STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT KESSLER	5011 KESSLER BLVD E, INDIANAPOLIS, , 46220

(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 Complaints IN00463741, IN00458766, and IN00458630. Complaint IN00463741 - State deficiencies related to the allegations are cited at R0052 and R0091. Complaint IN00458766 - No deficiencies related to the allegations are cited. Complaint IN00458630 - State deficiencies related to the allegations are cited at R0064. Survey date: August 5 and 6, 2025 Facility number: 010064 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	R 000 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.	

	Quality review completed on August 12, 2025.			
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; (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 ensure adequate supervision to prevent inappropriate sexual contact between two residents with impaired cognition for 2 of 2 residents reviewed for abuse. (Resident B and Resident C) Findings include: 1a. The clinical record for Resident B was reviewed 8/5/25 at 11:30 a.m. The diagnoses included, but were not limited to, vascular dementia. A Mini Mental State Examination (a brief exam to assess cognitive impairment in older adults), dated 4/4/25, indicated he had abnormal	R 0052	R 052 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Resident B and Resident C were immediately separated, placed under increased supervision, evaluated by NP/psychiatric services, and had service plans updated with targeted interventions; all responsible parties were notified, and the 7/14/25 incident was reported to IDOH.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 memory care residents have the potential to be affected by the same deficient practice and were reviewed for cognitive status and risk behaviors, and any identified residents had care plans and CNA/QMA task sheets updated within 24 hours.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 were re-educated on residents' rights, abuse prevention, dementia-related capacity for consent, sexual behavior interventions, and mandatory reporting, with training documented in personnel files.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be	08/15/2025

	cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts. A service plan, dated 4/30/25, indicated he needed moderate assistance with dressing, grooming, toileting, and communication. He did not have special care needs or behavioral expressions. 1b. The clinical record for Resident C was reviewed on 8/5/25 at 11:40 a.m. The diagnoses included, but were not limited to, mixed dementia with anxiety and depression. A Mini Mental State Examination, dated 4/24/25, indicated she had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts. A Service Plan, dated 5/5/25, indicated she needed minimal assistance with dressing and grooming. She required moderate assistance with toileting and maximum assistance with cognition and orientation. She had no behavioral expressions. Resident B's clinical record included a progress note, dated 7/14/25 at 10:00 a.m., that indicated Resident B was observed standing in room without clothes on while another		put into place;The DON or designee will conduct daily audits for 30 days, weekly incident log reviews, and monthly QA reviews of behavioral incidents, with random observation rounds on all shifts to monitor compliance.The abuse investigation form and care plan update policy were revised to ensure completion within 24 hours of incidents, with immediate task sheet updates for supervision needs.By what date will the systemic changes be completed.	

	resident was in the room. Resident B was redirected to put clothes back on and the other resident was redirected out of the room. The Nurse Practitioner (NP), Power of Attorney (POA), Director of Nursing (DON) and the Executive Director (ED) were notified. A progress note in Resident C's clinical record, dated 7/14/25 at 10:30 a.m., Resident C was observed standing in Resident B's room without clothes on. Staff assisted with clothing and redirected her to her own room. The Nurse Practitioner (NP), Power of Attorney (POA), Executive Director (ED), and Director of Nursing (DON) were made aware. Staff would continue to observe for any other unusual behaviors. The incident on 7/14/25 was not reported to the Indiana Department of Health. A physician's order, dated 7/16/25, indicated Resident C was to be evaluated by psychiatric services for hypersexuality. Resident B's clinical record contained an NP Progress Note, dated 7/17/25, that indicated Resident B was being seen due to concerns for inappropriate sexual behaviors. Resident B resided in the memory care unit.			

