STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT GERMAN CHURCH	2250 HARVEST MOON DR, INDIANAPOLIS, , 46229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 472410. Intake 472410- State deficiencies related to the allegations are cited at R0091, R0216, R0240, R0273. Survey dates: October 7 and 8th, 2026 Facility number: 003916 Residential Census: 54 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed October 13, 2026.	R 0000	**R 0091** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The controlled substance destruction and discharge logs for Resident K were audited for completeness. Because Resident K is deceased, no further direct corrective action is required for this resident. **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:** A 100% audit of all current resident charts and closed records involving controlled substance destructions or discharges over the past 30 days was completed by the Executive Director to ensure dual-licensure signatures were	

			properly executed. No other discrepancies were found. **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's "Medication Disposition of Controlled Drugs (In-House Destruction)" policy was reviewed. All licensed nurses and Qualified Medication Aides (QMAs) will receive re-education on the mandatory requirement for two licensed staff members to simultaneously witness, sign, and date all controlled substance destructions, returns, or discharges. Inservice date scheduled for November 12, 2026. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):**	

			The Director of Nursing or designee will audit 100% of controlled substance destruction and disposition logs weekly, beginning week of October 19, 2026, for three months, then monthly thereafter. Audit findings and compliance will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months to ensure continued compliance. **By what date will the systemic changes be completed:** Friday, October 30, 2026 **R 0117** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Immediate scheduling adjustments were completed for the affected dates (October 3, 4, 6, and 7, 2026) to verify that staff members on duty possessed current first aid and CPR certifications. **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:** A 100% audit of all current staff scheduling records and	

			CPR/First Aid certification files was completed by the Business Office Manager to ensure continuous 24/7 coverage of at least one certified, awake staff member is maintained across all shifts. **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 community will follow state regulations requiring at least one associate on each shift to maintain current CPR and First Aid certifications. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Executive Director or Business Office Manager will review the master scheduling and certification audit weekly, starting the week of October 19, 2026, for three months, and monthly thereafter, to ensure unbroken compliance. Findings will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	

			R 0216 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A comprehensive self-administration of medication assessment was immediately completed for Resident F by the Executive Director, verified with the physician, and documented in a nursing note. **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:** A 100% audit of all current resident records was completed by the Executive Director or designee to ensure that every resident self-administering medications has a current, documented self-administration assessment and monthly nursing verification notes. **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 "Medications - Self Administration" policy was reviewed. Nursing staff will receive re-education on the	

			requirement to perform and document formal self-administration assessments before a resident is permitted to manage their own medications, alongside mandatory monthly nursing progress note verifications. Inservice is scheduled for November 12, 2026. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Wellness Director or designee will audit new medication self-administration orders and monthly verifications weekly, starting the week of October 19, 2026, for three months, then monthly thereafter. Findings will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026 **R 0240** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Medications for Residents D, N, C, E, H, and M were immediately reordered,	

			expedited, and verified as delivered and administered. **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:** A 100% audit of all current residents receiving medication administration assistance from staff was completed to check for missing doses or delayed refills. All outstanding pharmacy orders were immediately addressed and resolved. **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 re-established strict communication pathways with both preferred and outside pharmacies regarding refill timelines, tracking, and delivery confirmations. Nursing staff will receive re-education on the "Medication Refills" policy, scheduled for November 11, 2026, specifically regarding the protocol to utilize backup supplies or reorder through the preferred pharmacy if an outside pharmacy fails to deliver within two days. **How the corrective action(s) will be monitored to ensure**	

			the deficient practice will not recur (Quality Assurance): The Wellness Director or designee will review all Medication Administration Record (MAR) "medication held/unavailable" entries daily Monday through Friday, starting the week of October 19, 2026, for three months. Audit findings and refill compliance will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026 **R 0273** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The air ventilation vents in the kitchen food preparation area and the dishwashing room are scheduled to be cleaned and sanitized thoroughly by a professional outside source. **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:**	

			A 100% inspection of all kitchen and dietary department ceilings, vents, and exhaust systems was completed to ensure complete cleanliness and compliance with sanitary standards across all food preparation and serving areas. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** A specialized third-party commercial cleaning contractor was secured to handle routine heavy-duty ceiling vent and exhaust maintenance. The "Daily Closing Checklist" was updated to include a weekly visual check of ceiling vents by the Dietary Manager. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Dietary Manager or Executive Director will inspect kitchen ventilation cleanliness weekly for three months, then monthly thereafter. Findings will be logged on the Daily Closing Checklist and reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:**	

			Friday, October 30, 2026 **R 0299** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The consultant pharmacist recommendations and prescriber notes for Resident C (dated August 12, 2026, and October 6, 2026) were printed, reviewed, re-submitted to the attending physician, and successfully resolved and documented in Resident C's clinical 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:** A 100% audit of all active consultant pharmacist Medication Regimen Review (MRR) reports from the past 60 days was completed to ensure every recommendation received a documented prescriber response and clinical follow-through.	

