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<td>R 0000</td>
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<td>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 residents or any employees agents or other individuals who drafted or who maybe 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.</td>
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<td>R 0092</td>
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<td>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (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: (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</td>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.
Based on interview and record review, the facility failed to conduct quarterly, 3rd shift fire drills for 54 of 54 residents in the facility.

Findings include:

The fire drill binder was provided by the Administrator on 5/20/19 at 3:04 p.m. It included three 3rd shift fire drill reports conducted 6/20/18, 1/30/19, and 4/27/19. There were no 3rd shift fire drills for the 3rd and 4th quarters of 2018.

An interview was conducted with the Maintenance Director on 5/21/19 at 9:08 a.m. She indicated she looked everywhere, but could not find anymore fire drill reports.

The Fire Drills policy was provided by the Administrator on 5/21/19 at 11:17 a.m. It read, "Every shift should participate at least once annually or per State requirements."
### Statement of Deficiencies and Plan of Correction

**Identification Number**

- **A. Building**: 00
- **B. Wing**: 00

**Date Survey Completed**

- 05/21/2019

**Name of Provider or Supplier**

- Bloom at German Church

**Address**

- 2250 Harvest Moon Dr
- Indianapolis, IN 46229

#### Summary Statement of Deficiency

**Prefix**

- R 0240

**Tag**

- Bldg. 00

**Regulatory or LSC Identifying Information**

- 410 IAC 16.2-5-4(d)

**Health Services - Deficiency**

- (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.

Based on interview and record review, the facility failed to notify the physician of a 7 pound weight gain in 24 hours and a 5 pound weight gain in 24 hours, as ordered, for 1 of 5 residents whose clinical records were reviewed. (Resident 1)

**Findings Include:**

- The clinical record for Resident 1 was reviewed on 5/20/19 at 1:55 p.m. The diagnoses for Resident 1 included, but were not limited to, congestive heart failure and edema.

- The May, 2019 physician's orders for Resident 1 read, "Check weight daily. Call [name and phone number of physician] if gains 3 pounds in 24 hours.

---

**Provider's Plan of Correction**

- **Prefix**
  - R 0240
- **Tag**
  - Bldg. 00

**Changes the facility will make to ensure that the deficient practice does not recur:**

- All staff will be in-serviced on Fire Drill Policy and Procedure on June 18th, 2019.

**How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:**

- Executive Director or designee will conduct Fire Drill Log audits weekly for two months and bi-weekly for the next 10 months.

**By what date will the systemic changes be completed:**

- June 26th, 2019

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**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**

- Resident 1 Physicians orders have been reviewed. Physician was notified of the weight gain for resident 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 with the order for

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*State Form Event ID: 83J011  Facility ID: 003916  If continuation sheet*
The May, 2019 MAR (medication administration record) for Resident 1 indicated the following weights in pounds on the following days:

5/9/19 - 172
5/10/19 - 179
5/14/19 - 174
5/15/19 - 179

There was no information in the clinical record to indicate Resident 1's physician was notified of the 7 pound weight gain on 5/10/19 and the 5 pound weight gain on 5/15/19.

An interview was conducted with the Wellness Director on 5/20/19 at 2:08 p.m. She indicated the physician was not notified of Resident 1's weight gains on 5/10/19 and 5/15/19, but should have been.

hours or 5 pounds in 1 week," effective 5/4/18.

daily weights have the potential to be affected. All weights have been reviewed and physicians have been notified per orders.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

All licensed nursing staff will be educated regarding daily weights and weight gain and notifying the physician for the weight gains. This will be conducted by June 13th, 2019.

How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:

The Wellness Director or designee will monitor all daily checks of weight gains. The Wellness Director or designee will review and update medical records daily.

By what date will the systemic changes will be completed:

June 26th, 2019

410 IAC 16.2-5-4(e)(6)
Health Services - Deficiency

(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating
the time and date of the contact.

