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	02/11/2022

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

(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. Survey dates: February 10 and 11, 2022. Facility number: 003915 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 1, 2022.	R 0000	R 000 Submission of this response and Plan of Correction is not a legal admission that the deficiency exists or, that the statement of deficiencies was correctly cited, and is not to be construed as an admission against any interest by the residence, or any employees, agents, or other individuals who drafted or who 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 the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observations, interview, and record review, the facility failed to ensure the dishwashing machine reached and maintained the appropriate wash and/or rinse temperatures and failed to maintain the dishwasher in good working condition for 6 of 6 dishwasher observations; and the facility failed to ensure general cleanliness of the floors and equipment throughout the kitchen	R 0154	R 154 Sanitation and Safety Standards What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Dishwasher temperature has been corrected to meet required	03/21/2022

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

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	and dry storage areas were maintained for 1 of 2 kitchen observations. Findings include: On 2/10/22 from 9:12 a.m., until 9:30 a.m., an initial general kitchen tour was conducted with the Head Cook 7. The dish washing area was observed. Back-splash and food debris were observed splattered on the dishwasher shelf, and surrounding walls beside the machine. The dishwasher was observed to have built up and caked on grit/grime along all the corner seals. A part of the dishwasher was a water-well that stuck out from the side. The full functionality of the dishwasher cycle could not be visualized at this time, because standing water full of bubbles and food debris filled the well and spilled over. Three cycles of a wash were observed, and the temperature did not rise above 100 degrees. Head Cook 7 indicated, it was a low temp machine which should reach 120 degree Fahrenheit (F) for a wash cycle and 150 degrees F for a rinse cycle. He did not know if the thermometer gauge was broken, or if the machine just did not reach the correct temperature. The reach-in refrigerators and freezers were observed to have smears and smudges of food or grease residue, and the handles were covered with smeared food residue. The kitchen floors throughout, were dingy and sticky so that the bottom of shoes could be felt sticking to the ground. The floors of the dry storage unit were sticky, and		specification. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents had the potential to be affected. Inservice kitchen staff on dish machine temperatures, the reporting of equipment malfunctions and protocol process in times of malfunctioning equipment. Inservice kitchen staff on kitchen cleanliness procedures. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Daily sign off logs for temperature and cleaning process implemented for kitchen staff. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place. Daily verification of temp logs and cleaning process by dietary manager implemented as a permanent procedure. By what date the systemic changes will be completed. Monday March 21st, 2022.	

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	under the metal storage shelves were littered with rubbish and debris. During an interview, on 2/10/22 at 9:25 a.m., Head Cook 7 indicated, the kitchen was, "cleaned as they go" throughout the day, but since it was just him and a dietary aid, some things were not cleaned as needed. At this time, Head Cook 7 indicated the dishwashing machine was very old, and always broken. They did the best they could and had washed when needed. Although he had worked with the same machine for many years, he was not a mechanic and did not know how to fix it when it was broken. On 2/11/22 at 11:15 a.m., a follow-up kitchen tour was conducted with the Kitchen Manager. Three more cycles of the dishwasher were observed, and the temperature gauge did not rise above 102. The water-well remained overflowing with bubbles and food debris. At this time, the Kitchen Manager explained, the purpose of the water well was to collect clean water where the wash, sanitizer, and rinse detergents were automatically dispensed, then flushed back into the machine at each designated part of the wash cycle. The water-well was clogged and had been so for quite some time, so staff should have manually pulled the plug. The plug was attached to a large metal spring that hung above the water well. It was observed to be fully clogged and caked with a dark grime. The Kitchen Manager indicated, when the well was too full it did not fill or drain properly which could create the potential of food debris or dirty water to re-cycle through which could re-contaminate the dishes. The Kitchen Manager indicated a service company for the machine was			

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	used on a regular basis, but the dishwasher was old and continued to malfunction. On 2/11/22 at 2:25 p.m., the Executive Director (ED) indicated the dishwasher was very old, and the kitchen needed a new machine. At this time, she provided a copy of the dishwasher service manual dated 5/2008. The service manual indicated, "...at the beginning of each cycle, detergent is metered into the wash water and the dishes are sprayed at high pressure ...When washing is complete a solenoid raises the stopper at the bottom of the sump, and soiled wash water drains by gravity from the machine. As water drains it washes the intake screen, thus removing food particles and soil and carrying it into a separate scrap trap. Near the end of drain, the freshwater solenoid valve opens and water flows through the pump and spray system. This pre-rinse carries away soap, soil and wash water from the dishes, cabinet spray system ...Daily Start-Up: ...fill machine with water using, 'Fill Switch.' If water temperature gauge has not reached 120 degree F. when the water level is just below overflow, drain water from the machine and continue to fill until proper temperature is attained ...Daily maintenance ...clean other food or soil from interior surfaces and clean cabinet exterior with soap and water ...clean thoroughly...." On 2/11/22 at 2:25 p.m., the ED provided a copy of current facility policy, titled, "Dining, Sanitation," dated 9/2011. The policy indicated, "It is the policy of the Dining Services Department to instruct and monitor associates in work habits and conditions which are conductive to the maintenance of a clean and sanitary environment...."			

