STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/23/2025

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 Intake IN00465536. Intake IN00465536 - State deficiencies related to the allegation(s) are cited at R52 and R356. Survey Dates: October 22 and 23, 2025 Facility Number: 010064 Residential Census: 55 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 31, 2025.	R 0000	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 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	R 0052 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	11/30/2025

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to ensure a resident remained free from neglect related to the lack of adequate supervision for a cognitively impaired resident, resulting in the resident being found in the parking lot of a local restaurant located near a busy intersection for 1 of 3 residents reviewed for exit seeking behaviors. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/22/25 at 1:24 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility on 10/2/25. The 9/23/25 Preadmission Evaluation indicated Resident B did not have behavioral issues of wandering, exit seeking, or left home and became lost, currently or in the past. The 9/23/25 Elopement Risk Evaluation indicated she was		practice; Resident B was immediately located and safely returned to the facility within approximately ten minutes of elopement. Resident B was assessed by the Director of Nursing (DON) and found to have no injuries. Resident B's care plan was updated immediately to include enhanced elopement precautions, including one-to-one supervision during periods of increased agitation, frequent safety checks, and environmental modifications to reduce the exit seeking triggers. The responsible staff members (CNA 2 and QMA 3) involved in the incident were counseled and re-educated on elopement prevention, emergency response procedures, and communication protocols during alarm activations. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. A comprehensive audit was conducted on all residents with cognitive impairment or identified exit-seeking/wandering behaviors. All residents were reassessed using the Elopement Risk Assessment Tool to ensure current risk status and care plans to reflect accurate supervision and interventions. Any resident identified as moderate or high risk for elopement had individualized interventions added, such as visual cues, and increased staff monitoring during shift transitions	

	cognitively impaired per the Folstein Mini Mental Exam and was ambulatory, even if unsafe for self-ambulation. The 10/8/25 progress note indicated Resident B was exit seeking with packed clothes and wanting to leave. The 10/11/25 progress note indicated Resident B was observed with increased confusion and agitation. She was wandering around the community upset with her son. She continued to go for exit doors looking for her son. The 10/14/25, 10:52 a.m. progress note indicated Resident B had been wandering around the facility and needing constant redirection. She was easily redirected but needed supervision. The 10/14/25, 10:55 a.m. progress note indicated she continued to need supervision secondary to wandering around the facility. The 10/14/25, 10:58 a.m. progress note indicated she continued to need supervision secondary to wandering around the facility. The 10/15/25, 8:35 p.m. note indicated she continued to wander around the unit in and out of resident's rooms. She was trying to adjust to her new		and alarm events.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 receive immediate re-education on Elopement prevention and resident supervision requirements. Immediate headcount and search protocol during and following fire alarms or emergency evacuations. Proper communication chain of command and reporting during emergency events. The facility installed louder exit door alarms on all memory care unit exits to improve staff awareness during any door breaches. The Fire alarm and door alarm systems were reviewed and re-tested by the Maintenance Director to ensure all alarms remain engaged during emergency events. The Elopement Response policy and Abuse/Neglect Policy were reviewed, and staff made aware of responsibilities during fire alarms and included immediate headcount expectations.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 Director of Nursing or designee will conduct unannounced audits twice weekly for four weeks, then monthly for 3 months, verifying staff response time and supervision in the memory care unit. Completion of headcounts during any alarm drills or real events. Documentation of elopement risk . Findings will be reviewed during the stand-up clinical meetings to identify trends and ensure corrective measures remain effective. Any	

	surroundings. The 10/16/25, 1:53 p.m. note indicated she wandered in and out of other resident's rooms, required constant reminders/redirection to her room. She spoke about being upset with her son "for putting her here and taking her money" asking other residents to help her get a lawyer. The 10/16/25, 8:31 p.m. note indicated she continued to wander around the unit in/out of residents' rooms. She was very disappointed of her son for putting her here, stated, "he doesn't care about her anymore." The 10/17/25, 6:17 p.m. note indicated she was wandering around the unit trying to get out. She was very concerned about being here and wanted to get out. The 10/10/25 Service Plan indicated she was independent with mobility. She had a memory or cognitive impairment, and the care team was to support her with orientation, redirection and wayfinding. It indicated she wandered throughout the building, and the plan was for the care team to monitor for changes in her condition and conduct a reappraisal as appropriate. There were no		noncompliance identified through audits will result in immediate retraining and disciplinary action if warranted.By what date will the systemic changes be completed. 11/30/2025	

other interventions listed to address her wandering, having her clothes packed, or her risk for exiting the facility.

