STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/17/2026

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 469021. Intake 469021 - Residential deficiencies related to the allegations are cited at R0036, R0052 and R0090. Survey date: April 17, 2026 Facility number: 003916 Residential Census: 57 These deficiencies reflect State Findings in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on April 21, 2026.	R 0000	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.	
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal	R 0036	**What corrective action(s) will be accomplished for those residents found to be affected by the same deficient**	05/02/2026

	representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (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. Based on observation, interview and record review, the facility failed to establish interventions and alter treatment of a resident who was admitted with a mental decline and had attempted to elope from the facility prior to the resident eloping from the facility for 1 of 3 residents reviewed for resident rights. (Resident B) Findings include: In an observation and interview with Resident B on 4-17-26 at 12:40 p.m., Resident B indicated that she was only visiting the facility and did not reside there. The resident was observed to be seated in the common area, near the entrance, and had her rollator (type of walker device) located adjacent to where she was seated. A review of Resident B's clinical record on 4-17-26 at 11:25 a.m.,		**practice:** Resident B's needs have exceeded the facility's ability to provide a safe environment due to elopement risk and cognitive impairment. Resident B has moved from Bloom and discharge planning was completed to ensure safe placement in an appropriate level of care. **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:** All residents to be reassessed for mental, physical and psychosocial status. A baseline will be established. All residents will be evaluated using Bloom's New Elopement Risk Assessment. This provides a scoring tool to help clarify potential risk. Care plans will be reviewed by our interdisciplinary team, and safety preventions will be added as needed. When a decline in condition or need to alter treatment is determined, resident's physicians and POAs will immediately be notified. Referrals and discharge planning will be completed for	

	indicated she was admitted to the facility approximately 4 months ago and had diagnoses which included, but were not limited to, Lewy Body disease (a progressive fatal brain disease which causes cognitive decline, hallucinations, depression, anxiety and stiffening movements) and dementia without behaviors. On 11-22-25, the resident had a Mini-Mental State Examination (MMSE). The MMSE indicated the resident displayed cognition of borderline dementia. On 12-19-25, the resident had a Montreal Cognitive Assessment (MCA, a rapid 30-point screening tool designed to detect early signs of mild cognitive impairment). The MCA was suggestive the resident had mild cognitive impairment. On 4-6-26, the resident was assessed for an Elopement Risk Evaluation. The elopement risk evaluation indicated Resident B was at risk for elopement due to a history of wandering, was ambulatory, made personal choices that could increase her risk of elopement, had attempted to leave the facility property in the past and expressed a desire to leave the facility property. A review of Resident B's most recent service plan, indicated the resident's service plan was updated on 4-6-26, for the purposes of a change in		residents in need of a higher level of care. **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** When a resident needs a change in care due to a decline, an incident will be created in August Health. Notifications to physicians and POAs will be required prior to closing the alert. All residents identified as an elopement risk will have their service plans reviewed weekly for 30 days and monthly thereafter, with immediate updates made following any incident or change in condition. The facility will maintain a log of all elopement incidents and attempts which will be reviewed weekly for the first 30 days and monthly thereafter to identify trends and implement necessary adjustments. **By what date will the systemic changes be completed:** Saturday, May 2, 2026	

	condition, and after the elopement on 4-5-26. The service plan indicated on 4-3-26 the resident tried to leave the facility and went out to the faciliyt parking lot and on 4-5-26 the resident went out of the facility to the street. The resident's service plan prior to 4-6-26 lacked interventions or care plan interventions related to the resident's mental decline. During an interview, on 4-17-26 at 11:20 a.m., the Executive Director (ED) indicated Resident B had tried to leave the facility, on 4-3-26, by following non staff members out of the facility locked door into the parking lot. The facility staff member had observed the resident leaving and was able to follow her to the outside and redirect the resident back into the facility for her safety. On 4-5-26 after the resident had not shown up for lunch Resident B was found to be missing. The ED was unsure exactly how long the resident had been outside the building before being identified as missing and at the time of the elopement, the facility did not have security cameras in place to aide in the determination of exactly when she left the building. In an interview with the Wellness Director, she			