	The facility reported that Resident B and another female resident (Resident C) were found in Resident B's room without clothing on. Due to both residents residing on the secured memory care unit there were concerns regarding capacity to give consent for sexual relationships. Resident B had poor judgement, and impaired memory. The assessment and plan indicated that due to Resident B having dementia and residing in secure memory care unit with other patients with impaired cognition, full consent for sexual activity cannot be given by either party. Resident C's clinical record contained a Psychiatric Initial Consult, dated 7/17/25, that indicated Resident C was being seen for an initial psychiatric evaluation due to hypersexuality. Resident C resided in the memory care unit. Resident C had recent sexual behaviors noted by staff. Resident C's cognitive status was forgetful and confused. She had a poor ability to plan, poor self-awareness and poor social cognition. The assessment and plan were for staff to implement interventions in attempt to prevent further incidents from occurring. Resident B and Resident C's service plans did not contain new interventions for			

	hypersexual behaviors. Resident B's clinical record contained a progress note, dated 7/30/25 at 7:11 p.m., that indicated the Qualified Medication Aide (QMA) had reported upon her return to the memory care unit, she had been informed that Resident C was in Resident B's room. Resident B was observed with his brief down to his knees and Resident C was putting her gown back on. The physician, POA, ED and Indiana Department of Health were made aware. On 8/5/25 at 11:59 a.m., the ED provided a copy of the Incident Report and Investigation file for the incident between Resident B and Resident C. The Incident Report, dated 7/30/25, indicated Resident B and Resident C were observed in Resident B's apartment. Resident B had his brief down to his knees and Resident C was putting her gown back on. The immediate action taken was the Certified Nurse Aide (CNA) pulled Resident B's brief back up and escorted Resident C to her apartment and helped Resident C get ready for bed. The Preventative Measures taken were to have Resident B and Resident C seen by the NP and psychiatric doctor. The follow up, added 7/31/25, was the family members, NP, ED,			

	and DON were notified. Staff would "keep an eye" on Resident B and Resident C and try to redirect them from entering others' apartments. A Witness Statement, completed by CNA 2 on 7/30/25, indicated she had observed Resident B with his pants and depend down to his knees. Resident C was putting her gown back on. Resident C was redirected back to her room. The investigation file did not contain any further interviews with staff. During an interview on 8/5/25 at 2:27 p.m., Licensed Practical Nurse (LPN) 3 indicated she had found Resident C in Resident B's room on 7/14/25. Resident C had been standing by the door of the room with her top off. LPN 3 found them and assisted Resident C to put her top back on. LPN 3 then redirected Resident C out of Resident B's room. Resident B and Resident C were not standing close to one another. During an interview on 8/5/25 at 2:27 p.m., the DON indicated she had been made aware of the incident, on 7/14/25, and had implemented increased supervision for both residents. Both families had been made aware. The family members had			

	indicated that the behaviors were "nothing new" for either resident. During an interview on 8/6/25 at 1:25 p.m., CNA 2 indicated she had witnessed the incident between Resident B and Resident C on 7/30/25. After dinner service, CNA 2 had started checking on the residents she was assigned to. She went to Resident B's door and knocked with no answer. She then knocked again with no answer. CNA 2 used her key to open Resident B's door and observed Resident C to be naked and leaning over the top of Resident B. Resident B had his brief on, but it was around his ankles. CNA 2 had told Resident C to get her clothes back on and assisted her to put her nightgown on. She had assisted Resident B to pull up his pants. CNA 2 then escorted Resident C back to her room. CNA 2 had not been made aware of previous sexual behaviors between Resident B and Resident C. CNA 2 had not been made aware that either Resident B or Resident C required additional supervision due to sexual behaviors. The resident task sheets were used to guide the care the residents needed, and neither Resident B nor Resident C's task sheets had been updated with new care needs.			

During an interview on 8/6/25 at 1:35 p.m., Qualified Medication Aide (QMA) 4 indicated she had been informed by CNA 2 of the incident between Resident B and Resident C. QMA 4 had seen Resident B and Resident C sitting at a table talking with each other prior to leaving the unit for a break. When she returned from her break, CNA 2 informed her what had happened. QMA 4 then reported the incident the DON. There had not been a licensed nurse on duty at the time of the incident. QMA 4 had not seen the DON or the ED come to the facility after the incident to assess Resident B and Resident C.

During an interview on 8/6/25 at 3:10 p.m., the ED indicated Resident B and Resident C were vulnerable residents and did not have the capacity to consent to sexual activity.