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R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure a biohazard closet was locked and secured to restrict public access for 3 of 3 observations of biohazard closets. Findings include: On 2/10/22 at 9:50 a.m., a closet marked with a red "Biohazard" sign was observed to be unlocked. Inside, there were 4 large cardboard boxes. Three were stacked one on top of the other in the corner of the closet. The fourth box sat on the floor, the top was open, and the box was lined with a red biohazard plastic liner. The open box was full of discarded sharps boxes which were observed to be full of small needles, and other wasted biohazard materials. On 2/10/22 at 11:15 a.m., the biohazard closet remained unlocked. On 2/11/22 at 10:52 a.m., the biohazard closet remained unlocked. During an interview, on 2/11/22 at 2:28 p.m., the Executive Director (ED) indicated the biohazard closet should be locked at all times and should only be accessible to designated staff with a key. On 2/11/22 at 3:00 p.m., the ED provided a copy of current facility policy, titled, "Bio-Hazard Waste,"	R 0155	R 155 Sanitation and Safety Standards What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Bio-hazardous door remains locked with proper signage and notification. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents have the potential to be affected. Inservice all staff on Bio-Hazardous Waste. Change Bio-Hazardous storage lock to an automatic lock. Restrict access to Bio-Hazardous storage room to authorized personnel only. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	03/21/2022

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	dated 5/2012. The policy indicated, "...storage areas of biomedical waste shall have restricted access from the general public and be accessible only to authorized personnel through the use of locks, signs, and/or location...."		recur. New automatic door lock will ensure door locks automatically after exit. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place. Confirmation of Bio-Hazard door lock to be completed by med pass associate every shift time three months. By what date the systemic changes will be completed. March 21st, 2022.	
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 observations, interview, and record review, the facility failed to ensure the appropriate use of eggs to prevent the potential of food borne illness for 2 of 2 kitchen observations, and the facility failed to ensure identifying labels were placed on food in the refrigerator for 1 of 2 kitchen observations. Findings include: 1. On 2/10/22 from 9:12 a.m., until 9:30 a.m., an initial general kitchen tour was conducted with Head Cook 7. A single, flat, carton of eggs was observed in the refrigerator. There was no original package to	R 0273	R 273 Food and Nutritional Services What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All non-pasteurized eggs have been discarded. Pasteuriz ed eggs are now in use for all residents and remain in original container. All food has been audited for dates and labels.	03/21/2022

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	identify when the eggs were received, their use by date, or if the eggs were pasteurized. One egg was observed to be cracked. During an interview, on 2/10/22 at 9:23 a.m., Head Cook 7 indicated, he believed the facility only purchased pasteurized eggs, so the ones in the refrigerator should be pasteurized. At this time, he indicated there were several residents who like over-easy eggs, and he often prepared over-easy eggs. On 2/11/22 at 11:15 a.m., a follow-up kitchen tour was conducted with the Kitchen Manager. At this time, the Kitchen Manager observed the carton of eggs in the refrigerator and indicated the original package must have been discarded. There was no way to identify when the eggs had been received, when they should be used by, and if they were pasteurized. During an interview, on 2/11/22 at 2:22 p.m., the Executive Director (ED) indicated the facility should only use pasteurized eggs, especially if they were not fully cooked, for example, prepared over-easy. The ED indicated, the facility usually only purchased pasteurized eggs, but for the past several months, the supply had been low so unpasteurized eggs had been ordered instead. On 2/11/22 at 2:25 p.m., the ED provided a copy of a current facility policy, titled, "Dining: Infection Control- Food Preparation & Service," dated 9/2011. The policy indicated, "...It is the policy of the Dining Service Department to prepare and serve all foods according to the procedures below in order to prevent the transmission of disease-carrying organisms ...Whole or liquid pasteurized eggs are the best choice for all egg preparations...."		How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents have the potential to be affected. Inservice all staff on the use of only pasteurized eggs. Inservice all staff on dates and labels of all food. Inservice all staff on storing eggs in original container. Implemented Egg ordering/storage and dates and labels to daily sign off. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Updated responsibilities and daily task sheets to include egg use, storage and dates and labels. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place. Daily confirmation of pasteurized eggs, original egg container and dates and labels to be verified daily by the Dietary Manager or Cook times three months. By what date the systemic	

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	2. On 2/10/22 from 9:12 a.m., until 9:30 a.m., an initial general kitchen tour was conducted with Head Cook 7. Inside the refrigerator the following was observed: a. An opened packet of sliced turkey. There was no label to indicated when the packed was opened and when it should have been used by. b. A whole turkey breast wrapped in saranwrap. There was no label to indicated when the packed was opened and when it should have been used by. c. A large plastic container which contained shredded cheese. A label was observed with an "open-date" of 1/24/22, but there was no use by date. d. An opened plastic bag of prepared salad. There was no label to indicated when the package was opened and when it should have been used by. Head Cook 7 indicated all foods should have been labeled with open and use by dates. On 2/11/22 at 1:20 p.m., the ED provided a copy of current facility policy, titled, "Dining- Infection Control- Food Storage," dated 9/2011. The policy indicated, "...It is the policy of the Dining Service Department to prepare and serve all foods according to the procedures below in order to prevent the transmission of disease-carrying organisms ...meats, poultry, seafood should be stored in the same areas and boxes or cryovac, and labeled as to when the item is scheduled for use...."		changes will be completed. March 21st, 2022.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall:			