Based on interview and record review, the facility failed to document a nurse's authorization for a QMA (Qualified Medication Aide) to administer 2 PRN (as needed) medications, when the nurse was not on the premises, for 1 of 5 residents whose clinical records were reviewed. (Resident 37)

Findings include:

The clinical record for Resident 37 was reviewed on 5/20/19 at 2:15 p.m. The diagnoses for Resident 37 included, but were not limited to, diabetic neuropathy and osteoarthritis.

The May, 2019 physician's orders for Resident 37 indicated for a 7.5-325 mg tablet of Hydrocodone/APAP to be given every 12 hours as needed for episodes of discomfort, effective 4/29/19. The orders indicated for Biofreeze Gel 4% to be applied to her left ankle every 6 hours as needed for episodes of discomfort, effective 4/29/19.

The May, 2019 MAR (medication administration record) indicated the PRN Biofreeze was administered by QMA 3 twice on 5/3/19 at 4:22 a.m. and 5:53 a.m.. The MAR indicated the PRN Hydrocodone/APAP was administered by QMA 3 on 5/3/19 at 4:22 a.m.

The May, 2019 nurse's notes did not reference contact with a nurse for the 5/3/19 Biofreeze applications and Hydrocodone/APAP administration.

An interview was conducted with the Wellness Director on 5/21/19 at 10:00 a.m. She indicated she gave authorization, over the phone, to QMA 3 for the PRN Biofreeze applications and PRN

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<td>What corrective actions will be accomplished for those residents found to have been affected by the defective practice:</td>
<td>What corrective action will be taken:</td>
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<td>Resident 37 receives as needed medications for her general discomfort and anxiety. Prior to administering as needed medication the QMA will notify the licensed nurse for authorization to administer the medication. After receiving the authorization from the licensed nurse, the QMA will document all actions taken on the MAR. In the event there is no licensed nurse on the premises the Wellness Director will be contacted for approval.</td>
<td>All residents receiving as needed medications have the potential to be affected. Prior to administering as needed medications the QMA will notify the licensed nurse for authorization to administer the medication. After receiving the authorization, the QMA will document all actions taken on the MAR. In the event there is no licensed nurse on the premises the Wellness Director will be contacted for approval.</td>
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| R 0273  | Hydrocodone administration on 5/3/19. She stated, "We're supposed to sign the narc [narcotic] sheet for the Hydrocodone and make a progress note for the Biofreeze. I gave authorization. I just didn't sign off. I remember he called me about the Biofreeze and I should have signed off, when I came in in the morning." | 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. | 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. | place or what systematic changes the facility will make to ensure that the deficient practice does not recur:  
Each QMA employed at the facility will receive re-education on June 25th, 2019 concerning the appropriate way to administer as needed medications. Prior to administering as needed medications the QMA will notify the Licensed Nurse. After receiving the authorization from a Licensed Nurse, the QMA will document all actions taken on the MAR. In the event there is no licensed nurse on the premises the Wellness Director will be contacted for approval.  
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 as needed medication given the prior 24 hours daily for 4 weeks, and then weekly for 3 quarters.  
By what dated will the systemic changes be completed:  
June 26th, 2019 | |
Based on observation and interview, the facility failed to ensure food was stored and served under sanitary conditions 1 of 1 kitchens. (The Main Kitchen)

Findings include:

1. During the initial tour of the kitchen on 5/20/19 at 12:31 p.m. with the Executive Chef (EC) the following was observed:

   a. In the freezer, an opened box of Eggo waffles with the inner plastic bag ripped open leaving the waffles inside open to the air.

   b. In the refrigerator, a pan of red jello was not covered thus leaving the jello open to the air, unlabeled and undated.

   c. A Majic Cup with broken packaging leaving the contents open to the air in the refrigerator.

   d. An opened plastic package of sliced ham did not have an opened date in the refrigerator.

   e. An opened jug of milk did not have an opened date in the refrigerator.

   f. A black pitcher was in the refrigerator without a label and without a date was identified by EC as milk.

   g. A plastic baggie containing an opened package of cream cheese was not labeled or dated in the refrigerator.

In an interview with EC at the same time, she indicated previously opened items needed to be labeled, dated and securely closed as to prevent contamination.

