 5, 2024.	R 0000	*Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James P Kesler	Executive Director	08/16/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	writing and kept in the facility. Based on observation, interview and record review, the facility failed to ensure a self-administration of medication assessment was completed prior to allowing the resident to self-administer medications for 1 of 1 resident reviewed for self-administration of medications. (Resident C) Finding includes: During a random observation, on 7/29/24 at 9:29 a.m., Resident C was up in the first-floor dining room talking with another resident. She was observed to pick up a clear plastic medication cup and pour the medications into her left hand. There were no staff in the area. The resident indicated she was just now taking her medications. They are binders, thyroid medication, heart pill, thinner and her water pill. She took them after dialysis. The clinical record for Resident C was reviewed on 7/30/24 at 11:41 a.m. The diagnoses included, but were not limited to, aortic stenosis, chronic heart failure, and coronary artery disease. The resident did not have a self-administration of medication assessment in the record. A physician's order, initiated on 7/23/24, indicated levothyroxine (a thyroid medication) 75 micrograms (mcg) every morning. "...MKAB...." (may keep at bedside). A physician's order, initiated on 2/22/24, indicated to take 2 tablets of sevelamer (a phosphate binder) 800 milligrams (mg) Three times a day with meals at 10:00 a.m., 12:00 p.m., and 5:00 p.m. A physician's order, initiated on 1/3/24, indicated	R 0216	R 216 Plan of Correction Text: What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure a self-administration assessment was completed prior to allowing the resident to self- administer medications for 1 of 1 resident reviewed. Wellness Director completed self-administration assessment for resident 1 of 1. 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 living in the community have the potential to be affected. All current residents will have a self-administration assessment completed by 08/25/2024. Moving forward, all residents will have a completed self-administration assessment per Bloom at Willow Self-Administration Assessment Policy. What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur: All residents will have a self-administration assessment completed upon admission and as directed by the Bloom at Willow Self-Administration Assessment Policy.	08/25/2024

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	to take one torsemide (a diuretic) 20 milligrams twice daily at 10:00 a.m., and 5:00 p.m. A physician's order, initiated on 3/5/24, indicated to take one amlodipine (a blood pressure medication) 10 mg once a day at 10:00 a.m. A physician's order, initiated on 1/2/24, indicated to take one carvedilol (a blood pressure medication) 25 mg twice daily at 10:00 a.m., and 12:00 p.m. A physician's order, initiated on 1/2/24, indicated to take one clopidogrel (a medication to slow clotting) 75 mg twice daily at 10:00 a.m., and 9:00 p.m. A physician's order, initiated on 1/2/24, indicated to take one hydralazine (a medication for high blood pressure) 100 mg three daily at 10:00 a.m., 2:00 p.m., and 9:00 p.m. During an interview, on 7/30/24 at 12:17 p.m., the Director of Nursing indicated the levothyroxine was left at bedside. She had an order to leave that medication at the bedside. The resident needed to have a self-administer assessment to self-administer medications. She had started to self-administer her medications after dialysis. A facility policy, titled "Medication--Self-Administration," dated as issued May 2012 and received from the Executive Director on 7/30/24 at 12:40 p.m., indicated "...All residents have the right to self-administer medications upon...they are able to demonstrate to the Wellness Director that they are capable of following the directions for the medications and have been assessed using a recognized self-administration of medication assessment		How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place: Wellness Director and Executive Director reviewed policy and procedure for Self-Administration Assessment. Wellness Director or designee will monitor weekly that each resident completes self-administration assessment upon admission and per Bloom at Willow Self-Administration Assessment Policy for one year. Completion Date: August 25, 2024	

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	tool...." This citation relates to Complaint IN00438591.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure resident service plans were signed by the resident or resident representative for 6 of 7 residents reviewed for signed service plans.	R 0217	**R 217** **What corrective action(s) will be accomplished for those residents found to have been**	08/25/2024