A tour of the memory care unit of the facility, located on the third floor, and interview was conducted with the Director of Nursing (DON) on 10/22/25 at 10:35 a.m. There were two exit doors on the unit. One was located in the living room area and led to a stairwell to the first floor, where there was another exit door leading directly outside. This exit door had a fire alarm nearby, on the wall to the left of the door. The DON indicated Resident B exuded exit-seeking behaviors and got out of the facility once, this past Saturday, when the fire alarm by the living room exit door was pulled. When the fire alarm was pulled, all of the fire doors shut, and all of the exit doors opened, including the two exit doors on the memory care unit. After doing a head count, staff realized Resident B was missing. All staff began to search for her. The DON was off that day and headed to the facility after receiving the phone call that Resident B was missing. Resident B was found near the street by a local restaurant. Certified Nurse Aide (CNA) 3 assisted Resident B into her car and returned her to the facility. The DON completed an assessment of Resident B,

	and they informed the Administrator, Resident B's physician, and Resident B's son of the incident. They thought Resident B was gone from the facility for about ten minutes, as she was back by the time the DON reached the facility. The 10/19/25 follow-up incident report was provided by the Administrator on 10/22/25 at 11:02 a.m. It indicated, on 10/18/25 at 7:01 p.m., a resident on the memory care unit of the facility pulled the fire alarm located near the living room area. When QMA (Qualified Medication Aide) 3 did a head count, they found that Resident B was not on the unit. CNA 2 was on break at the time and saw Resident B in the road near a local restaurant. CNA 2 safely brought Resident B back to the facility. The DON assessed Resident B with no injuries noted. Staff were re-educated on the importance of maintaining constant supervision and accountability of all residents, especially during emergency situations such as fire alarms. QMA 3 and CNA 2 were counseled and re-trained on proper response and communication during emergency events. An interview was conducted with CNA 2 on 10/22/25 at 11:48 a.m. She indicated she'd worked at the facility for about			

	18 months, and she usually worked on the memory care unit of the facility. She was on break when the fire alarm went off on 10/18/25. She was outside at the time and could hear the alarm going off. QMA 3 called her and informed her they did a head count and Resident B was missing. So, CNA 2 went to her car to drive around and look for her. While driving, CNA 2 spotted Resident B walking toward the parking lot of a nearby fast food restaurant. CNA 2 did not see Resident B cross a street or in the street at anytime. The facility's property backs up against the property of a fast food burger restaurant. The fast food burger restaurant backs up against a fast food taco restaurant. You could walk from the facility to the fast food taco restaurant by going through the grassy area of the facility, then through the fast food burger parking lot, then reach the parking lot of the fast food taco restaurant, where Resident B was found. From the time CNA 2 spotted Resident B walking, CNA 2 had to make three right turns to enter into the taco restaurant parking lot. CNA 2 got out of her car and called Resident B's name to come towards her. Resident B and CNA 2 walked towards each other. By the time they made actual contact, it was in the parking lot of the taco restaurant. She was able to			

	assist Resident B into her car and bring her back to the facility. Resident B hadn't made it to the busy intersection yet, and she was "so glad." Resident B didn't look afraid when she found her and was "probably looking for her son." She thought it was about seven minutes from the time she heard the alarm go off until she reached Resident B in the taco restaurant parking lot. She and the other staff were retrained to listen and look at the actual exit doors when the fire alarm went off. An interview was conducted with QMA 3 on 10/22/25 at 1:07 p.m. He indicated he'd worked at the facility for two years on all units. Resident B was new to the memory care unit, and on Saturday, the fire alarm went off. After the alarm was reset, one of the exit doors on the unit was heard alarming also. He did a head count and noticed Resident B was not there. He called CNA 2, who was on break and informed her Resident B was missing. They were retrained afterwards to ensure they do a head count and to keep an eye on residents trying to escape. An observation of exit doors in the facility and interview was conducted with the Maintenance Director on 10/22/25 at 1:45 p.m. An observation of the exit door in the living room area of			