This Residential Tag relates to Complaint IN00463741.

Based on interview and record review, the facility failed to ensure adequate supervision to prevent inappropriate sexual contact between two residents with impaired cognition for 2 of 2 residents reviewed for abuse. (Resident B and Resident C)

Findings include:

1a. The clinical record for Resident B was reviewed 8/5/25

at 11:30 a.m. The diagnoses included, but were not limited to, vascular dementia.

A Mini Mental State Examination (a brief exam to assess cognitive impairment in older adults), dated 4/4/25, indicated he had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts.

A service plan, dated 4/30/25, indicated he needed moderate assistance with dressing, grooming, toileting, and communication. He did not have special care needs or behavioral expressions.

1b. The clinical record for Resident C was reviewed on 8/5/25 at 11:40 a.m. The diagnoses included, but were not limited to, mixed dementia with anxiety and depression.

A Mini Mental State Examination, dated 4/24/25, indicated she had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts.

A Service Plan, dated 5/5/25, indicated she needed minimal assistance with dressing and grooming. She required moderate assistance with toileting and maximum assistance with cognition and

orientation. She had no behavioral expressions.

Resident B's clinical record included a progress note, dated 7/14/25 at 10:00 a.m., that indicated Resident B was observed standing in room without clothes on while another resident was in the room. Resident B was redirected to put clothes back on and the other resident was redirected out of the room. The Nurse Practitioner (NP), Power of Attorney (POA), Director of Nursing (DON) and the Executive Director (ED) were notified.

A progress note in Resident C's clinical record, dated 7/14/25 at 10:30 a.m., Resident C was observed standing in Resident B's room without clothes on. Staff assisted with clothing and redirected her to her own room. The Nurse Practitioner (NP), Power of Attorney (POA), Executive Director (ED), and Director of Nursing (DON) were made aware. Staff would continue to observe for any other unusual behaviors.

The incident on 7/14/25 was not reported to the Indiana Department of Health.

A physician's order, dated 7/16/25, indicated Resident C was to be evaluated by psychiatric services for

	hypersexuality. Resident B's clinical record contained an NP Progress Note, dated 7/17/25, that indicated Resident B was being seen due to concerns for inappropriate sexual behaviors. Resident B resided in the memory care unit. The facility reported that Resident B and another female resident (Resident C) were found in Resident B's room without clothing on. Due to both residents residing on the secured memory care unit there were concerns regarding capacity to give consent for sexual relationships. Resident B had poor judgement, and impaired memory. The assessment and plan indicated that due to Resident B having dementia and residing in secure memory care unit with other patients with impaired cognition, full consent for sexual activity cannot be given by either party. Resident C's clinical record contained a Psychiatric Initial Consult, dated 7/17/25, that indicated Resident C was being seen for an initial psychiatric evaluation due to hypersexuality. Resident C resided in the memory care unit. Resident C had recent sexual behaviors noted by staff. Resident C's cognitive status was forgetful and confused. She had a poor ability to plan, poor self-awareness and poor social			

	cognition. The assessment and plan were for staff to implement interventions in attempt to prevent further incidents from occurring. Resident B and Resident C's service plans did not contain new interventions for hypersexual behaviors. Resident B's clinical record contained a progress note, dated 7/30/25 at 7:11 p.m., that indicated the Qualified Medication Aide (QMA) had reported upon her return to the memory care unit, she had been informed that Resident C was in Resident B's room. Resident B was observed with his brief down to his knees and Resident C was putting her gown back on. The physician, POA, ED and Indiana Department of Health were made aware. On 8/5/25 at 11:59 a.m., the ED provided a copy of the Incident Report and Investigation file for the incident between Resident B and Resident C. The Incident Report, dated 7/30/25, indicated Resident B and Resident C were observed in Resident B's apartment. Resident B had his brief down to his knees and Resident C was putting her gown back on. The immediate action taken was the Certified Nurse Aide (CNA) pulled Resident B's brief back			

	up and escorted Resident C to her apartment and helped Resident C get ready for bed. The Preventative Measures taken were to have Resident B and Resident C seen by the NP and psychiatric doctor. The follow up, added 7/31/25, was the family members, NP, ED, and DON were notified. Staff would "keep an eye" on Resident B and Resident C and try to redirect them from entering others' apartments. A Witness Statement, completed by CNA 2 on 7/30/25, indicated she had observed Resident B with his pants and depend down to his knees. Resident C was putting her gown back on. Resident C was redirected back to her room. The investigation file did not contain any further interviews with staff.			