			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 community will follow the Consultant Pharmacist Retainer Agreement implemented and duly executed between Bloom at German Church and Williams Bros. Pharmacy to ensure medication regimen reviews are conducted, and any identified recommendations or concerns are communicated and addressed in accordance with the agreement. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Wellness Director or designee will audit 100% of consultant pharmacist review reports and follow-up logs weekly, starting the week of October 19, 2026, for three months, and monthly thereafter. Audit findings and compliance will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	

R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure that controlled substances were destroyed by two licensed staff members, as required, for 1 of 3 residents reviewed for death/discharge. Findings include: The clinical record for Resident K was reviewed on 10/8/2026 at 1:05 PM. The medical diagnoses included, but were not limited to, cancer and a brain aneurysm. A physician order dated, 5/26/2026, indicated Resident K was to receive tramadol, a controlled substance commonly	R 0091	**R 0091** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The controlled substance destruction and discharge logs for Resident K were audited for completeness. Because Resident K is deceased, no further direct corrective action is required for this resident. **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:** A 100% audit of all current resident charts and closed records involving controlled substance destructions or discharges over the past 30 days was completed by the Executive Director to ensure dual-licensure signatures were properly executed. No other discrepancies were found. **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's "Medication Disposition of Controlled Drugs (In-House Destruction)" policy	10/30/2026

	used to treat pain, every 6 hours as needed for pain. A physician order, dated 5/14/2026, indicated Resident K was to receive clonazepam, a controlled substance commonly used to treat anxiety, nightly. A nursing progress note, dated 6/14/2026, indicated staff found Resident K on the floor after hearing a sound coming from the resident 's room. Resident K was transferred emergently to a local hospital. A nursing progress note, dated 6/16/2026, indicated Resident K passed away while at the hospital. A controlled substance record for tramadol indicated that 20 tablets were filled on 5/26/2026. The Director of Nursing signed on 5/26/2026 that 20 tablets were flushed. On the same record, the Director of Nursing signed that 18 tablets were discharged with the resident on 6/16/2026, with a handwritten note reading "RHC," a common abbreviation for "respirations have ceased." No second licensed staff member signed for the disposition of the medication. A controlled substance record for clonazepam indicated that 30 tablets were filled on 5/8/2026. The Director of		was reviewed. All licensed nurses and Qualified Medication Aides (QMAs) will receive re-education on the mandatory requirement for two licensed staff members to simultaneously witness, sign, and date all controlled substance destructions, returns, or discharges. Inservice date scheduled for November 12, 2026. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Director of Nursing or designee will audit 100% of controlled substance destruction and disposition logs weekly, beginning week of October 19, 2026, for three months, then monthly thereafter. Audit findings and compliance will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months to ensure continued compliance. **By what date will the systemic changes be completed:** Friday, October 30, 2026	

	Nursing signed, without a date, that 1 tablet was flushed. On the same form, the Director of Nursing signed that 1 tablet was discharged with the resident on 6/16/2026, with a handwritten note of "RHC." No second licensed staff member signed for the disposition of the medication. During an interview, on 10/8/2026 at 1:55 PM, the Executive Director stated that the Director of Nursing was the only signature observed under the disposition of remaining doses on both controlled substance logs. The Executive Director indicated that it was the facility's expectation to follow their policies in adherence with state guidelines. A policy titled, "Medication Disposition of Controlled Drugs (In-House Destruction)", was provided by the Markerting Director. The policy indicated that two designated staff members will sign the form to attest to the disposition of controlled substances. This Residential tag relates to relates to Intake 472410.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in	R 0117	**R 0117** **What corrective action(s) will be accomplished for those**	10/30/2026

	number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure at least one awake staff member with current first aid certification was present at all times for 4 of 7 days reviewed. Findings include: The CPR/First Aid worksheet, completed by the facility and provided by the Business Office		**residents found to have been affected by the deficient practice:** Immediate scheduling adjustments were completed for the affected dates (October 3, 4, 6, and 7, 2026) to verify that staff members on duty possessed current first aid and CPR certifications. **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:** A 100% audit of all current staff scheduling records and CPR/First Aid certification files was completed by the Business Office Manager to ensure continuous 24/7 coverage of at least one certified, awake staff member is maintained across all shifts. **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 community will follow state regulations requiring at least one associate on each shift to maintain current CPR and First Aid certifications. **How the corrective action(s) will be monitored to ensure**	