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

All residents residing at the facility and utilizing the dining services have the potential to be affected. All food and drinks in the freezer and refrigerator have been dated and labeled with open dates and discard dates. Staff was educated on sanitation and safe food handling standards.

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 and utilizing the dining services have the potential to be affected. All food and drinks in the freezer and refrigerator have been dated and labeled with open dates and discard dates. Staff was educated on sanitation and safe food handling standards.

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:

All Staff working in the affected area will be educated on June 25th, 2019 on labeling of food and drinks and the food handling standards.
2. During the lunch service on 5/21/19 at 12:05 p.m. with the EC the following was observed:

   a. The Activities Program Director placed her bare thumb on the top of plate when she picked up a plate of food to serve to a resident.

   b. The DON placed her bare thumb on the top of the plate when she picked up a plate of food to serve to a resident.

   In an interview with EC at that time she indicated the tops of the plates, where residents food may touch, should not be touched with bare hands. The EC then immediately educated staff on the correct way to pick up plates of food.

   c. The ED picked up a butter packet, out of a plastic bin containing many butter packets, with her bare hand then placed the packet of butter onto the lunch plate. The butter packet was touching the food on the plate.

   Interview with the EC at that time, indicated the butter packets should not be placed on the plate and should not have touched the food on the plate.

   The Retail Food Establishment Sanitation Requirements state, "Sec. 144. (a) Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants."

   An Infection Control-Food Storage policy received on 5/20/19 from EC states, "...16. Leftovers are placed in containers that allow chilling in a short period of time. They are be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:

   The Executive Director or her designee will educate the staff on safe food handling standards.

   By what date the systemic changes will be completed.

   June 26th, 2019

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State Form Event ID: 83J011  Facility ID: 003916  If continuation sheet  Page 8 of 12
R 0301
Bldg. 00

**Summary Statement of Deficiency**

410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency

(5) Labeling of prescription drugs shall include the following:

(A) Resident's full name.
(B) Physician's name.
(C) Prescription number.
(D) Name and strength of the drug.
(E) Directions for use.
(F) Date of issue and expiration date (when applicable).
(G) Name and address of the pharmacy that filled the prescription.

If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.

Based on observation and interview the facility failed to assure insulin pens were labeled with resident's full name, physicians name, and prescription number for 2 of 51 residents reviewed for medication storage (Resident 37 and 42).

Findings include:

1. The clinical record for Resident 37 was reviewed on 5/21/2019 at 11:45 a.m. The diagnosis for Resident 37 included, but were not limited to, diabetes.

On 5/22/2019 at 11:30 a.m., the refrigerator in the medication room was observed. The refrigerator contained a Levamir (type of insulin) flex pen. The flex pen was opened and missing the lid of the pen. It had an unreadable name written on it with black marker. The physicians name and prescription number were not present on the flex pen.

**Provider's Plan of Correction**

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

Resident 37 has a diagnosis of diabetes and has a physician's order for a Levamir Flex Pen. Resident 37 Levamir Flex Pen is properly labeled with name, physicians name and prescription number on it.

Resident 42 has a diagnosis of diabetes and has a physician's order for a Lantus Flex Pen. The Lantus Flex Pen is properly labeled with resident's name, Physicians name and prescription number.

How the facility will identify other residents having the
During an interview on 5/21/2019 at 11:30 a.m., the D.W. (Director of Wellness) indicated the Levamir flex pen belonged to Resident 37. She indicated there was not a pharmacy label on the pen.

2. The clinical record for Resident 42 was reviewed on 5/21/2019 at 11:45 a.m. The diagnosis for Resident 42 included, but were not limited to, diabetes.

On 5/22/2019 at 11:30 a.m., the refrigerator in the medication room was observed. The refrigerator contained a Lantus (type of insulin) flex pen. The flex pen was opened and missing the lid of the pen. It had a worn pharmacy label on it. The label did not contain the full name of Resident 42, the physicians name or the prescription number.