	the memory care unit was made. It led into a stairwell, down two flights of stairs, to the first floor, where there was another exit door, leading directly outside. The Maintenance Director indicated when the fire alarm went off, all fire doors closed, and all exit door alarms disengaged, including the exit doors into the stairwells from the memory care unit and exit doors out of the building. There was a key for the pull fire alarms, that you had to use to reset the pull alarms. There were keys located at the fire panel downstairs and inside of the medication cart. Staff called to ask him how to shut off the pull alarm on Saturday, because the staff didn't know how or "their minds just went blank." An interview was conducted with the Administrator on 10/22/25 at 11:30 a.m. She indicated they retrained staff on how to reset the fire alarm, when the alarm was pulled. Staff knew how to reset it, when it was set off by a smoke detector, but not by a pull station, which involved the use of a key. They also ordered louder door alarms for the exit doors. When she reviewed the camera, she saw Resident B pacing in the living room area just prior to the alarm going off, so she was pretty sure Resident B was the one who pulled the			

	fire alarm. The Abuse, Neglect and Exploitation Reporting and Investigation policy was provided by the DON on 10/22/25 at 10:30 a.m. It indicated, "[Name of facility] is committed to maintaining a safe environment for each resident, visitor and associate. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director, or designee, or the supervisor on duty for investigation and appropriate follow-up...Neglect is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly confining a resident; or depriving a resident or [sic] necessary support, including food, shelter and medical care." This Citation relates to Intake IN00465536. Based on observation, interview, and record review, the facility failed to ensure a resident remained free from neglect related to the lack of adequate supervision for a cognitively impaired resident, resulting in the resident being found in the parking lot of a local restaurant located near a busy intersection for 1 of 3 residents reviewed for exit			

seeking behaviors. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 10/22/25 at 1:24 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility on 10/2/25.

The 9/23/25 Preadmission Evaluation indicated Resident B did not have behavioral issues of wandering, exit seeking, or left home and became lost, currently or in the past.

The 9/23/25 Elopement Risk Evaluation indicated she was cognitively impaired per the Folstein Mini Mental Exam and was ambulatory, even if unsafe for self-ambulation.

The 10/8/25 progress note indicated Resident B was exit seeking with packed clothes and wanting to leave.

The 10/11/25 progress note indicated Resident B was observed with increased confusion and agitation. She was wandering around the community upset with her son. She continued to go for exit doors looking for her son.

The 10/14/25, 10:52 a.m. progress note indicated Resident B had been wandering around the facility and needing constant redirection. She was

easily redirected but needed supervision.

The 10/14/25, 10:55 a.m. progress note indicated she continued to need supervision secondary to wandering around the facility.

The 10/14/25, 10:58 a.m. progress note indicated she continued to need supervision secondary to wandering around the facility.

The 10/15/25, 8:35 p.m. note indicated she continued to wander around the unit in and out of resident's rooms. She was trying to adjust to her new surroundings.

The 10/16/25, 1:53 p.m. note indicated she wandered in and out of other resident's rooms, required constant reminders/redirection to her room. She spoke about being upset with her son "for putting her here and taking her money" asking other residents to help her get a lawyer.

The 10/16/25, 8:31 p.m. note indicated she continued to wander around the unit in/out of residents' rooms. She was very disappointed of her son for putting her here, stated, "he doesn't care about her anymore."

The 10/17/25, 6:17 p.m. note indicated she was wandering

	around the unit trying to get out. She was very concerned about being here and wanted to get out. The 10/10/25 Service Plan indicated she was independent with mobility. She had a memory or cognitive impairment, and the care team was to support her with orientation, redirection and wayfinding. It indicated she wandered throughout the building, and the plan was for the care team to monitor for changes in her condition and conduct a reappraisal as appropriate. There were no other interventions listed to address her wandering, having her clothes packed, or her risk for exiting the facility. A tour of the memory care unit of the facility, located on the third floor, and interview was conducted with the Director of Nursing (DON) on 10/22/25 at 10:35 a.m. There were two exit doors on the unit. One was located in the living room area and led to a stairwell to the first floor, where there was another exit door leading directly outside. This exit door had a fire alarm nearby, on the wall to the left of the door. The DON indicated Resident B exuded exit-seeking behaviors and got out of the facility once, this past Saturday, when the fire alarm by the living room exit door was			