	Manager on 10/8/2026 at 11:30 AM, indicated missing documentation of first aid-certified coverage on 10/3/2026, 10/4/2026, 10/6/2026, and 10/7/2026. During an interview with the Business Office Manager on 10/8/2026 at 3:15 PM, she stated she maintained records of CPR, first aid, and licensure for facility staff. The Business Office Manager verified she could not locate documentation demonstrating first aid-certified staff coverage for 4 of the 7 days reviewed. During an interview on 10/8/2026 at 3:20 PM, the Business Office Manager stated she had spoken with the facility's corporate support and was informed that the facility did not have a policy specific to first aid coverage, but would defer to state regulatory requirements.		**the deficient practice will not recur (Quality Assurance):** The Executive Director or Business Office Manager will review the master scheduling and certification audit weekly, starting the week of October 19, 2026, for three months, and monthly thereafter, to ensure unbroken compliance. Findings will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (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.	R 0216	**R 0216** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A comprehensive self-administration of medication assessment was immediately completed for Resident F by the	10/30/2026

	(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 writing and kept in the facility. Based on interview and record review, the facility failed to ensure a self-administration of medication assessment was completed for 1 of 5 residents reviewed for medication management (Resident F). Findings include: The clinical record for Resident F was reviewed on 10/8/2026 at 11:30 AM. The medical diagnoses included, but were not limited to, pain. The individualized service plan dated, 7/23/2026, indicated Resident F either did not receive medications or self-managed medications. The medication administration record for Resident F for October 2026 indicated Resident F self-administered multiple medications. No progress notes dated,		Executive Director, verified with the physician, and documented in a nursing note. **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:** A 100% audit of all current resident records was completed by the Executive Director or designee to ensure that every resident self-administering medications has a current, documented self-administration assessment and monthly nursing verification notes. **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 "Medications - Self Administration" policy was reviewed. Nursing staff will receive re-education on the requirement to perform and document formal self-administration assessments before a resident is permitted to manage their own medications, alongside mandatory monthly nursing progress note verifications. Inservice is scheduled for November 12, 2026. **How the corrective action(s)**	

	7/14/2026 through 10/8/2026, addressed Resident F's self-administration of medication ability. During an interview on 10/7/2026 at 11:45 AM, LPN 4 stated that Resident F self-administered his medications. During an interview on 10/8/2026 at 2:15 PM, the Executive Director stated the facility could not locate a self-administration of medication assessment for Resident F. A policy titled, "Medications - Self Administration", was provided by the Marketing Director on 10/8/2026 at 2:45 PM. The policy indicated that residents who demonstrate to the Wellness Director that they are capable of following directions for medication and who have been assessed using a recognized self-administration tool may qualify for self-administration of medications. The Wellness Director then reports to the physician to obtain the physician ' s final determination. Nursing staff are required to verify the resident ' s ability to self-administer monthly and document this verification in a nursing note.		**will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Wellness Director or designee will audit new medication self-administration orders and monthly verifications weekly, starting the week of October 19, 2026, for three months, then monthly thereafter. Findings will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	

	This Residential tag relates to relates to Intake 472410.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. 4. The clinical record for Resident E was reviewed on 10/8/2026 at 11:05 AM. The medical diagnoses included, but were not limited to, cancer and seizures. An individualized service plan dated 7/16/2026 indicated Resident E did not receive medications or manage her own medications. The same service plan indicated Resident E required medications to be passed once a day for 5-10 medications. During an observation on 10/8/2026 at 11:30 AM, LPN 4 was observed passing medications to Resident E.	R 0240	**R 0240** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Medications for Residents D, N, C, E, H, and M were immediately reordered, expedited, and verified as delivered and administered. **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:** A 100% audit of all current residents receiving medication administration assistance from staff was completed to check for missing doses or delayed refills. All outstanding pharmacy orders were immediately addressed and resolved. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**	10/30/2026