	During an interview on 8/5/25 at 2:27 p.m., Licensed Practical Nurse (LPN) 3 indicated she had found Resident C in Resident B's room on 7/14/25. Resident C had been standing by the door of the room with her top off. LPN 3 found them and assisted Resident C to put her top back on. LPN 3 then redirected Resident C out of Resident B's room. Resident B and Resident C were not standing close to one another. During an interview on 8/5/25 at 2:27 p.m., the DON indicated she had been made aware of the incident, on 7/14/25, and had implemented increased supervision for both residents. Both families had been made aware. The family members had indicated that the behaviors were "nothing new" for either resident. During an interview on 8/6/25 at 1:25 p.m., CNA 2 indicated she had witnessed the incident between Resident B and Resident C on 7/30/25. After dinner service, CNA 2 had started checking on the residents she was assigned to. She went to Resident B's door and knocked with no answer. She then knocked again with no answer. CNA 2 used her key to open Resident B's door and observed Resident C to be naked and leaning over the top of Resident B. Resident B had			

	his brief on, but it was around his ankles. CNA 2 had told Resident C to get her clothes back on and assisted her to put her nightgown on. She had assisted Resident B to pull up his pants. CNA 2 then escorted Resident C back to her room. CNA 2 had not been made aware of previous sexual behaviors between Resident B and Resident C. CNA 2 had not been made aware that either Resident B or Resident C required additional supervision due to sexual behaviors. The resident task sheets were used to guide the care the residents needed, and neither Resident B nor Resident C's task sheets had been updated with new care needs.			

	During an interview on 8/6/25 at 1:35 p.m., Qualified Medication Aide (QMA) 4 indicated she had been informed by CNA 2 of the incident between Resident B and Resident C. QMA 4 had seen Resident B and Resident C sitting at a table talking with each other prior to leaving the unit for a break. When she returned from her break, CNA 2 informed her what had happened. QMA 4 then reported the incident the DON. There had not been a licensed nurse on duty at the time of the incident. QMA 4 had not seen the DON or the ED come to the facility after the incident to assess Resident B and Resident C. During an interview on 8/6/25 at 3:10 p.m., the ED indicated Resident B and Resident C were vulnerable residents and did not have the capacity to consent to sexual activity. This Residential Tag relates to Complaint IN00463741.			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are	R 0064	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; This facility will ensure that residents' property, including medications, is protected from loss or misappropriation at all times. How the facility will identify other	09/09/2025

	reported to the resident. Based on interview and record review, the facility failed to protect a resident's narcotic medication from loss for 1 of 3 residents reviewed for misappropriation of property. (Resident G) Findings include: The clinical record for Resident G was reviewed on 8/6/25 at 10:00 a.m. The diagnoses included, but were not limited to, arthritis and hypertension. A service plan, dated 3/28/25, indicated she required staff assistance to order, store, and dispensing medications. A physician's order, dated 8/8/24, indicated Resident G was to receive oxycodone (narcotic pain medication) IR (Immediate Release) 5 milligram (mg); one tablet every six hours as needed for pain. A Resident Service Note, dated 4/29/25, indicated Resident G was missing a card of 25 tablets of oxycodone along with the count sheet for the medication. The Executive Director (ED) was notified. On 8/5/25 at 11:37 a.m., the ED provided an Incident Report, submitted to the Indiana Department of Health on		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 by the same deficient practice. Resident G's physician, responsible party, and pharmacy were notified immediately upon discovery of the missing narcotic medication. The incident was reported to the IDOH and other regulatory agencies as required.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 policies have been revised and re-educated to all nurses for controlled substance requiring count verification and signature by both off going and ongoing nurses between shifts including accurate documentation and immediate reporting of discrepancies.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place;The DON or designee will conduct random narcotic count audits on all shifts 3 times per week for 12 weeks, then monthly thereafter. Findings will be reviewed during the morning stand up meeting. Corrective action will be taken immediately for any identified discrepancies.By what date will the systemic changes be completed.9/9/2025	