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	(Residents 1, 2, B, 5, 6 and Resident C) Findings include: 1. The clinical record for Resident 1 was reviewed on 7/30/24 at 11:19 a.m. The diagnoses included, but were not limited to, dementia, hypertension, and osteoarthritis. The service plans, dated 4/8/24 and 7/9/24, were not signed by the resident or resident representative. 2. The clinical record for Resident 2 was reviewed on 7/30/24 at 11:19 a.m. The diagnoses included, but were not limited to, dementia and hypertension. The service plans, dated 3/12/24 and 7/15/24, were not signed by the resident or resident representative. 3. The clinical record for Resident B was reviewed on 7/30/24 at 11:27 a.m. The diagnoses included, but were not limited to, dementia, diabetes, and hypothyroidism. The service plan, dated 5/15/24, was not signed by the resident or resident representative. 4. The clinical record for Resident 5 was reviewed on 7/30/24 at 12:24 p.m. The diagnoses included, but were not limited to, dementia, fibromyalgia, and neuropathy. The service plan, dated 5/21/24, was not signed by the resident or resident representative. 5. The clinical record for Resident 6 was reviewed on 7/29/24 at 11:32 a.m. The diagnoses included,		**affected by the deficient practice:** Residents 1,2,B,5, and resident C care plans were reviewed and signed by the family (POA), resident and Executive Director. **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:** Complete chart audit performed on 8/19/2024 to verify that care plans have been signed by all parties. Any care plans found to have missing signatures were flagged for the responsible parties to sign the care plan by 8/25/2024. **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** Wellness Director and Executive Director will review charts monthly to ensure all care plans have been signed by all responsible parties per policy. **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:** The Executive Director is responsible for sustained compliance. The ED or designee will complete audits by reviewing 3 charts weekly for 4 weeks,	

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	but were not limited to, dementia, memory loss, and incontinence of bladder. The service plan, dated 3/30/24, was not signed by the resident or resident representative. 6. The clinical record for Resident C was reviewed on 7/30/24 at 11:41 a.m. The diagnoses included, but were not limited to, aortic stenosis, chronic heart failure, and coronary artery disease. The service plan, dated 6/6/24, was not signed by the resident or resident representative. During an interview, on 7/30/24 at 1:33 p.m., the Executive Director indicated there was no policy and the facility followed the state regulations.		biweekly for 4 weeks, then monthly for 10 months to ensure care plans are signed. The audit will be discussed at monthly QI meetings. Monitoring will be on-going. **By what date will the systemic changes be completed** 8/25/2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure food items had open dates and were closed off from air, the dishwasher reached the appropriate temperatures for both the wash and rinse cycles, the sanitizer solution used to clean kitchen surfaces reached at least 150 part per million (ppm), and failed to ensure clean metal serving pans had been completely dry prior to storing for 2 of 3 kitchens reviewed. (the memory care unit kitchen and the main kitchen) Findings include: 1. During an observation of the memory care unit	R 0273	R 273 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to ensure food items had open dates and were closed off from air, the dishwasher reached the appropriate temperature for both the wash and rinse cycles, the sanitizer solution used to clean kitchen surfaces reached at least	08/25/2024

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	kitchen, on 7/30/24 at 8:28 a.m., a plate was found, covered with paper towels, and stored in the refrigerator. There was no label or date on the plate. Upon inspection, the plate contained eight (8) brownies. In the freezer, a one (1) gallon container of Neapolitan ice cream was found open with approximately 1/3 remaining, a one (1) gallon of vanilla ice cream was found open with approximately ¾ remaining, and a four (4) ounce cup of chocolate ice cream was found with a lid bent in the center and loosely placed on the container. None of the items had an open date. During an interview, on 7/30/24, CNA 2 indicated everything should have been labeled, dated, and closed. 2. During an observation of the main kitchen, on 7/30/24 beginning at 8:40 a.m., the dishwasher was observed for two (2) cycles. The first cycle registered a wash temperature of 110 degrees Fahrenheit (F) and a rinse cycle of 110 F. The dishwasher function was observed again, and on the second run the wash temperature reached 116 F and the rinse temperature reached 114 F. During an interview, on 7/30/24 at 8:40 a.m., the Dietary Manager indicated the dishwasher was a low temperature model and needed to reach 120 F for both cycles. 3. The sanitizer solution, used to clean kitchen surfaces, was checked for concentration and registered zero (0). During an interview, on 7/30/24 at 8:46 a.m., the Dietary Manager indicated the concentration should be at least 200 ppm. The sanitizer solution was changed every two (2) hours.		150 part per million, and failed to ensure clean metal serving pans had been completely dry prior to storing for 2 of 3 kitchens reviewed **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 living in the community have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All staff working in the affected area will be educated by August 22, 2024, on labeling of food and drinks, infection control/sanitation, and food handling standards. All food and drink have been properly labeled and stored. The dish machine has been repaired and is operating at the correct temperature for both wash and rinse cycles. Thermometer has been replaced in freezer. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place?** Dietary Manager or designee will conduct daily audits. Audit results will be reviewed by Quality	