	The September 2026 Medication Administration Record indicated staff were administering Resident E ' s medications. Two administrations were noted as held due to medications not being available. The October 2026 Medication Administration Record indicated staff were administering Resident E ' s medications. One administration was noted as held due to medication not being available. 5. The clinical record for Resident H was reviewed on 10/8/2026 at 12:10 PM. The medical diagnoses included, but were not limited to, dementia and visual impairments. An individualized service plan dated 9/23/2026 indicated Resident H required assistance with medication management. Resident H utilized 11 or more medications, required injections three times a day, and had medications passed three times a day. The September 2026 Medication Administration Record indicated staff were administering Resident H ' s medications. One administration was noted as held due to medication not being available. 6. The clinical record for		The facility re-established strict communication pathways with both preferred and outside pharmacies regarding refill timelines, tracking, and delivery confirmations. Nursing staff will receive re-education on the "Medication Refills" policy, scheduled for November 11, 2026, specifically regarding the protocol to utilize backup supplies or reorder through the preferred pharmacy if an outside pharmacy fails to deliver within two days. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Wellness Director or designee will review all Medication Administration Record (MAR) "medication held/unavailable" entries daily Monday through Friday, starting the week of October 19, 2026, for three months. Audit findings and refill compliance will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	

	Resident M was reviewed on 10/8/2026 at 12:50 PM. The medical diagnoses included, but were not limited to, diabetes and anxiety. An individualized service plan dated 7/11/2026 indicated Resident M required assistance with medication management. Resident M utilized 5-10 medications, required injections three times a day, and had medications passed two times a day. The October 2026 Medication Administration Record indicated staff were administering Resident M ' s medications. Three administrations were noted as held due to medications not being available. During an interview, on 10/8/2026 at 11:45 AM, LPN 4 stated there were times when medications were not available for administration. LPN 4 stated she believed it was an ongoing issue with the pharmacy. During an interview, on 10/8/2026 at 12:45 PM, LPN 5 stated there were many times she did not have medications available to administer to residents. She stated staff would reorder medications from the pharmacy, but the medications would not be delivered. She stated she would call the pharmacy, and the			

	pharmacy would indicate the medications had been delivered; however, when she requested information on when and to whom the medications were delivered, the pharmacy would then respond that the medications had not been delivered and would send them out. LPN 5 stated this had been occurring for some time. She further stated this occurred the previous week with Resident M, when the resident was prescribed an antibiotic and the medication was delayed by a day. During an interview, on 10/9/2026 at 11:30 AM, QMA 7 stated there were issues with obtaining medications, primarily for residents who use outside pharmacies. She stated that when medications were not available, staff would call the pharmacy or the resident ' s family and then document the issue. She stated they did not obtain backup medication from the facility's contracted pharmacy. A policy titled, "Medications", was provided by the Marketing Director on 10/8/2026 at 2:30 PM. The policy indicated the medication cart was to contain all items necessary for the proper administration of medications. The nurse was responsible for obtaining the			

	correct medication, time, dosage, and route of administration as ordered by the physician. If the resident ' s medications came from the preferred pharmacy, the nurse or designee would obtain refills and new labels as needed. If medications were obtained from an outside pharmacy, it was the resident ' s responsible party ' s responsibility to ensure all medications were brought in timely. Staff were required to reorder medications in a timely manner from the preferred pharmacy or notify responsible parties in a timely manner regarding refills from an outside pharmacy. A policy titled, "Medication Refills", was provided by the Marketing Director on 10/8/2026 at 2:30 PM. The policy indicated it was the responsibility of the facility to obtain refills for medications and treatments unless otherwise specified. In the event a resident ' s responsible party was designated to obtain medications, but a refill was not delivered within two days of depletion, facility staff were required to reorder medications through the preferred pharmacy. This Residential tag relates to relates to Intake 472410. Based on interview and record			

review, the facility failed to ensure mediations were readily available for administration, in accordance with their service plans, for 6 of 6 residents whose medications were reviewed. (Residents D, N, C, E, H, and M)

Findings include:

1. The clinical record for Resident D was reviewed on 10/8/26 at 12:21 p.m. Resident D's diagnoses included, but were not limited to, anxiety and hyponatremia (a medical condition where the concentration of sodium in your blood drops below the normal range, causing excess water to move into your cells and make them swell.)

Resident D's service plan, dated 6/20/26, indicated Resident D required assistance from staff with medication management two or more times daily for more than eleven medications.