	4/30/25. The Incident Report indicated, on 4/29/25, a Licensed Practical Nurse (LPN) conducted a count of medications on cart one and discovered that a card of narcotic medication and the narcotic count sheet were missing from medication cart one. The immediate action taken was the LPN had immediately notified the ED, and an investigation was started. The Preventative Measures Taken was that all associates would be educated, on 5/1/25, on drug count sheets and procedure. The Follow Up, added 5/2/25, was that upon conclusion of the investigation, it was concluded that misconduct was found, and company policy was violated. All nursing staff were in-serviced and re-educated on their job descriptions. During an interview on 8/5/25 at 11:46 a.m., the ED indicated Resident G's oxycodone had never been located. During an interview on 8/6/25 at 9:45 a.m., the ED indicated, on 5/1/25, she had in-serviced the licensed nursing staff about their responsibility to count narcotics at the beginning and end of each shift to ensure accuracy of the narcotic medications in the medication carts. She had used the Medication Technician Job Description to educate the			

licensed staff because the facility did not have a policy in place for reconciliation of narcotic medications between shifts.

During an interview on 8/6/25 at 10:15 a.m., the Director of Nursing (DON) indicated the nursing staff should count the narcotics on the medication carts with the off-going nurse at change of shifts to verify the narcotic counts were correct.

This Residential Tag relates to Complaint IN00458630.

Based on interview and record review, the facility failed to protect a resident's narcotic medication from loss for 1 of 3 residents reviewed for misappropriation of property. (Resident G)

Findings include:

The clinical record for Resident G was reviewed on 8/6/25 at 10:00 a.m. The diagnoses included, but were not limited to, arthritis and hypertension.

A service plan, dated 3/28/25, indicated she required staff assistance to order, store, and dispensing medications.

A physician's order, dated 8/8/24, indicated Resident G was to receive oxycodone (narcotic pain medication) IR (Immediate Release) 5 milligram

	(mg); one tablet every six hours as needed for pain. A Resident Service Note, dated 4/29/25, indicated Resident G was missing a card of 25 tablets of oxycodone along with the count sheet for the medication. The Executive Director (ED) was notified. On 8/5/25 at 11:37 a.m., the ED provided an Incident Report, submitted to the Indiana Department of Health on 4/30/25. The Incident Report indicated, on 4/29/25, a Licensed Practical Nurse (LPN) conducted a count of medications on cart one and discovered that a card of narcotic medication and the narcotic count sheet were missing from medication cart one. The immediate action taken was the LPN had immediately notified the ED, and an investigation was started. The Preventative Measures Taken was that all associates would be educated, on 5/1/25, on drug count sheets and procedure. The Follow Up, added 5/2/25, was that upon conclusion of the investigation, it was concluded that misconduct was found, and company policy was violated. All nursing staff were in-serviced and re-educated on their job descriptions. During an interview on 8/5/25 at			

	11:46 a.m., the ED indicated Resident G's oxycodone had never been located. During an interview on 8/6/25 at 9:45 a.m., the ED indicated, on 5/1/25, she had in-serviced the licensed nursing staff about their responsibility to count narcotics at the beginning and end of each shift to ensure accuracy of the narcotic medications in the medication carts. She had used the Medication Technician Job Description to educate the licensed staff because the facility did not have a policy in place for reconciliation of narcotic medications between shifts. During an interview on 8/6/25 at 10:15 a.m., the Director of Nursing (DON) indicated the nursing staff should count the narcotics on the medication carts with the off-going nurse at change of shifts to verify the narcotic counts were correct. This Residential Tag relates to Complaint IN00458630.			
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	R 0091	R 091 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;The outdated abuse policy was immediately replaced with the most current state specific company policy on Abuse and Neglect and	09/12/2025

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 develop and implement an abuse policy that states the assurance that all residents that reside in the facility were free of abuse, including sexual abuse, for 2 of 2 residents reviewed for abuse. (Resident B and Resident C)

Findings include:

1a. The clinical record for Resident B was reviewed 8/5/25 at 11:30 a.m. The diagnoses included, but were not limited to, vascular dementia. He resided on the secured memory care unit.