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	4. During an observation, on 7/30/24 at 8:49 a.m., the chest freezer was found to have a broken thermometer. The thermometer was not showing the temperature and instead had broken red liquid across all the scale lines in the capillary tube. During an interview, the Dietary Manager indicated the freezer required a new thermometer. 5. During an observation, on 7/30/24 at 8:49 a.m., water drops were found on clean stored metal serving pans stacked on top of other clean metal serving pans. At that time, the Dietary Manager informed a dietary staff member the items need to be dry before storing. During an interview, on 7/30/24 at 9:00 a.m., the Dietary Manager indicated all food items in the refrigerators and freezers were to be labeled and dated. During an interview, on 7/30/24 at 10:08 a.m., the Executive Director indicated the facility did not have a policy on storing clean dry dishes and indicated dishes should not be stored with water between them. The facility did not have a policy addressing thermometers in freezers/refrigerators, and all thermometers should be working. The facility followed the state regulations. A facility document, titled "Sanitizer Test Procedure," received from the Executive Director on 7/30/24 at 10:41 a.m., indicated the sanitizer solution was to be at 150-400 ppm. A facility policy, titled "Food Returned from Residents," dated as revised September 2011 and received from the Executive Director on 7/30/24 at		Assurance Program. **Completion Date**: 8/25/2024	

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	10:08 a.m., did not address labeling and dating food. A facility document for the dishwasher, titled "General Operating Instructions," undated and received from the Executive Director on 7/30/24 at 10:41 a.m., indicated "...It is recommended that 140 (degree) F be used...." A facility policy, titled "Dish Washing Temperatures," dated as revised September 2011 and received from the Executive Director on 7/30/24 at 10:08 a.m., indicated "...When temperatures are not at the satisfactory levels, dish washing is stopped, and corrective action is taken...."			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to assess and document in the resident's clinical record an injury which resulted in a bruise on the wrist for 1 of 1 resident reviewed for documentation. (Resident B) Finding includes: During an interview, on 7/30/24 at 12:05 p.m., the Director of Nursing indicated she received a text, from the QMA, on Saturday night (related to	R 0349	R 349 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The facility failed to assess and document in a resident's medical record an injury which resulted in a bruise on the	08/25/2024