	acknowledged the the Elopement Risk Assessment form did not have a scoring tool for a specific level of risk, she simply used her "best judgement" in regards to what, if any, interventions should have been put into place for each resident's elopement risk. On 4-17-26 at 1:14 p.m., the Marketing Director provided a copy of a document entitled, "Admission/Discharge Criteria," with a revision date of December, 2016. This document indicated, "Admission Criteria. The community may admit and retain age 62 and older adults who meet the following criteria: a. Can exhibit signs of confusion and forgetfulness...b. Can exhibit wandering behavior, but if elopement is a risk, behavior must be managed through programmatic services...j. Cannot be a danger to himself/herself or others...Discharge Criteria. Residency will be terminated when any of the following conditions occur...c. The resident requires care or service that is not available at the community..." On 4-17-26 at 12:59 p.m., the ED provided a copy of a document entitled, "Elopement Prevention," with an issue date of May, 2-12. This policy			

	indicated, "It is the policy of this community to keep all clients safe from harm. Those at risk for elopement will be identified and proactive interventions will be implemented. 1. The client will be evaluated for risk factors using the Elopement Risk Evaluation form at pre-admission, admission, quarterly, and with a significant change in condition...3. Clients who are evaluated to be at risk for elopement will have preventative measures as part of their Personal Service Plan to reduce the risk for elopement and injury. 4. If a client is identified as being an elopement risk, a plan would be developed to determine the level of the client's risk for elopement and implementation of risk-reducing interventions." This citation relates to Intake 469021.			
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;	R 0052	**What corrective action(s) will be accomplished for those residents found to be affected by the same deficient practice:** An interdisciplinary team review determined the resident's needs exceeded the facility's ability to provide a safe environment due to elopement risk and cognitive impairment. Resident B was referred to and accepted by facilities which can provide a safe, secure	05/02/2026

	(5) neglect; and (6) involuntary seclusion. Based on interview and record review, the residents have the right to be free from neglect, resulting in a resident identified by the facility as having a mental decline with a diagnosis of dementia, who had attempted to elope from the facility and two days later, successfully eloped from the facility. The resident was found approximately 0.1 miles from the facility off of the facility property for 1 of 3 residents reviewed for neglect. (Resident B) Findings include: The Indiana Department of Health, Long Term Care Division, received a report of unusual occurrence on 4-5-26, indicating Resident B had eloped from the facility on 4-5-26, around lunch time. The report stipulated facility staff had notified the Executive Director (ED) and Wellness Director around 12:47 p.m., the resident was unable to be located inside or outside the facility premises. The resident was subsequently located 10 minutes later off the facility premises. Another resident had reported to staff, he had observed Resident B leaving the building with a family, later identified as not		environment. Resident B was issued a 30-day notice and remained on 15-minute checks until discharge. An extra staff member was scheduled for busy weekend hours to ensure safety. Resident B has now admitted to a facility which provides the care and security required. **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 will be completed, including Elopement Risk Evaluation on all residents, to identify any residents at risk for elopement. Any resident identified as at risk will have individualized interventions implemented and Service Plans revised to reflect current needs. Effective immediately, Elopement Risk Evaluations will be completed on all residents upon admission, quarterly, and with any change in condition. All staff were re-educated on elopement prevention, supervision expectations, emergency response	

	Resident B's family. In interviews with the ED on 4-17-26 at 11:20 a.m., the ED described Resident B as very pleasant, but demented person. She indicated, on 4-3-26, two days prior to the elopement, Resident B had followed another group of persons (non-staff members) outside into the parking lot area. However, at that time, a facility staff member had observed the resident exiting and was able to follow her to the outside and redirect her to return to the safety of the facility. Since the return of the resident from the 4-5-26 elopement, the resident was being monitored with "15 minute" (staff visible checking on the resident every 15 minutes) checks by staff to ensure her safety, and that was to continue until the resident was able to be placed into a secured dementia care unit. The reason the staff found out she was missing was that she had not shown up for lunch. The ED was unsure exactly how long the resident had been outside the building until she was identified as missing and at the time of the elopement, the facility did not have security cameras in place to aide in the determination of exactly when she left the building. During and interview with the		procedures, and identification of at-risk residents. **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The facility will ensure ongoing monitoring and sustained compliance related to elopement risk through a structured and documented process. Weekly environmental audits of all exits and secured areas will be completed, with a monthly audit conducted by the Executive Director/designee to ensure continued compliance. All residents identified as an elopement risk will have their service plans reviewed weekly for 30 days and monthly thereafter to identify trends and implement necessary adjustments. Elopement risk monitoring will also be incorporated into the facilities Quality Assurance Oversight Program, where leadership will review audit finding, incident trends, and overall compliance. Any identified deficiencies will be addressed immediately through corrective action, including reeducation, process adjustments, or additional safeguards to ensure resident safety and prevent recurrence. **By what date will the systemic changes be completed:**	