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	CNA 2 safely brought Resident B back to the facility. The DON assessed Resident B with no injuries noted. Staff were re-educated on the importance of maintaining constant supervision and accountability of all residents, especially during emergency situations such as fire alarms. QMA 3 and CNA 2 were counseled and re-trained on proper response and communication during emergency events. An interview was conducted with CNA 2 on 10/22/25 at 11:48 a.m. She indicated she'd worked at the facility for about 18 months, and she usually worked on the memory care unit of the facility. She was on break when the fire alarm went off on 10/18/25. She was outside at the time and could hear the alarm going off. QMA 3 called her and informed her they did a head count and Resident B was missing. So, CNA 2 went to her car to drive around and look for her. While driving, CNA 2 spotted Resident B walking toward the parking lot of a nearby fast food restaurant. CNA 2 did not see Resident B cross a street or in the street at anytime. The facility's property backs up against the property of a fast food burger restaurant. The fast food burger restaurant backs up against a fast food taco restaurant. You could walk from the facility to the fast food			

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	An observation of exit doors in the facility and interview was conducted with the Maintenance Director on 10/22/25 at 1:45 p.m. An observation of the exit door in the living room area of the memory care unit was made. It led into a stairwell, down two flights of stairs, to the first floor, where there was another exit door, leading directly outside. The Maintenance Director indicated when the fire alarm went off, all fire doors closed, and all exit door alarms disengaged, including the exit doors into the stairwells from the memory care unit and exit doors out of the building. There was a key for the pull fire alarms, that you had to use to reset the pull alarms. There were keys located at the fire panel downstairs and inside of the medication cart. Staff called to ask him how to shut off the pull alarm on Saturday, because the staff didn't know how or "their minds just went blank." An interview was conducted with the Administrator on 10/22/25 at 11:30 a.m. She indicated they retrained staff on how to reset the fire alarm, when the alarm was pulled. Staff knew how to reset it, when it was set off by a smoke detector, but not by a pull station, which involved the use of a key. They also ordered louder door alarms for the exit			

	doors. When she reviewed the camera, she saw Resident B pacing in the living room area just prior to the alarm going off, so she was pretty sure Resident B was the one who pulled the fire alarm. The Abuse, Neglect and Exploitation Reporting and Investigation policy was provided by the DON on 10/22/25 at 10:30 a.m. It indicated, "[Name of facility] is committed to maintaining a safe environment for each resident, visitor and associate. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director, or designee, or the supervisor on duty for investigation and appropriate follow-up...Neglect is defined in Indiana as an act or omission which places a resident in a situation that may endanger the resident's life or health; abandoning or cruelly confining a resident; or depriving a resident or [sic] necessary support, including food, shelter and medical care." This Citation relates to Intake IN00465536.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible	R 0356	R 0356 What corrective action(s) will be accomplished for those residents found to have been	11/30/2025

	for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on observation, interview, and record review, the facility failed to ensure a resident's photograph, identification information, and emergency contact information was included in the current emergency binder for 1 of 3 residents reviewed for exit seeking behaviors. (Resident B)		affected by the deficient practice; - Resident B’s photograph, identification information, and emergency contact data were immediately added to her emergency binder and elopement risk binder on 10/22/25. The Director of Nursing verified that all required emergency information was accurate and complete, including the resident’s name, sex, room number, age, physician, responsible party, hospital preference, and allergies. Staff were re-educated on the importance of maintaining complete emergency binders for all residents, especially those in the memory care unit. How identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. - A facility wide audit of all resident emergency information binders was completed by the Director of Nursing and designee to ensure every record contained all eight required data elements, including a current photograph. Any missing photographs or incomplete data were corrected immediately by the nursing team. Going forward, any newly admitted resident will have their photograph taken, and their emergency information verified within 24 hours of admission.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 Emergency Information File	

