STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/11/2026

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 469410. Intake 469410 - State deficiency related to the allegations is cited at R217 Survey date: May 11, 2026 Facility number: 003916 Residential Census: 57 This State Residential Finding is cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on May 12, 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 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and	R 0217	R0090 An interdisciplinary team review determined that Resident B's needs exceeded the facility's ability to provide a safe environment due to elopement	05/29/2026

	document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.		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. All residents have the potential to be affected by the same deficient practi To ensure the deficient practice does not recur, the facility has 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,	

	Based on observation, interview and record review, the facility failed to timely ensure a resident's service plan was updated with the risk of elopement for 1 of 3 residents' evaluations and service plans reviewed. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/11/26 at 11:30 a.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease (impairment or death of nerve cells in the brain) and major neurocognitive disorder (a decline in cognitive) due to another medical condition. The resident was admitted to the facility on 3/19/26. A Mini Mental State Examination, dated 3/12/26, indicated Resident B was cognitively intact. A nursing note, dated 3/20/26, indicated Resident B had exited the building and was found out front. The resident had stated he was not staying in the facility. Staff was able to bring resident back into building.		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 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. The corrective actions will be monitored through a structured and documented quality assurance process. Weekly environmental audits of all exits	

	A resident assessment, dated 3/22/26, indicated Resident B had difficulty with concentration and was forgetful occasionally. The resident did not wander and was not an elopement risk. A service plan unsigned by resident dated 3/24/26, indicated the resident's cognition support was needed minimally due to forgetfulness and difficulty concentrating. The resident did not have any history of wandering or elopement. A medical provider visit note, dated 4/6/26, indicated Resident B's diagnoses included, but were not limited to, Parkinson's Disease and Major Neurocognitive disorder due to another medical condition. The medical provider ordered the resident to be evaluated and seen by psych as needed. A psych visit note for Resident B, dated 4/3/26, indicated the resident was admitted to the facility on 3/19/26. The resident had gotten confused and tried to elope. He was observed by staff using a walker turned backwards. The resident had stated, "I am going home." Resident B was easily redirected back into the facility. The resident had not made any other elopement attempts. Resident B had severe cognitive linguistic deficit (grammar and vocabulary may be intact, but		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	

poor memory recall, focus, reasoning, trouble staying on topic) due to Parkinson's Disease. Psych Provider 2 indicated she would conduct Montreal Cognition Assessment (a screening tool to determine if cognitive impairment and early dementia) on Resident B the next week.

A Montreal Cognition Assessment (MOCA), dated 4/10/26, indicated Psych Provider 2 had conducted a cognition assessment with Resident B. The resident scored a 14 out of 30 on the assessment. The score total indicated the resident was moderately cognitively impaired.

Resident B's service plan was not updated with a risk of elopement.

A nursing note written by the Wellness Director, dated 4/27/26, indicated a staff member had pulled into the parking to arrive to work, and saw Resident B walking on the side of the road in a close housing neighborhood. The staff member was able to bring the resident back to the building. The Wellness Director had been notified a staff member had given the resident the door code to leave the facility. Resident B had scored 14/30 on MOCA mental assessment. "Resident has Parkinson's disease that

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.

Please accept response for citation R0217 beginning here.

R0217

What corrective action(s) will be accomplished for those residents found to be affected by the same deficient practice: An interdisciplinary team review determined that Resident B's cognitive scores since admitting to Bloom indicate that Resident B has good days and challenging days. Risk Elopement Assessment shows that Resident B is considered at risk. Resident B's service plan had not been updated to reflect necessary level of care over a period of more than two weeks.

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

	has resulted in mental cognitive decline." The Wellness Director had ordered staff to check on resident every 15 minutes. A nursing note written by Executive Director (ED), dated 4/28/26, indicated she had given Resident B the door code to exit the building at approximately 3:00 p.m. on 4/27/26. The resident had asked her to leave, so he could take a walk. She has had multiple conversations with Resident B each day, and he had not made any statements to the ED the desire to leave the facility. The resident wanted to look around the neighborhood. The resident did not elope. An interview was conducted with the ED and Wellness Director on 5/11/26 at 9:40 a.m. The ED indicated Resident B leaving the facility was not considered an elopement. He had requested on the evening of 4/27/26 for the exit code to take a walk in the neighborhood to get some fresh air. "I know him better than anyone here." She had spoken to the resident multiple times daily. He had never voiced anything to her about wanting to leave the facility. The resident was cognitively intact. She had conducted the cognitive assessment on him prior to admission. As of 4/27/26, the		**to ensure that the deficient practice does not recur:** A 100% audit has been 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 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. 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 has also been incorporated into the facilities	

	Wellness Director was not aware she had given him the code to leave and reported he had eloped. The resident was placed on 15 minute checks until today. He was currently on hourly checks as of that day. The Wellness Director indicated the resident's cognition had decline since admission. He was unable to leave the facility unattended. An interview was conducted with the Wellness Director on 5/11/26 at 1:38 p.m. She indicated Resident B had exited the building on another occasion, the day he was admitted. He was found at the dumpsters on the facility property. He had voiced he was not staying and did report he wanted to go home. He had not made any other attempts to leave until 4/27/26. Resident B had been confused since admission. He turned his walker backwards often. He was not cognitively intact. The resident's service plan should have been updated. An observation and interview was conducted with Resident B on 5/11/26 at 2:03 p.m. The resident was observed clean and dressed. He was pleasantly confused during the interview. He indicated he could not recall a time he was walking outside in the neighborhood. The staff		Quality Assurance Oversight Program, where leadership will review audit findings, incident trends, and overall compliance. Any identified deficiencies will be addressed immediately through corrective action, including re-education, process adjustments, or additional safeguards to ensure resident safety and prevent recurrence. **By what date will the systemic changes be completed:** Friday, May 29, 2026	

	treated him great in the facility. He did not like his apartment. "It's too small." A service plan policy was provided by the ED on 5/12/26 at 1:56 p.m. It indicated, "...A Resident Service Plan should be developed, implemented and maintained for each resident. Procedure:...2. The Resident Service Plan should be reviewed and revised as necessary by the community care team under the direction of the Executive Director, Wellness Director, or designee: A. Following a change in the condition of the resident that results in altered care needs over a period of greater than two weeks...5. Upon initial review and subsequent changes, members of the community care team that contributed to the Resident Service Plan, including the Executive Director, Wellness Director, or designee, and the resident/legally responsible party should sign the Resident Service Plan." This citation relates to Intake 469410.			

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) DATE05/29/2026