	ED and the Maintenance Director, on 4-17-26 at 5:00 p.m., the ED indicated once she was made aware of the elopement, she directed the staff to begin searching the facility property again and to have some of the staff begin to look in the surrounding neighborhood. The ED made the facility's management team aware of the situation. She added the Maintenance Director requested the Dietary staff to begin looking for Resident B by driving around the neighborhood, which was how the resident was located near a local road and intersection by the entrance road into the facility grounds. The Maintenance Director indicated Resident B was located approximately one block from facility at the intersection of two local roads close to the facility entrance road. The distance from the facility's entrance to where the resident was located was confirmed to be 0.1 miles (the resident was fully dressed and the outdoor temperature on 4/5/26 at 12:00 noon, was between 50 to 54 degrees Fahrenheit). The pathway from the facility was observed to have walking paths and/or sidewalks available for use. The Maintenance Director indicated the exit doors were all secured, which would have required the resident to input the security		Saturday, May 2, 2026	

	code or walk out of the door while it was opened. The ED indicated at the time of the elopement, the facility did not have any security cameras. In an observation and interview with Resident B on 4-17-26 at 12:40 p.m., Resident B indicated she was only visiting the facility and did not reside there. She was observed to be seated in the common area, near the entrance, and had her rollator (type of walker device) located adjacent to where she was seated. She did not recall the elopement event of 4-5-26. A review of Resident B's clinical record on 4-17-26 at 11:25 a.m., indicated she was admitted to the facility approximately 4 months ago and has diagnoses which included, but were not limited to, Lewy Body disease (a progressive fatal brain disease which causes cognitive decline, hallucinations, depression, anxiety and stiffening movements) and dementia without behaviors. It indicated on 11-22-25, she had a MMSE (Mini-Mental State Examination) which indicated she displayed cognition of borderline dementia. A "Montreal Cognitive Assessment," dated 12-19-25, was suggestive of mild cognitive impairment. In an interview with the ED on			

	4-17-26 at 1:20 p.m., she indicated she was unaware how the Wellness Director made the determination for a resident assessment to ensure the service plan included the resident being a higher risk from a non-risk resident for elopement. In an interview with the Wellness Director and ED on 4-17-26 at 1:40 p.m., the Wellness Director indicated although the Elopement Risk Assessment form did not have a scoring tool for specific level of risk, she simply used her best judgement in regards to what, if any, interventions should have been put into place for each resident's elopement risk. The ED indicated she considered the elopement risking tool as a part of her facility's emergency protocols/prevention. She had noticed when she provided the elopement drills binder for review, that the facility had missed four months of elopement drills for the months of August, September, October and November 2025. On 4-17-26 at 1:14 p.m., the Marketing Director provided a copy of a document entitled, "Admission/Discharge Criteria," with a revision date of December 2016. This document indicated, "Admission Criteria. The community may admit and			

	retain age 62 and older adults who meet the following criteria: a. Can exhibit signs of confusion and forgetfulness...b. Can exhibit wandering behavior, but if elopement is a risk, behavior must be managed through programmatic services...j. Cannot be a danger to himself/herself or others...Discharge Criteria. Residency will be terminated when any of the following conditions occur...c. The resident requires care or service that is not available at the community..." On 4-17-26 at 12:59 p.m., the ED provided a copy of a document entitled, "Elopement Prevention," with an issue date of May 2, 2012. This policy indicated, "It is the policy of this community to keep all clients safe from harm. Those at risk for elopement will be identified and proactive interventions will be implemented. 1. The client will be evaluated for risk factors using the Elopement Risk Evaluation form at pre-admission, admission, quarterly, and with a significant change in condition...3. Clients who are evaluated to be at risk for elopement will have preventative measures as part of their Personal Service Plan to reduce the risk for elopement and injury. 4. If a client is identified as being an			

	elopement risk, a plan would be developed to determine the level of the client's risk for elopement and implementation of risk-reducing interventions." This citation relates to Intake 469021.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number	R 0090	**What corrective action(s) will be accomplished for those residents found to be affected by the same deficient practice:**	05/02/2026