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	bruise), there was no licensed staff in the facility to assess the bruise/injury. She returned to the facility on Monday and saw the bruise. It was reddish purple and about the side of a half dollar. She did not document the bruise or assessment and she should have. During an interview, on 7/30/24 at 12:10 p.m., the Executive Director indicated the bruise was not there on Thursday but was there on Saturday when the resident's spouse visited. The spouse informed him of the bruise on Monday. A facility obtained employee statement, dated 7/11/24 at 5:53 p.m., indicated Resident B had his hands on another resident's door. Resident B was agitated. CNA 1 was trying to get Resident B's hands off the door. CNA 3 was behind the resident and another employee was by his side. CNA 3 gently touched the resident's shoulder trying to get him to move from the door. The statement was signed by CNA 3. A facility obtained employee statement, dated 7/11/24 at 5:56 p.m., indicated CNA 1 was writing the statement regarding an incident. Per the statement, Resident B was displaying sundowning behavior "...ranting and raving...in (word salad) ...and barricade a resident's door and wanted more desert...." The dessert was provided but the resident was still in a "...hostile mood...." CNA 1 did enlist the assistance of another employee the resident was more comfortable with, and the resident's wife did visit and calm him down. The clinical record for Resident B was reviewed on 7/30/24 at 11:27 a.m. The diagnoses included, but were not limited to, dementia, diabetes, and hypothyroidism.		wrist for 1 of 1 residents reviewed for documentation. **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 residing at the facility have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All nursing staff will be educated in assessment and documentation by August 22, 2024. An audit of all charts will be completed by August 23,2024 to ensure that assessments and documentation are included in the residents medical record. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** Wellness Director or designee will review all charts 1 time per week for 1 month then monthly for 11 months to ensure assessments and documentation is included in the medical record. Completion Date: 8//25/2024	

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	There was no documentation found in the chart to show the resident had been displaying behaviors, the resident had sustained a bruise to his wrist, or the injury had been assessed. During an interview, on 7/30/24 at 1:33 p.m., the Director of Nursing indicated a bruise/injury was an exception and should have been documented and assessed. A facility policy, titled "Documentation by Exception," dated as last revised May 2012 and received from the Executive Director on 7/30/24 at 12:40 p.m., indicated "...Except for the Medication Record, it is...policy that the provision of services and issues that are related to a resident's current status is charted by exception...." This citation relates to Complaint IN00438591.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure residents had an annual health statement (statement the resident showed no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter) in the record for 7 of 7 residents. (Residents 1, 2, B, 4, 5, 6 and C) Findings include:	R 0409	R 409 Plan of Correction Text: **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** This RULE is not met as evidenced by: Based on interview and record review, the	08/25/2024

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BLOOM AT WILLOW	2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268

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	1. The clinical record for Resident 1 was reviewed on 7/30/24 at 11:19 a.m. The diagnoses included, but were not limited to, dementia, hypertension, and osteoarthritis. The resident did not have an annual health statement in their record. 2. The clinical record for Resident 2 was reviewed on 7/30/24 at 11:19 a.m. The diagnoses included, but were not limited to, dementia and hypertension. The resident did not have an annual health statement in their record. 3. The clinical record for Resident B was reviewed on 7/30/24 at 11:27 a.m. The diagnoses included, but were not limited to, dementia, diabetes, and hypothyroidism. The resident did not have an annual health statement in their record. 4. The clinical record for Resident 4 was reviewed on 7/29/24 at 11:13 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety disorder. The resident did not have an annual health statement in their record. 5. The clinical record for Resident 5 was reviewed on 7/30/24 at 12:24 p.m. The diagnoses included, but were not limited to, dementia, fibromyalgia, and neuropathy. The resident did not have an annual health statement in their record.		facility failed to ensure that residents had annual health statement (statement the resident showed no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter) in the record of 7 of 7 residents. **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 residing in the facility have the potential to be affected. **What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:** All nursing staff will be educated on Annual Health Statement by August 22, 2024. All residents will have an annual health statement signed by their physician in their medical record. **How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put in place:** An audit tool for Annual Health Statement for all residents has been implemented by the Wellness Director. A monthly audit will be conducted by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/30/2024

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

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	6. The clinical record for Resident 6 was reviewed on 7/29/24 at 11:32 a.m. The diagnoses included, but were not limited to, dementia, memory loss, and incontinence of bladder. The resident did not have an annual health statement in their record. 7. The clinical record for Resident C was reviewed on 7/30/24 at 11:41 a.m. The diagnoses included, but were not limited to, aortic stenosis, chronic heart failure, and coronary artery disease. The resident did not have an annual health statement in their record. During an interview, on 7/30/24 at 1:42 p.m., the Executive Director indicated they did not have the annual health assessments, statements, or a policy. The facility followed the state regulations.		Wellness Director or designee. Completion Date: 8/25/24	