During an interview on 5/21/2019 at 11:30 a.m., the D.W. indicated the Lantus flex pen belonged to Resident 42. She indicated the pharmacy label did not contain Resident 42's full name.

On 5/21/2019 at 12:01 p.m., the D.W. provided the Medication Storage (Central Location) Policy, dated May 2012. The policy read as follows: "Policy: Bloom communities will have a designated and secured medicine storage room that may only be accessed by the Wellness Director, a Nurse supervisor or the Executive Director. Procedure: 1. Medications shall be stored in the container which is supplied by the pharmacy. These medications containers shall retain their original pharmacist label..."

Potential to be affected by the same deficient practice and what corrective action will be taken:

All residents who have medication administered by facility staff have the potential to be affected. Upon receipt of all resident medication the licensed nurse will review for proper labeling of medication to include resident name, physician name and prescription.

What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur:

On June 25th, 2019 all licensed nurses and QMA will be educated on the proper labeling and storage of medication to include insulin pens.

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:

The Wellness Director or designee will review all insulin pens and medications daily for two weeks to insure they are properly labeled and stored correctly then weekly for the following 48 weeks.

By what date will the systemic changes be completed:

June 26th, 2019
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<td>2250 HARVEST MOON DR</td>
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**Chest X-ray Completed No More Than Six (6) Months Prior to Admission:**

Based on interview and record review, the facility failed to ensure a resident had a chest x-ray completed no more than 6 months prior to admission for 1 resident reviewed of 2 residents admitted to the facility in the past 30 days. (Resident 37)

**Findings Include:**

The clinical record for Resident 37 was reviewed on 5/20/19 at 2:15 p.m. The diagnoses for Resident 37 included, but were not limited to, Parkinson's disease. She was admitted to the facility on 4/29/19.

The clinical record for Resident 37 included a chest x-ray dated 3/17/18. No chest x-ray within 6 months of Resident 37's 4/29/19 admission date could be located.

An interview was conducted with the Wellness Director on 5/21/19 at 9:42 a.m. She indicated the facility did not have a chest x-ray within 6 months of Resident 37's admission, because she incorrectly thought Resident 37's 3/17/18 chest x-ray was dated 3/17/19.

The TB (Tuberculin) Testing policy was provided by the Wellness Director on 5/21/19 at 11:18 a.m. It did not reference chest x-rays upon admission.

**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**

Resident number 37 had received a chest X-Ray on 4/08/19. The results of the X-Ray were not in the resident's record at time of survey. The report is now located in the resident's record.

**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. All residents residing at the facility have chest x ray located in the resident record per the Admission Policy and Procedure will be followed.

**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 Executive Director or designee will ensure all requirements are met and documents placed in residents medical record upon admission to include a diagnostic chest x ray.

**How the corrective actions will be monitored to ensure the deficient practice will not recur:**

Resident number 37 had received a chest X-Ray on 4/08/19. The results of the X-Ray were not in the resident's record at time of survey. The report is now located in the resident's record.

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:

Resident number 37 had received a chest X-Ray on 4/08/19. The results of the X-Ray were not in the resident's record at time of survey. The report is now located in the resident's record.

**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**

Resident number 37 had received a chest X-Ray on 4/08/19. The results of the X-Ray were not in the resident's record at time of survey. The report is now located in the resident's record.

**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:**

Resident number 37 had received a chest X-Ray on 4/08/19. The results of the X-Ray were not in the resident's record at time of survey. The report is now located in the resident's record.
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** BLOOM AT GERMAN CHURCH

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 2250 HARVEST MOON DR, INDIANAPOLIS, IN 46229

**ID**

**PREFIX**

**TAG**

**SUMMARY STATEMENT OF DEFICIENCY**

I.E. **what quality assurance program will be put into place:**

The Executive Director or designee will review all admission paperwork 24 hours prior to move in monthly for 12 months.

By what date will the systemic changes will be completed:

June 26th, 2019

**ID**

**PREFIX**

**TAG**

**DATE**

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**State Form Event ID:** 83J011 **Facility ID:** 003916 **If continuation sheet** Page 12 of 12