	published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the administration failed to be responsible for the overall		An interdisciplinary team review determined that Resident B's needs exceeded the facility's ability to provide a safe environment due to elopement risk and cognitive impairment. Resident B had exited the building two days prior to the elopement, and staff immediately returned the resident to the building and notified the physician and POA. Resident B has since been discharged to a facility capable of providing an appropriate level of care. The facility has implemented a new Elopement Risk Assessment tool to more clearly identify residents at risk. Care Plans for all at-risk residents are being reviewed and revised by the interdisciplinary team, and physicians and POAs will be notified immediately of any required changes in treatment. **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:** To ensure the deficient practice does not recur, the facility has	

	management of facility related to the failure to prevent an elopment by a resident with a mental decline and prior attempted elopment for 1 of 3 residents reviewed for Administration and Managment. (Resident B) Findings include: In interviews with the Executive Director (ED) on 4-17-26 at 11:20 a.m., the ED indicated on 4-3-26, two days prior to the elopement, Resident B had followed another group of non staff persons outside into the parking lot area. However, at that time, facility staff had observed her exiting and were able to redirect her to return to the safety of the facility. The resident was found missing when she failed to show up for lunch. The ED was unsure exactly how long the resident had been outside the building and off facility property. The facility did not have security cameras in place to aide in the determination of exactly when she left the building. In an interview with the ED on 4-17-26 at 1:20 p.m., she indicated facility had missed four months of elopment drills, for the months of August, September, October and November, 2025. In an interview with the ED on		implemented systemic changes to strengthen administrative oversight and elopement-prevention processes. A 100% audit, including Elopement Risk Evaluations for all residents, was completed to identify any individual at risk for elopement. Residents identified as at risk received immediate individualized interventions, and Service Plans were updated. Effective immediately, Elopement Risk Evaluations will be completed upon admission, quarterly, and with any change in condition. All staff were re-educated on elopement prevention, supervision expectations, emergency response procedures, and identification of at-risk residents. Signage has been posted at visitor-accessible exits instructing guests not to hold doors for others and to notify staff before allowing anyone to exit. Interior and exterior cameras were installed to support root-cause analysis of elopement risks and to enhance administrative oversight. Administrative oversight has been strengthened through a structured review of all elopement incidents and attempts by the Executive Director and Director of Nursing within 24 hours, mandatory administrative sign-off on all risk assessments and care-plan	

	4-17-26 at 5:00 p.m., she indicated once she was made aware of the resident's elopement, she directed the staff to begin searching the facility property again and to have some of the staff begin to look in the surrounding neighborhood. A review of Resident B's clinical record on 4-17-26 at 11:25 a.m., indicated she was admitted to the facility approximately 4 months ago and has diagnoses which included, but were not limited to, Lewy Body disease (a progressive fatal brain disease which causes cognitive decline, hallucinations, depression, anxiety and stiffening movements) and dementia without behaviors. On 4-17-26 at 12:59 p.m., the ED provided a copy of a document entitled, "Elopement Prevention," with an issue date of May, 2-12. This policy indicated, "It is the policy of this community to keep all clients safe from harm. Those at risk for elopement will be identified and proactive interventions will be implemented..." This citation relates to Intake 469021.		updates for residents identified as elopement risks, and monthly leadership review of environmental safety, staffing adequacy, and supervision practices to ensure systems supporting elopement prevention remain effective. **How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The corrective actions will be monitored through a structured and documented quality assurance process. Weekly environmental audits of all exits and secured areas will be completed, with results reviewed by the Executive Director or designee, and a monthly administrative audit will be conducted to ensure continued compliance and identify trends. All residents identified as an elopement risk will have their Service Plans reviewed weekly for 30 days and monthly thereafter, with immediate updates following any incident or change in condition. The facility will maintain a log of all elopement incidents and attempts, which will be reviewed weekly for the first 30 days and monthly thereafter to identify systemic issues requiring administrative	

			intervention. Administrative performance will be monitored through monthly QA meetings where leadership will review elopement-related audit findings, camera review summaries when relevant, incident trends, and compliance with risk-assessment requirements. Any identified lapses will result in immediate corrective action, including reeducation, procedural modification, or implementation of additional safeguards. The Executive Director and Director of Nursing will conduct a quarterly evaluation of the entire elopement-prevention system, with findings documented and incorporated into ongoing operational improvements. Elopement-risk monitoring will be fully integrated into the facility's Quality Assurance Oversight Program to ensure long-term compliance and accountability at the administrative level. **Date of Compliance:** Saturday, May 2, 2026	

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) DATE05/12/2026