	Findings include: The clinical record for Resident B was reviewed on 10/22/25 at 1:24 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility on 10/2/25. Her electronic clinical record did not include a photograph of her. The 9/23/25 Elopement Risk Evaluation indicated she was cognitively impaired per the Folstein Mini Mental Exam and was ambulatory, even if unsafe for self-ambulation. The 10/19/25 follow-up incident report was provided by the Administrator on 10/22/25 at 11:02 a.m. It indicated, on 10/18/25 at 7:01 p.m., a resident on the memory care unit of the facility pulled the fire alarm located near the living room area. When QMA (Qualified Medication Aide) 3 did a head count, they found that Resident B was not on the unit. CNA (Certified Nurse Aide) 2 was on break at the time and saw Resident B in the road near a local restaurant. CNA 2 safely brought Resident B back to the facility. The DON (Director of Nursing) assessed Resident B with no injuries noted. Staff were re-educated on the importance of maintaining constant supervision and accountability of all residents, especially during emergency		procedure was reviewed and revised to ensure: each resident's emergency information file is maintained in both the emergency binder and elopement binder. The file includes all items required under 410 IAC 162-5-8.1 (1-8). A process for monthly verification of accuracy and currency of photos and contact data is in place. The Admissions and Memory Care Director were assigned responsibility for ensuring all new resident records are complete before admission packets are finalized. All photographs are now securely stored electronically and printed for binders immediately upon completion to prevent omission.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 audits of 5 residents per week for 8 weeks, then monthly for 3 months, to verify completeness.- Audit results will be reported monthly in the Clinical Meetings – Any identified discrepancies will be corrected immediately and used as a learning opportunity for staff re-educationBy what date will the systemic changes be completed.	

situations such as fire alarms. QMA 3 and CNA 2 were counseled and re-trained on proper response and communication during emergency events.

An observation and review of the memory care unit emergency binder, located at the memory care unit's nurses' station, was made with the DON on 10/22/25 at 2:30 p.m. An interview was conducted with the DON at this time. Resident B walked past the nurse's station during the interview. Resident B's photograph, identification information, and emergency contact information was not included in the emergency binder. The DON indicated there was an elopement risk binder downstairs, and perhaps Resident B's photograph/information was in there.

An observation and review of the elopement risk binder located behind the front desk of the facility was made with the Administrator on 10/22/25 at 2:44 p.m. An interview was conducted with the Administrator at this time. Resident B's photograph, identification information, and emergency contact information was not included in the elopement risk binder. The Administrator indicated Resident

B's photograph and information should be included.

The Elopement Prevention policy was provided by the DON on 10/22/25 at 12:00 p.m. It indicated, "It is the policy of this community to keep all residents safe from harm. Those at risk for elopement will be identified and proactive interventions will be implemented. Procedure: 1. The resident will be evaluated for elopement risk factors using the Elopement Risk Evaluation form at pre-admission, admission, quarterly, and with a significant change in condition. 2. All residents will have photographs taken and adhered to the Resident's Record for use in the event of an emergency. If the resident is determined to be at risk for eloping, file an Elopement Identification form in his/her file in case it is needed for future use."

This Citation relates to Intake IN00465536.

Based on observation, interview, and record review, the facility failed to ensure a resident's photograph, identification information, and emergency contact information was included in the current emergency binder for 1 of 3 residents reviewed for exit seeking behaviors. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 10/22/25 at 1:24 p.m. Her diagnoses included, but were not limited to, dementia. She was admitted to the facility on 10/2/25. Her electronic clinical record did not include a photograph of her.

The 9/23/25 Elopement Risk Evaluation indicated she was cognitively impaired per the Folstein Mini Mental Exam and was ambulatory, even if unsafe for self-ambulation.

The 10/19/25 follow-up incident report was provided by the Administrator on 10/22/25 at 11:02 a.m. It indicated, on 10/18/25 at 7:01 p.m., a resident on the memory care unit of the facility pulled the fire alarm located near the living room area. When QMA (Qualified Medication Aide) 3 did a head count, they found that Resident B was not on the unit. CNA (Certified Nurse Aide) 2 was on break at the time and saw Resident B in the road near a local restaurant. CNA 2 safely brought Resident B back to the facility. The DON (Director of Nursing) assessed Resident B with no injuries noted. Staff were re-educated on the importance of maintaining constant supervision and accountability of all residents, especially during emergency situations such as fire alarms. QMA 3 and CNA 2 were

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This Citation relates to Intake

	IN00465536.			

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 SIGNATUREHelga A Bradley	TITLEExecutive Director	(X6) DATE11/07/2025