

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                         |                                                                                                                                                                                                      | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>08/13/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BLOOM AT WILLOW  |                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>2725 LAKE CIRCLE DR, INDIANAPOLIS, ,<br>46268 |                                                                                                                                                                                                      |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                     | ID PREFIX<br>TAG                                                                              | PROVIDER'S PLAN OF CORRECTION...                                                                                                                                                                     | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                               | <p>INITIAL COMMENTS</p> <p>This visit was for the<br/>Investigation of Intake 471222.</p> <p>Intake 471222-State<br/>deficiencies related to the<br/>allegations are cited at R36.</p> <p>Survey date: August 12 and 13,<br/>2026</p> <p>Facility number: 010234</p> <p>Residential Census: 60</p> <p>These State Residential<br/>Findings are cited in accordance<br/>with 410 IAC 16.2-5.</p> <p>Quality review was completed<br/>on August 13, 2026.</p> | R 0000                                                                                        |                                                                                                                                                                                                      |                                                                 |                                                 |
| R 0036                                               | <p>Residents' Rights- Deficiency</p> <p>410 IAC 16.2-5-1.2(k)(1-2)</p> <p>(k) The facility must immediately<br/>consult the resident ' s physician<br/>and the resident ' s legal<br/>representative when the facility has</p>                                                                                                                                                                                                                              | R 0036                                                                                        | Submission of this Plan of<br>Correction does not constitute<br>an admission or agreement by<br>the provider... The Plan of<br>Correction is submitted as a<br>credible allegation of<br>compliance. | 09/25/2026                                                      |                                                 |

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| <p>noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on interview and record review, the facility failed to notify the physician or nurse practitioner when a resident had refused to provide a urine sample for testing and failed to notify the resident's representative when the resident refused bathing for nine (9) consecutive shower/bathing days for 1 of 3 residents reviewed for notification. (Resident 3)</p> <p>Findings include:</p> <p>During an interview, on 8/12/26 at 10:01 a.m., LPN 1 indicated the CNAs assisted residents with showers or shower reminders. If a resident refused showers or bathing after being offered or reminded three (3) times, the refusal should be documented in the progress notes and the resident's representative would be notified.</p> <p>During an interview, on 8/12/26 at 2:28 p.m., the Executive</p> | <p>R-036</p> <p>- Resident 3 has been assessed, and will continue to be monitored</p> <p>- All residents have the potential to be affected.</p> <p>- In an effort to ensure the deficient practice will not recur, all staff were re-educated on proper notification practices to physicians and families, as well as proper documentation techniques.</p> <p>- In an effort to ensure continued monitoring of documentation and notification practices, the Executive Director/designee will conduct weekly audits x 4 weeks, and monthly x 5 months. With additional education provided as needed.</p> <p>- Date of Compliance: 9/25/2026</p> |  |
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FORM APPROVED

OMB NO. 0938-0391

Director indicated Resident 3 was provided with a collection device, in the toilet, for a urine specimen, but the resident would not provide the sample. The Director of Nursing was in contact with the Nurse Practitioner related to the resident not providing the urine sample however she did not chart the notification.

The clinical record for Resident 3 was reviewed on 8/12/26 at 10:27 a.m. The diagnoses included, but were not limited to, knee arthritis requiring a rollator (walker with wheels).

A progress note, dated 6/8/26, indicated the resident had displayed increased confusion, and a collection device was placed in the commode. The staff was to collect the specimen, send it out for testing, and continue to monitor Resident 3 for increased confusion.

There were no notes to show the physician had been informed the resident was not providing a urine sample.

The resident went to the hospital, on 6/10/26, for an unrelated incident and was found to have a urinary tract infection.

The shower records, dated 6/1/26 to 8/13/26, were

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reviewed. The resident refused to bath or shower on 7/1, 7/4, 7/8, 7/11, 7/15, 7/22, 7/25, 8/5 and 8/8/26.

There was no documentation to show the resident's representative had been notified of the refusals.

The facility policy related to notification was requested on 8/12/26 at 2:30 p.m.

During an interview, on 8/13/26 at 8:44 a.m., the Executive Director indicated the facility did not have a policy related to notification. She indicated the facility followed the State of Indiana regulations.

This citation relates to Intake 471222.

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  
SIGNATUREKourtney Harvey

TITLEExecutive Director

(X6) DATE08/27/2026