The October, 2026 physician's orders indicated to administer one 1000 mg tablet of Sodium Chloride twice a day, starting 2/4/25; one 10 mg tablet of Buspirone three times daily, starting 7/9/26; and to apply Hydrocortisone 2.5% cream to Resident D's neck twice daily, starting 9/30/26.

The September, 2026 and

	October, 2026 medication administration records (MARs) indicated the Sodium Chloride was not administered once on 9/30/26 because the medication was unavailable. The Buspirone was not administered at lunch on 10/7/26 because the medication was unavailable. The Hydrocortisone cream was not applied once on 10/1/26 and once on 10/4/26 because the cream was unavailable. 2. The clinical record for Resident N was reviewed on 10/8/26 at 10:55 a.m. Resident N's diagnoses included, but were not limited to, arthritis. Resident N's service plan, dated 9/18/26, indicated Resident N required assistance from staff with medication management two or more times daily for more than eleven medications. The October, 2026 physician's orders indicated to administer one Hydrocodone-Acetaminophen 5-325 mg tablet every four hours, starting 9/11/26. The September, 2026 MAR indicated the Hydrocodone-Acetaminophen was not administered four times on 9/16/26 because the medication was unavailable. 3. The clinical record for Resident C was reviewed on			

	10/8/26 at 11:22 a.m. Resident C's diagnoses included, but were not limited to, sleep apnea. Resident C's service plan, dated 8/22/26, indicated Resident C required assistance from staff with medication management four or more times daily for more than eleven medications, including inhalers and injections. The October, 2026 physician's orders indicated to administer the Optichamber Diamond inhaler once a day, starting 5/24/26; two puffs of the Breztri Aerosphere inhaler twice a day, starting 9/3/26; one 100 mg capsule of Docusate Sodium twice a day, starting 4/27/26; one 200 mg tablet of Hydroxychloroquine every day from 5/24/26 to 9/28/2026; two 200 mg tablets of Hydroxychloroquine daily, starting 9/28/26; and one 120 mg/ml pen injection of Emgality every month, starting 5/29/26. The September, 2026 and October, 2026 MARs indicated the Optichamber Diamond inhaler was not administered on 9/16/26, 9/22/26, 9/23/26, 9/26/26, and 10/2/26, because the medication was not available. The Breztri inhaler was not administered twice on 9/15/26, once on 9/16/26, once on 9/17/26, once on 9/18/26,			

	twice on 9/19/26, and once on 9/20/26, because the medication was not available. The Docusate Sodium was not administered once on 9/15/26, because the medication was not available. The Hydroxychloroquine was not administered on 9/22/26. The Emgality injection was not administered on 9/30/26, because the medication was not available. An interview was conducted with Resident C on 10/8/26 at 1:02 p.m. Resident C indicated she did not get her inhaler for a while. Once she was told the insurance would not pay for it. Another time she was told it was unavailable at the pharmacy and the nursing staff never called her physician to see if they could prescribe something else.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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 and interview, the facility failed to ensure that the air ventilation	R 0273	**R 0273** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	10/30/2026

	vents in the kitchen, including the dishwashing room and areas near food service equipment, were maintained in a clean condition and free of debris. This deficient practice had the potential to affect 54 of 54 residents who could potentially receive meals prepared in the facility's kitchen. Findings include: During an observation, on 10/7/2026 at 12:10 PM, the air ventilation vent located on the ceiling near the food preparation area and steam table in the kitchen was noted to have brown debris on its surface and was not maintained in a clean condition. Additionally, the air ventilation vent on the ceiling in the dishwashing room was observed to have black and brown substances on the vent and extending onto the surrounding ceiling surface. During an interview on 10/7/2026 at 12:15 PM, the Dietary Manager stated that staff attempt to clean the vents at least quarterly. The Dietary Manager indicated due to the height and difficulty of accessing the vents, the facility has been working on obtaining a contractor to complete the cleaning. A policy titled, "Daily Closing of the Kitchen", was provided by		The air ventilation vents in the kitchen food preparation area and the dishwashing room are scheduled to be cleaned and sanitized thoroughly by a professional outside source. **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:** A 100% inspection of all kitchen and dietary department ceilings, vents, and exhaust systems was completed to ensure complete cleanliness and compliance with sanitary standards across all food preparation and serving areas. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** A specialized third-party commercial cleaning contractor was secured to handle routine heavy-duty ceiling vent and exhaust maintenance. The "Daily Closing Checklist" was updated to include a weekly visual check of ceiling vents by the Dietary Manager.	