A Mini Mental State Examination (a brief exam to assess cognitive impairment in older adults), dated 4/4/25, indicated he had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts.

Exploitation Incident Reporting Policy." Residents B and C were assessed for safety and wellbeing, and responsible parties and physicians were notified. The July 30 incident was reported to the IDOH, and corrective steps were initiated.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 by the same deficient practice. All residents were assessed to ensure they remained free from abuse or neglect. Staff were re-educated on mandatory reporting, abuse prevention, and resident's rights. The updated abuse policy was made available to residents and families upon request.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 Administrator and Director of Nursing (DON) implemented a policy review schedule to ensure all policies are current and compliant with state regulations. Annual review and updates to the policy manual will include resident rights, personnel administration, facility operations, and abuse prevention. All staff will receive refresher training on abuse prevention and reporting annually and at orientation.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, , what quality assurance program will be put into place;The DON/designee will conduct random staff interviews weekly for 12 weeks to verify staff knowledge of abuse

	1b. The clinical record for Resident C was reviewed on 8/5/25 at 11:40 a.m. The diagnoses included, but were not limited to, mixed dementia with anxiety and depression. She resided on the secured memory care unit. A Mini Mental State Examination, dated 4/24/25, indicated she had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts. Resident B's clinical record included a progress note, dated 7/14/25 at 10:00 a.m., that indicated Resident B was observed standing in room without clothes on while another resident (Resident C) was in the room. Resident B was redirected to put clothes back on and the other resident was redirected out of the room. The Nurse Practitioner (NP), Power of Attorney (POA), Director of Nursing (DON) and the Executive Director (ED) were notified. A progress note in Resident C's clinical record, dated 7/14/25 at 10:30 a.m., indicated Resident C was observed standing in Resident B's room without clothes on. Staff assisted with clothing and redirected her to her own room. The Nurse Practitioner (NP), Power of		reporting procedures. Policy compliance and incident reports will be reviewed monthly in morning stand up clinical meetings. Noncompliance will result in immediate corrective counseling or retraining.By what date will the systemic changes be completed. 9/12/2025	

Attorney (POA), Executive Director (ED), and Director of Nursing (DON) were made aware. Staff would continue to observe for any other unusual behaviors.

The incident between Resident B and Resident C, on 7/14/25, was not reported to the Indiana Department of Health.

Resident B's clinical record contained a progress note, dated 7/30/25 at 7:11 p.m., that indicated the Qualified Medication Aide (QMA) had reported upon her return to the memory care unit she had been informed that Resident C was in Resident B's room. Resident B was observed with his brief down to his knees and Resident C was putting her gown back on. The physician, POA, ED and Indiana Department of Health were made aware.

On 8/5/25 at 11:59 a.m., the ED provided a copy of the Incident Report submitted to the Indiana Department of Health and investigation file for the incident between Resident B and Resident C on 7/30/25.

The Incident Report, dated 7/30/25, indicated Resident B and Resident C were observed in Resident B's apartment. Resident B had his brief down to his knees and Resident C was putting her gown back on. The

immediate action taken was the Certified Nurse Aide (CNA) pulled Resident B's brief back up and escorted Resident C to her apartment and helped Resident C get ready for bed. The Preventative Measures taken were to have Resident B and Resident C seen by the NP and psychiatric doctor. The follow up, added 7/31/25, was the family members, NP, ED, and DON were notified. Staff would "keep an eye" on Resident B and Resident C and try to redirect them from entering others' apartments.

A Witness Statement, completed by CNA 2, on 7/30/25, indicated she had observed Resident B with his pants and depend down to his knees. Resident C was putting her gown back on. Resident C was redirected back to her room.

