STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

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

(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 Survey dates: July 14 and 15 2025. Facility number: 010234 Residential Census: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 22, 2025.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (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	R 0092	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible	08/08/2025

	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 conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure the fire department was invited at least every 6 months and there were at least 12 fire drills conducted in a year for 3 of the 12 months reviewed. (March, May and June 2025). Findings include: The fire drills were reviewed on 7/14/25 at 11:15 a.m. March, May and June 2025 did not have a fire drill report. There was a fire department invite for April 2025, but there was no documentation of the fire department being invited to a		allegation of compliance. R-092All fire drills located were placed into a new binder for monitoring and continued access to complete fire drills per company policy and in accordance with state regulations.All residents have the potential to be affected. ensure the deficient practice will not recur, all Fire Drills completed, and invitations extended to the local fire department, will be documented and logged into the new binder located in the Executive Directors office. A check list will be utilized in the front of the binder to include the month, shift, and date of completed fire drill.A monthly audit will be conducted by the Executive Director and Maintenance Director to ensure each monthly fire drill is completed on the appropriate shift, Fire Drill record is completed, and check list and marked correctly for compliance with company policy and state regulations.Date of Compliance: 8/8/2025	

	fire drill prior to April 2025 for the 2 invites every 6 months. During an interview, on 7/14/25 at 2:45 p.m., the Executive Director (ED) indicated she could not find March, May or June 2025 fire drills. During an interview, on 7/15/25 at 9:15 a.m., the ED indicated she could not find the fire drills. During an interview, on 7/15/25 at 10:00 a.m., the ED indicated they should complete fire drills once a month and alternate shifts with each fire drill. They should invite the fire department at least twice a year and she only had documentation for April 2025. A current facility policy, titled "Fire Drills," dated as issued September 2011 and received from the ED on 7/15/25 at 10:00 a.m., indicated "...Fire Drills should be executed on a monthly basis per the Evacuation Plan. Every shift should participate at least once annually or per State requirements. 1. A designated associate should complete a Fire Drill Report after the fire drill is finished...." Based on interview and record review, the facility failed to ensure the fire department was invited at least every 6 months and there were at least 12 fire drills conducted in a year for 3			

	of the 12 months reviewed. (March, May and June 2025). Findings include: The fire drills were reviewed on 7/14/25 at 11:15 a.m. March, May and June 2025 did not have a fire drill report. There was a fire department invite for April 2025, but there was no documentation of the fire department being invited to a fire drill prior to April 2025 for the 2 invites every 6 months. During an interview, on 7/14/25 at 2:45 p.m., the Executive Director (ED) indicated she could not find March, May or June 2025 fire drills. During an interview, on 7/15/25 at 9:15 a.m., the ED indicated she could not find the fire drills. During an interview, on 7/15/25 at 10:00 a.m., the ED indicated they should complete fire drills once a month and alternate shifts with each fire drill. They should invite the fire department at least twice a year and she only had documentation for April 2025. A current facility policy, titled "Fire Drills," dated as issued September 2011 and received from the ED on 7/15/25 at 10:00 a.m., indicated "...Fire Drills should be executed on a monthly basis per the Evacuation Plan. Every shift			

	should participate at least once annually or per State requirements. 1. A designated associate should complete a Fire Drill Report after the fire drill is finished...."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall: (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 observation and interview, the facility failed to ensure the medication cart was free of loose pills, medications were dated, and the controlled	R 0298	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance.	08/08/2025

drug count sheet was signed for 1 of 3 medication carts reviewed for medication storage. (second floor medication cart)

Findings include:

The 200-hall medication cart was reviewed on 7/14/25 at 2:51 p.m. The following were observed:

1. The first drawer of the medication cart had one (1) loose pill. Incruse Ellipta (an oral inhalation medication) with 5 of 30 doses left had instructions to discard 6 weeks after opened and did not have an open date. Trelegy inhalation powder with 17 of 30 doses left had instructions to discard 6 weeks after opened and did not have an open date. Stiolto Respimat inhaler had instructions to discard 6 months after the cartage was inserted and did not have an opened date.

2. In the second drawer there were 11 loose pills.

3. In the third drawer there were 18 and a half loose pills.

4. The narcotic count book for the 200-hall was missing the nurse's signature, for the on-coming and off-going 6:00 a.m. to 2:00 p.m. shift, for the date of 7/13/25.

During an interview, on 7/14/25 at 3:18 p.m., QMA 7 indicated

	the nurses, and the Director of Nursing (DON) performed medication cart audits. During an interview, on 7/14/25 at 3:28 p.m., QMA 7 indicated the count sheet would be signed off after every shift. QMA 7 indicated she did not work on 7/13/25, but whomever did work should have signed the sheet after counting the medications. During an interview, on 7/15/25 at 10:05 a.m., the Executive Director (ED) indicated the pharmacist completed medication cart audits and was unsure why there were issues with loose pills and medications without opened dates. During an interview, on 7/15/25 at 11:35 a.m., the DON indicated the pharmacist audited the medication carts every 30 days and checked for expired medications and loose pills in the carts. She tried to follow behind the pharmacist to ensure the carts were free from these issues. The nurses should also check the medication carts daily for loose pills. A current facility policy, titled "Storing General Medications," dated May 2012 and received from the ED on 7/15/25 at 11:17 a.m., indicated "...Medications must be stored in a clean and neat, locked container or medication cart...."			