	the Executive Director on 10/8/2026 at 2:33 PM. The policy indicated to complete the "Daily Closing Checklist". The "Daily Closing Checklist", was provided by the Executive Director on 10/8/2026 at 2:33 PM. The checklist indicated to ensure the floors, walls, and ceiling were clean and free of repair. This Residential tag relates to relates to Intake 472410.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Dietary Manager or Executive Director will inspect kitchen ventilation cleanliness weekly for three months, then monthly thereafter. Findings will be logged on the Daily Closing Checklist and reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review, the facility failed to address a resident's pharmacy reviews/recommendations for 1 of 4 residents whose pharmacy reviews/recommendations were reviewed, and to have a policy to address medication reviews, recommendations, and physician notification of such for 53 of 54 residents in the facility	R 0299	**R 0299** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The consultant pharmacist recommendations and prescriber notes for Resident C (dated August 12, 2026, and October 6, 2026) were printed, reviewed, re-submitted to the attending physician, and successfully resolved and documented in Resident C's clinical record. **How the facility will identify other residents having the**	10/30/2026

	subject to pharmacy reviews. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/8/26 at 11:22 a.m. Resident C's diagnoses included, but were not limited to, sleep apnea. Resident C's service plan, dated 8/22/26, indicated Resident C required assistance from staff with medication management four or more times daily for more than eleven medications, including inhalers and injections. The October, 2026 physician's orders indicated to administer one 0.625 mg tablet of Premarin every 14 days, starting 4/20/26; apply Premarin vaginal cream 0.0625% twice weekly that could be self administered, starting 6/5/26; 17 grams of Polyethylene Glycol 3350 mixed in eight ounces of water every day, starting 4/27/26; one 100 mg capsule of Docusate Sodium twice a day, hold for loose stool, starting 4/27/26; and one injection of Emgality (injectable medication to prevent migraines and treat episodic cluster headaches in adults) every month, starting 5/29/26. The Note To Attending Physician/Prescriber, dated 8/12/26 indicated Resident C had an order for Premarin		**potential to be affected by the same deficient practice and what corrective action will be taken:** A 100% audit of all active consultant pharmacist Medication Regimen Review (MRR) reports from the past 60 days was completed to ensure every recommendation received a documented prescriber response and clinical follow-through. **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 community will follow the Consultant Pharmacist Retainer Agreement implemented and duly executed between Bloom at German Church and Williams Bros. Pharmacy to ensure medication regimen reviews are conducted, and any identified recommendations or concerns are communicated and addressed in accordance with the agreement. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Wellness Director or designee will audit 100% of consultant pharmacist review reports and follow-up logs	

	tablets every 14 days and an order for Premarin vaginal cream twice weekly, and to please clarify if the Premarin tablets should be discontinued. There was not Physician/Prescriber Response on the note or documented in the clinical record. The Note To Attending Physician/Prescriber, dated 8/12/26 indicated Resident C was receiving Polyethylene Glycol 3350 and Docusate Sodium on a routine basis, and would it be appropriate to discontinue the Docusate Sodium order or change the Docusate Sodium order to 100 mg twice a day as needed for constipation. There was not Physician/Prescriber Response on the note or documented in the clinical record. The Consultant Pharmacist's Medication Regimen Review form, dated 10/6/26, indicated Resident C's Emgality injection was marked as not administered on 9/30/26 due to it not being available. This should have been followed-up on and once received, administered. Please investigate as there is no documentation of this. There was no information documented in the follow-through section of the form or documented in the clinical record. An interview was conducted		weekly, starting the week of October 19, 2026, for three months, and monthly thereafter. Audit findings and compliance will be reviewed through the facility's Quality Assurance program monthly for a minimum of three months. **By what date will the systemic changes be completed:** Friday, October 30, 2026	

	with the Executive Director on 10/8/26 at 3:07 p.m. She indicated she spoke with pharmacy who informed her they sent the pharmacy recommendations directly to Resident C's physician, as Resident C did not see the facility's physician/nurse practitioner. The ED was unable to provide verification the three pharmacy reviews/recommendations from 8/12/26 and 10/6/26 were addressed. There was no facility policy to address medication reviews, recommendations, and physician notification of such. They were just supposed to "just stay on top of it."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREEmily Schafer	TITLEDirector of Community Operations	(X6) DATE10/22/2026