The investigation file did not contain any other staff interviews.

On 8/5/25 at 11:36 a.m., the ED provided the Abuse and Neglect Policy, last revised May 2012, which indicated " Policy: 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. This policy will insure [sic] that proper reporting procedures are followed when a

	case of abuse, neglect, or exploitation is reported. Abuse-Physical abuse or psychological abuse. 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, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery...Physical abuse does not include altercations or acts of assault between vulnerable adults...The act of alleged abuse, neglect or exploitation must be reported within the first 24 hours or the next business day, either written or orally, to the local Long Term Care Ombudsman Program Office and the appropriate State office which will investigate reports of alleged abuse, neglect and exploitation. It is recommended by the Long Term Care Ombudsman Program that statements be taken from residents, caregivers or witnesses. Procedure: The investigation of any act of abuse, neglect or exploitation should include the following: Notification of the incident to the Executive Director and the date the notification occurred. The date the investigation of the incident began. Record of statements or interviews of all involved... [State specific regulations will apply] ..."				

During an interview on 8/6/25 at 2:20 p.m., the ED indicated the Abuse Policy, last revised May 2012, was the most current Abuse Policy available. The policy did not directly address sexual abuse or cognitively impaired residents who were unable to consent to sexual activities. The incident between Resident B and Resident C did not seem to meet "sexual battery". The ED was unsure what the phrase physical abuse, does not include altercations or acts of assault between vulnerable adults, was referring to. The facility provided services for vulnerable adults.

During an interview on 8/6/25 at 3:10 p.m., the ED indicated Resident B and Resident C were vulnerable residents and did not have the capacity to consent to sexual activity.

On 8/7/25 at 2:10 p.m., the Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, was retrieved from the in.gov. health website. The policy indicated "...Licensed Residential Care Facilities...C. Types of Incidents Reportable under stat rules Any occurrence that directly threatens the welfare, safety, or health of a resident, such as 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or

mental anguish. The word 'willful' means that the individual's action was deliberate [not inadvertent or accidental] regardless of whether the individual intended to inflict injury or harm...d. Sexual Abuse: Sexual harassment, sexual coercion, or sexual assault. Examples include but are not limited to: nonconsensual sexual contact with a resident by another resident or visitor, any staff to resident sexual contact, any sexual contact involving a resident who lacks the ability to give consent because of cognitive impairment, gestures, sharing pornography, photographing resident's rectal, genital or breast areas, and/ or exhibitionism..."

This Residential Tag relates to Complaint IN00463741.

Based on interview and record review, the facility failed to develop and implement an abuse policy that states the assurance that all residents that reside in the facility were free of abuse, including sexual abuse, for 2 of 2 residents reviewed for abuse. (Resident B and Resident C)

Findings include:

1a. The clinical record for Resident B was reviewed 8/5/25 at 11:30 a.m. The diagnoses

included, but were not limited to, vascular dementia. He resided on the secured memory care unit.

A Mini Mental State Examination (a brief exam to assess cognitive impairment in older adults), dated 4/4/25, indicated he had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts.

1b. The clinical record for Resident C was reviewed on 8/5/25 at 11:40 a.m. The diagnoses included, but were not limited to, mixed dementia with anxiety and depression. She resided on the secured memory care unit.

A Mini Mental State Examination, dated 4/24/25, indicated she had abnormal cognitive ability with memory, thinking, attention, reasoning, decision making and dealing with concepts.

Resident B's clinical record included a progress note, dated 7/14/25 at 10:00 a.m., that indicated Resident B was observed standing in room without clothes on while another resident (Resident C) was in the room. Resident B was redirected to put clothes back on and the other resident was redirected out of the room. The

Nurse Practitioner (NP), Power of Attorney (POA), Director of Nursing (DON) and the Executive Director (ED) were notified.

A progress note in Resident C's clinical record, dated 7/14/25 at 10:30 a.m., indicated Resident C was observed standing in Resident B's room without clothes on. Staff assisted with clothing and redirected her to her own room. The Nurse Practitioner (NP), Power of Attorney (POA), Executive Director (ED), and Director of Nursing (DON) were made aware. Staff would continue to observe for any other unusual behaviors.

