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	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOM AT KESSLER	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00436512. Complaint IN00436512 - No deficiencies related to the allegations are cited. Survey dates: July 22, 2024 Facility number: 010064 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 23, 2024.	R 0000	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 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Helga A Bradley | Executive Director | 08/08/2024

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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	annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure a health screen was conducted prior to working with residents for 2 of 5 employee files reviewed. (Dementia Care Director and Qualified Medication Aide 3) Findings include: The employee files for Dementia Care Director and Qualified Medication Aide (QMA) 3 were reviewed on 7/22/24 at 2:00 p.m. There were no	R 0121	R 121 • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A review of all current employee personnel records was completed to identify any employee who is lacking physical health screens and/or TB screenings. The results of this review were discussed with the ED and policy reviewed.	08/20/2024

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	employee health screens within the employee files. An interview conducted with the Administrator, on 7/22/24 at 3:00 p.m., indicated the facility was unable to locate a health screen for Dementia Care Director and QMA 3's personnel files. The expectations are for the Business Office Manager to ensure the employee files are complete. The Business Office Manager was new to the position and had a checklist to ensure the employee files had complete information.		• 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. A physical health screen will be completed for any employee identified to be lacking the screen in their personnel file. Any employee identified to be lacking the TB skin test will be given a 1st step and 2nd step per requirements. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The facility has initiated a partnership with NP Tiffany Smith to complete all new hire physical health screenings. TB screens will be administered at least 48 hours prior to new employee's actual start date and read prior to employee having any resident contact. A binder is kept and updated with all current TB screens and annual risk assessments. • 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 An audit will be conducted weekly of at least 3 employees files for 3	

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			months or until 100% compliance is achieved. The TB binder will be reviewed weekly during morning stand up meeting for 3 months. • By what date the systemic changes will be completed. Audits will be completed by 8/20/24	
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			

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	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 service plans were signed by the resident and/or resident representative for 5 of 7 resident records reviewed. (Resident R47, R10, R31, R9, and R44) Findings include: 1. The clinical record for Resident R47 was reviewed on 7/22/24 at 10:45 a.m. An assessment for Resident R47, dated 7/10/24, indicated an evaluation was completed in regards to activities of daily living (ADL) care, health services, social services, social history and recreational habits and history, and administrative. The assessment was signed by the Director of Nursing (DON) and the Administrator. The signature lines for the resident and/or family/responsible party were blank. 2. The clinical record for Resident R10 was reviewed on 7/22/24 at 11:00 a.m. An assessment for Resident R10, dated 4/17/24, indicated an evaluation was completed in regards to ADL care, health services, social services, social history and recreational habits and history, and administrative. The assessment was signed by the DON and the Administrator. The signature lines for the resident and/or family/responsible party were blank. 3. The clinical record for Resident R31 was reviewed on 7/22/24 at 11:10 a.m. The diagnosis included, but were not limited to, dementia.	R 0217	R 217 • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R47, R10, R31, and R44 was reviewed with resident/family member or POA and signatures obtained on 8/1/24. • 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. Audit of current Service Plans was completed on 8/7/24. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The ED and DON were re-educated on 7/22/24 by the Regional Director on the regulation for obtaining signatures on resident service plans. Process implemented by the ED and DON to ensure that signatures are obtained timely on updated service plans by contacting the families via email, phone and postal service. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	08/20/2024

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	An assessment for Resident R31, dated 5/16/24, indicated an evaluation was completed in regards to ADL care, health services, social services, social history and recreational habits and history, and administrative. The assessment was signed by the DON and the Administrator. The signature lines for the resident and/or family/responsible party were blank. 4. The clinical record for Resident R9 was reviewed on 7/22/24 at 11:20 a.m. An assessment for Resident R9, dated 5/30/24, indicated an evaluation was completed in regards to ADL care, health services, social services, social history and recreational habits and history, and administrative. The assessment was signed by the DON and the Administrator. The signature lines for the resident and/or family/responsible party were blank. 5. The clinical record for Resident R44 was reviewed on 7/22/24 at 11:30 a.m. An assessment for Resident R44, dated 4/17/24, indicated an evaluation was completed in regards to ADL care, health services, social services, social history and recreational habits and history, and administrative. The assessment was signed by the DON and the Administrator. The signature lines for the resident and/or family/responsible party were blank. An interview conducted with the Administrator, on 7/22/24 at 5:15 p.m., indicated the DON was not aware of having the resident and/or responsible party sign the service plan. A policy titled "Resident Service Plan", issue date		i.e., what quality assurance program will be put into place; and The DON is responsible for sustained compliance. DON or designee will audit resident records for service plan signatures. 5 records will be reviewed weekly for 2 weeks then, 3 records weekly for 2 weeks then 2 records weekly for 2 weeks then 1 record weekly on-going. Audits will be reviewed at stand up clinical mtg. Continued review will be based on 6 months of sustained compliance. • By what date the systemic changes will be completed. Audits will be completed by 08/20/24	

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	of May 2012, was provided by the Administrator on 7/22/24 at 5:14 p.m. The policy indicated the following, "...5. Upon initial review and subsequent changes, members of the community care team that contributed to the Resident Service Plan, including the Executive Director, Wellness Director, or designee, and the resident/legally responsible party should sign the Resident Service Plan...."			
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 adequate food storage regarding expired food in the main kitchen, cover seasonings with sealed lids, and ensure a thermometer in the holding refrigerator located in the main kitchen. This had the potential to affect all 48 residents that reside in the facility. Findings include: A tour was conducted of the main kitchen, on 7/22/24 from 10:20 a.m. to 10:35 a.m., with Cook 4. The holding refrigerator did not have a thermometer located within the refrigerator. The outside digital temperature read 37 degrees. The dry storage room contained 24 containers of different seasonings on a shelf. Four of the containers had lids that were open and exposed the seasonings. The main refrigerator had a box that contained three containers of mango salsa with a best by date of 4/22/24. There was a box that contained packaged, sealed avocados with a	R 0273	R 273 • What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The thermometer has been placed in the holding refrigerator. The lids on the 4 seasonings have been cleaned and closed properly. The 3-mango salsas have been discarded along with the avocados. • 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. Kitchen staff was in serviced on 7/31/24 on proper food storage and labeling.	08/20/2024

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	best by date, of 6/29/24, and were brown in appearance. Cook 4 was informed of the expired food and she indicated she would discard those items. Cook 4 indicated the seasonings could have the substance built up on the lid that would cause the lid not to close. Cook 4 was going to clean the lids off to see if they would close. A policy titled "Infection Control - Food Storage", issue date of September 2011, was provided by the Administrator on 7/22/24 at 5:14 p.m. The policy indicated the following, "...7. Food storage areas are to be toured three (3) times daily by the Dietary Service Director, or designee, to review compliance...10. Dry bulk foods, such as flour, sugar and cereals, are stored in metal or plastic containers with tight fitting lids...."		• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The DSM was retrained by the ED on 7/31/24 regarding the regulation for proper food storage and labeling. • 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 ED is responsible for sustained compliance. DSM or designee will audit the dry storage daily for 2 weeks then weekly for 3 weeks then on going for proper food storage and labeling. ED or designee will spot check dry storage weekly for 3 weeks then on going thereafter. • By what date the systemic changes will be completed. Audits will be completed by 8/22/24	