STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/17/2026

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 the Investigation of Intake 470050. Intake 470050 - State deficiencies related to the allegations are cited at R0052. Survey date: June 12, 2026 Facility number: 003916 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 6/4/26.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	**R0052** **What corrective action(s) will be accomplished for those residents found to be affected by the same deficient practice:** An interdisciplinary	06/26/2026

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident which resulted in the resident being fearful of further sexual assault and not leaving their room, for 2 of 4 residents reviewed for abuse (Resident D and Resident E). Findings include: 1 a. The clinical record for Resident D was 6/17/26 at 11:10 a.m. The resident's diagnosis included, but were not limited to, Frontocortex dementia (progressive brain disorder caused by degeneration of the frontal and temporal lobes of the brain). An undated pre-admission assessment indicated Resident D had no behavior expressions and that "female attention could be a problem". A Resident Assessment, dated 4/26/26, indicated Resident D was independent in mobility and		team review determined that Resident D's behavior's exceeded the facility's ability to provide a safe environment for him and other residents, due to his actions and cognitive impairment. Resident D has moved back in with his wife, in independent living. He was issued an immediate move-out notice, and was placed on 1:1 observation until he was discharged. Resident E is relieved that Resident D has left the facility. She speaks with me frequently and is doing alright, according to her. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. **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 100% audit of resident records will be completed to verify that resident assessments accurately reflect current behaviors, supervision needs, and individualized interventions. Service Plans will be reviewed and revised as needed to ensure appropriate interventions are in place for residents exhibiting behaviors that may	

	Acts of Daily Living (ADL) care. The resident had frontal lobe dementia and no behavior problems, the pre-admission assessment indicated that female attention could be a problem. A progress note, dated 6/2/26 at 9:49 a.m., indicated a housekeeper was cleaning Resident D's bathroom when Resident D opened the door to the bathroom. Resident D was naked and masturbating. Resident D then went to his bed and told the housekeeper to keep her gloves on and that he had money. The housekeeper left Resident D's room and informed the management staff. A Psychiatric Nurse Practitioner Progress Note, dated 6/5/26, indicated Resident D had been seen due to inappropriate sexual behaviors. Resident D had ongoing reports of inappropriate sexual behaviors directed toward female staff members. The staff reported these behaviors have occurred on multiple occasions and appear to be continuing despite redirections. 1 b. The clinical record for Resident E was reviewed on 6/17/26 at 11:20 a.m. The resident's diagnosis included, but were not limited to, dementia (decline in mental abilities that were severe		place themselves or others at risk. Effective immediately, the interdisciplinary team will review any resident demonstrating new or escalating behaviors, significant cognitive changes, or involvement in an abuse allegation or behavioral incident to determine whether additional interventions, increased supervision, outside services, or transfer to a higher level of care are necessary to maintain resident safety. All associates will receive re-education on the facility's Abuse Prevention Policy, resident rights, mandatory reporting requirements, recognition of abuse, supervision expectations, behavior management techniques, de-escalation strategies, emergency response procedures, and the importance of promptly reporting changes in resident behavior to nursing and administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (Quality Assurance):** The Executive Director or designee will complete weekly audits for four consecutive weeks to verify that resident assessments are current, Service Plans accurately reflect	

	enough to interfere with daily life). A Resident Assessment, dated 5/2/26, indicated Resident E needed moderate assistance with mobility and used a walker or a wheelchair. The resident needed minimal assistance with cognition and occasional reminders due to dementia. On 6/17/26 at 10:45 a.m., the Executive Director (ED) provided an Incident Report that had been sent to the Indiana Department of Health (IDOH) on 6/8/26 at 8:45 a.m. The Incident Report indicated Resident D and Resident E had been involved in an incident. The Brief Description, added 6/8/26, indicated the ED was informed by a staff member that Resident E stated Resident D had "groped" Resident E's breast. Resident E had been uncharacteristically quiet. Resident E had not opened the door when the ED had gone to check on her. The Immediate Action Taken was that Resident E was placed on one-on-one observation (observation of resident by staff). An interview was conducted with Resident E on 6/17/26 1:45 p.m. Resident E indicated Resident D had come up behind her, put his arm around her chest, grabbed her breast. Resident E had been very upset		resident behaviors and supervision needs, individualized interventions are implemented, and abuse allegations are reported, investigated, and documented according to facility policy and state requirements. Residents exhibiting behaviors that may place themselves or others at risk will be reviewed by the interdisciplinary team weekly for 30 days and monthly thereafter to evaluate the effectiveness of interventions and revise Service Plans as needed. Audit findings, incident trends, abuse allegations, and compliance with abuse prevention policies will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program monthly for a minimum of three months. Any identified deficiencies will be addressed immediately through corrective action, including additional staff education, revision of resident interventions, increased supervision, or process improvements to ensure continued compliance and resident safety. **By what date will the systemic changes be completed:** Friday, July 10 , 2026	

	and frightened when the incident occurred. Resident E was concerned that Resident D had misinterpreted something she had done or said. Resident E had stayed in her room for a couple of days after the incident occurred. Resident E was afraid that Resident D would come back again and rape her. Resident E was afraid that Resident D would try to get into her room. Resident E was trying to keep her door locked, but sometimes she forgot. Resident E was worried that she may have said or done something that made Resident D think he could do that to her. Resident E thought that what happened was "disgusting and foul". Resident E was scared that it would happen to another resident that lived at the facility. An interview was conducted with the ED on 6/17/26 at 3:00 p.m. The ED indicated she had done the Pre-Admission Assessment for Resident D. Resident D was living at another facility prior to coming to this facility. During the Pre-Admission Assessment, the previous facility had informed the ED that Resident D had a "girlfriend". The "girlfriend" would initiate a relationship with Resident D and then "whine" about him touching her. The previous facility had asked Resident D to leave because			

the "girlfriend" had accused Resident D of touching her. The ED indicated there had been no interventions or precautions put into place when Resident D admitted to the facility.

An interview was conducted with the Director of Nursing (DON) on 6/17/26 at 3:10 p.m. The DON indicated she had not been made aware of the accusations of inappropriate sexual behaviors at the previous facility prior to Resident D's admission. If the DON would have known, she would not have admitted Resident D because of the risk to female residents at the facility.

On 6/17/26 at 11:35 a.m., the ED provided the Abuse and Neglect Policy, dated September 2011, that read "...It is the policy of Bloom Senior Living to ensure that all reporting of abuse and neglect is handled in accordance with State rules and regulations...Physical Abuse- Intentionally inflicting or allowing injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to...actual or attempted sexual battery..."

This Residential Tag relates to Intake 470050

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 SIGNATUREKim Lingle	TITLEExecutive Director	(X6) DATE07/07/2026