The incident between Resident B and Resident C, on 7/14/25, was not reported to the Indiana Department of Health.

Resident B's clinical record contained a progress note, dated 7/30/25 at 7:11 p.m., that indicated the Qualified Medication Aide (QMA) had reported upon her return to the memory care unit she had been informed that Resident C was in Resident B's room. Resident B was observed with his brief down to his knees and Resident C was putting her gown back on. The physician, POA, ED and Indiana Department of Health were made aware.

On 8/5/25 at 11:59 a.m., the ED provided a copy of the Incident Report submitted to the Indiana Department of Health and investigation file for the incident between Resident B and Resident C on 7/30/25.

The Incident Report, dated 7/30/25, indicated Resident B and Resident C were observed in Resident B's apartment. Resident B had his brief down to his knees and Resident C was putting her gown back on. The immediate action taken was the Certified Nurse Aide (CNA) pulled Resident B's brief back up and escorted Resident C to her apartment and helped Resident C get ready for bed. The Preventative Measures taken were to have Resident B and Resident C seen by the NP and psychiatric doctor. The follow up, added 7/31/25, was the family members, NP, ED, and DON were notified. Staff would "keep an eye" on Resident B and Resident C and try to redirect them from entering others' apartments.

A Witness Statement, completed by CNA 2, on 7/30/25, indicated she had observed Resident B with his pants and depend down to his knees. Resident C was putting her gown back on. Resident C was redirected back to her room.

The investigation file did not contain any other staff interviews.

On 8/5/25 at 11:36 a.m., the ED provided the Abuse and Neglect Policy, last revised May 2012, which indicated " Policy: 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. This policy will insure [sic] that proper reporting procedures are followed when a case of abuse, neglect, or exploitation is reported. Abuse-Physical abuse or psychological abuse. 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, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery...Physical abuse does not include altercations or acts of assault between vulnerable adults...The act of alleged abuse, neglect or exploitation must be reported within the first 24 hours or the next business day, either written or orally, to the local Long Term Care Ombudsman Program Office and the appropriate State office which will investigate reports of alleged abuse, neglect and exploitation. It is recommended by the Long Term Care Ombudsman Program that

statements be taken from residents, caregivers or witnesses. Procedure: The investigation of any act of abuse, neglect or exploitation should include the following: Notification of the incident to the Executive Director and the date the notification occurred. The date the investigation of the incident began. Record of statements or interviews of all involved... [State specific regulations will apply] ..."

During an interview on 8/6/25 at 2:20 p.m., the ED indicated the Abuse Policy, last revised May 2012, was the most current Abuse Policy available. The policy did not directly address sexual abuse or cognitively impaired residents who were unable to consent to sexual activities. The incident between Resident B and Resident C did not seem to meet "sexual battery". The ED was unsure what the phrase physical abuse, does not include altercations or acts of assault between vulnerable adults, was referring to. The facility provided services for vulnerable adults.

During an interview on 8/6/25 at 3:10 p.m., the ED indicated Resident B and Resident C were vulnerable residents and did not have the capacity to consent to sexual activity.

On 8/7/25 at 2:10 p.m., the

Long-Term Care Abuse and Incident Reporting Policy, effective 12/8/22, was retrieved from the in.gov. health website. The policy indicated "...Licensed Residential Care Facilities...C. Types of Incidents Reportable under stat rules Any occurrence that directly threatens the welfare, safety, or health of a resident, such as 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. The word 'willful' means that the individual's action was deliberate [not inadvertent or accidental] regardless of whether the individual intended to inflict injury or harm...d. Sexual Abuse: Sexual harassment, sexual coercion, or sexual assault. Examples include but are not limited to: nonconsensual sexual contact with a resident by another resident or visitor, any staff to resident sexual contact, any sexual contact involving a resident who lacks the ability to give consent because of cognitive impairment, gestures, sharing pornography, photographing resident's rectal, genital or breast areas, and/ or exhibitionism..."

This Residential Tag relates to Complaint IN00463741.

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