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	(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 interview and record review, the facility failed to ensure pharmacy reviews were completed every 60 days for 1 of 7 residents reviewed for pharmacy reviews (Resident 8). Findings include: On 2/10/22 at 10:45 a.m., Resident 8's record was reviewed. His diagnoses included, but were not limited to, metastatic (secondary malignant growths) kidney disease, cognitive impairment (trouble remembering, learning, concentrating or making daily decisions), and dementia (memory disorder, personality changes and impaired reasoning). A pharmacy review in Resident 8's chart indicated his medications were reviewed on 2/10/22 by Pharmacist 10. The facility was unable to provide pharmacy medication reviews for October and December 2021. During an interview, on 2/11/22 at 1:27 p.m., the Director of Nursing (DON) indicated she called the facility's pharmacy. Pharmacist 10 told her since they were an Assisted Living (AL) facility,	R 0298	R 298 Pharmaceutical Services What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Notification to pharmaceutical consultant for resident medication review. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents have the potential to be affected. Inservice key nursing personnel on pharmaceutical review requirements. Consult with Pharmaceutical provider for compliance needs. Arrange consultant pharmaceutical review of all residents. What measures will be put into	03/21/2022

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	the pharmacist did not do medication reviews every 60 days. She was concerned about his statement since it was not consistent with residential regulations. She had asked for the medication reviews for the last 6 months for Resident 8. Pharmacist 10 only provided one pharmacy review, dated 2/11//22. A pharmacy review document, titled, "Grandview Pharmacy," dated 2/11/22, was provided by the Executive Director (ED), on 2/11/22 at 2:07 p.m. A review of the pharmacy review, PharmD 10 indicated, " ...Upon review of all medication on the patient's profile (dating 10/1/21 to present), there were no clinically significant medication issues found ...." A current policy, titled, "Consultant Pharmacist Agreement, Schedule 1-A, Required Consultant Services" dated 5/1/21, was provided by the ED, on 2/11/22 at 2:30 p.m. A review of the agreement, indicated, " ...Consultant shall assist Facility in determining that residents' medication therapy is necessary and appropriate ...."		place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Implementation of workflow sheet to confirm pharmaceutical review and Wellness Director/PCP involvement. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place. Executive Director to review workflow sheet times 3 pharmaceutical review visits. By what date the systemic changes will be completed. March 21st, 2022	
R 0383 Bldg. 00	410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs.			

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	(D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview, the facility failed to ensure a resident with a serious mental health illness had a care plan in place and in conjunction with a mental health provider for 1 of 1 resident reviewed for a serious mental health diagnoses (Resident 16). Findings include: On 2/10/22 at 1:45 p.m., Resident 16's medical record was reviewed. She had a current diagnosis which included, but was not limited to, schizophrenia with chronic paranoia and delusional disorder. She had a current physician order, dated 6/3/21, for Aripiprazole (an antipsychotic medication) 5 mg (milligrams) to be given every morning for psychosis. The most recent psychiatric progress note was dated 9/18/19 and indicated, "...recommendations for attending physician: 1. Patient's Abilify [an antipsychotic medication] was discontinued since prior encounter in April 2019. Unfortunately, patient has become increasingly psychotic with subsequent distress. In view of increased psychosis, you may wish to consider the medical appropriates of resuming prior dose of Abilify... please add diagnosis of delusional disorder... will follow up as appropriate...." Resident 16 medical record lacked documentation of a plan/goal/schedule for psychiatric follow up. The most recent care plan for Resident 16 was dated 11/22/21. The care plan lacked	R 0383	R 383 Mental Health Screening What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? For the affected resident, the PCP was notified for a scheduled visit. Care plan has been updated for affected resident to reflect mental health provider name and contact information. How the facility will identify other residents having the potential to be affected by the same practice and what corrective action will be taken. Resident's chart audit to identify further deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Implementation of admission check list to identify and care plan for mental illness. How the corrective action will be monitored to ensure the deficient practice will not recur, I.e., what quality assurance program will be put into place. Executive Director will audit each new admission for mental illness care planning times three months. By what date the systemic	03/21/2022

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	documentation of Resident 16's mental illness, her psychiatric care provider, and/or how to monitor/document for signs and symptoms of her condition. During an interview on 2/11/22 at 2:20 p.m., the Executive Director (ED) indicated, Resident 16 would only be seen by her psychiatric provider on an as needed basis for an increase of behaviors or change in mental health status. Resident 16 was pleasant and did not have any current behaviors, but the medical record and care plan should reflect who her psychiatric provider was and how to get in contact with them if needed. At this time, the ED indicated the facility followed state rules, and any resident who received Medicaid services should have been screened and care planned for those mental health conditions.		changes will be completed. March 21st, 2022	