A current facility policy, titled "Medication Storage (Central Location)," dated May 2012 and received from the ED on 7/15/25 at 9:33 a.m., indicated "...Medication shall be stored in the container which is supplied by the pharmacy...."

Based on observation and interview, the facility failed to ensure the medication cart was free of loose pills, medications were dated, and the controlled drug count sheet was signed for 1 of 3 medication carts reviewed for medication storage. (second floor medication cart)

Findings include:

The 200-hall medication cart was reviewed on 7/14/25 at 2:51 p.m. The following were observed:

1. The first drawer of the medication cart had one (1) loose pill. Incruse Ellipta (an oral inhalation medication) with 5 of 30 doses left had instructions to discard 6 weeks after opened and did not have an open date. Trelegy inhalation powder with 17 of 30 doses left had instructions to discard 6 weeks after opened and did not have an open date. Stiolto Respimat inhaler had instructions to discard 6 months after the cartage was inserted and did not have an opened date.

2. In the second drawer there

were 11 loose pills.

3. In the third drawer there were 18 and a half loose pills.

4. The narcotic count book for the 200-hall was missing the nurse's signature, for the on-coming and off-going 6:00 a.m. to 2:00 p.m. shift, for the date of 7/13/25.

During an interview, on 7/14/25 at 3:18 p.m., QMA 7 indicated the nurses, and the Director of Nursing (DON) performed medication cart audits.

During an interview, on 7/14/25 at 3:28 p.m., QMA 7 indicated the count sheet would be signed off after every shift. QMA 7 indicated she did not work on 7/13/25, but whomever did work should have signed the sheet after counting the medications.

During an interview, on 7/15/25 at 10:05 a.m., the Executive Director (ED) indicated the pharmacist completed medication cart audits and was unsure why there were issues with loose pills and medications without opened dates.

During an interview, on 7/15/25 at 11:35 a.m., the DON indicated the pharmacist audited the medication carts every 30 days and checked for expired medications and loose pills in the carts. She tried to follow behind the pharmacist to ensure

	the carts were free from these issues. The nurses should also check the medication carts daily for loose pills. A current facility policy, titled "Storing General Medications," dated May 2012 and received from the ED on 7/15/25 at 11:17 a.m., indicated "...Medications must be stored in a clean and neat, locked container or medication cart...." A current facility policy, titled "Medication Storage (Central Location)," dated May 2012 and received from the ED on 7/15/25 at 9:33 a.m., indicated "...Medication shall be stored in the container which is supplied by the pharmacy...."			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure a health assessment which included a statement the resident showed no evidence of tuberculosis in an infectious	R 0409	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance. Resident #61 has and no further corrective action can take place. identify any other residents who have a potential to be affected an audit was conducted to review the records of all clinical record to determine if any further deficient practices could be identified.	08/08/2025

	stage as verified upon admission and yearly thereafter was obtained for 1 of 7 residents reviewed for annual health statements. (Resident 61) Findings include: The clinical record for Resident 61 was reviewed on 7/14/25 at 12:19 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with psychotic disturbances, and major depressive disorder. Resident 61's record did not contain an annual health statement. During an interview, on 7/15/25 at 10:05 a.m., the Executive Director indicated she was unable to find an annual health statement for Resident 61 and the facility did not have a policy that included annual health statements. Based on interview and record review, the facility failed to ensure a health assessment which included a statement the resident showed no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter was obtained for 1 of 7 residents reviewed for annual health statements. (Resident 61)		ensure the deficient practice will not recur, education was completed with nursing staff to ensure all residents have proper documentation of health statement that resident is free of TB upon admission, and annually thereafter, to maintain compliance with state regulations. ensure continued monitoring to ensure corrective actions are sustained, Director of Nursing/Designee will conduct clinical record reviews to ensure that each resident has an annual health statement that is up to date and within compliance of state regulations, times 6 months. Should concerns or noncompliance be identified, additional education shall be provided. Continued monitoring may be increased or decreased on the basis of findings.	

	Findings include: The clinical record for Resident 61 was reviewed on 7/14/25 at 12:19 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with psychotic disturbances, and major depressive disorder. Resident 61's record did not contain an annual health statement. During an interview, on 7/15/25 at 10:05 a.m., the Executive Director indicated she was unable to find an annual health statement for Resident 61 and the facility did not have a policy that included annual health statements.				

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 SIGNATURE	TITLE	(X6) DATE