STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOM AT WILLOW	2725 LAKE CIRCLE DR, INDIANAPOLIS, , 46268

(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 468317. Intake 468317-State deficiencies related to the allegations were cited at R52. Survey dates: March 19, 2026 Facility number: 010234 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 24, 2026.	R 0000		
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;	R 0052	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	04/15/2026

	(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 a resident was free from neglect, when a cognitively impaired resident wandered away from the facility for an undetermined amount of time for 1 of 3 residents reviewed for elopement. (Resident B) This deficient practice resulted in Resident B ambulating an undetermined route and was found approximately 21 miles away from the facility without staff knowledge. Findings include: The clinical record for Resident B was reviewed on 3/19/26 at 12:30 p.m. The diagnoses included, but were not limited to, chronic kidney disease, alcohol use, emphysema, and hypertension. The resident had been admitted to the facility on 1/30/26. His face sheet had diagnoses of Alzheimer's disease and dementia. A Mini Mental State		submitted because of requirements under state law. Please accept this Plan of Correction as our credible allegation of compliance. R-052 1. 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 not readmitted to the facility, and discharge planning was completed to ensure safe placement in an appropriate level of care. 2. All residents have the potential to be affected. 3. In an effort to ensure the deficient practice will not recur, a 100% audit was completed, including Elopement Risk Evaluation on all residents, to identify any residents at risk for elopement. Any residents identified as at risk had individualized interventions implemented and Service Plans revised to reflect current needs. Effective immediately, Elopement Risk Evaluations will be completed on all	

	Examination, dated 1/15/26, indicated Resident B had a moderate cognitive impairment. An elopement risk evaluation, dated 1/15/26, indicated Resident B had scored below a 24 on the Mini Mental State Exam and had attempted to leave the community unaccompanied in the past. He was not placed in the memory care unit and was admitted to the first floor of the facility. A hospital emergency room document, dated 2/26/26, indicated Resident B arrived at the hospital by ambulance after eloping from his assisted living facility on the north side of Indianapolis. He was found wandering near the corner of Sumner and Shelby street in Greenwood with an altered mental status. (The location listed was 22 miles from the facility according to Goggle maps) (According to Goggle maps, if Resident B walked the distance, it would take approximately 5 hours and 51 minutes) Resident B's assisted living facility would not accept him back due to not having any available memory care beds. He was admitted by the hospitalist team for his intellectual disability and related safety concerns since he was unable to discharge back to the facility. The hospital document indicated		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. 4. In an effort to ensure continued monitoring to ensure the corrective actions are sustained 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, 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	

	Resident B's behaviors at the assisted living facility were reported as wandering, disturbing other facility residents and entering their rooms, going into the facility kitchen, disrupting staff, and taking/hiding items from general areas. A facility written statement, dated 2/26/26, indicated RN 1 had last seen Resident B sitting on a couch in the lounge between 6:45 p.m. and 6:50 p.m., when the resident told her he was heading home. He was then observed walking towards his room. She was the last staff member to have seen the resident before the fire alarm was pulled. The facility timeline of events indicated: At 8:42 p.m., a fire alarm was pulled on the 3rd floor, west stairwell, by a memory care resident. At 8:52 p.m., the Director of Nursing (DON) was notified staff were unable to locate Resident B after the fire alarm was pulled. At 8:59 p.m., the DON arrived at the premises to assist in the search for Resident B in the building and on the premises. At 9:26 p.m., the DON asked for assistance from other		the first 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 findings, 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. Date of Compliance: 4/15/2025	

managers.

At 9:31 p.m., the Executive Director (ED) was on the way to the facility, and all department heads were notified to head to the facility.

At 9:58 p.m., the facility and premises were searched two times. Local surroundings were searched, but Resident B was not found.

At 9:59 p.m., 911 was called to assist in locating the resident

At approximately 10:30 p.m., Resident B's sister called the facility and indicated the resident was at the hospital. An Emergency Medical Technician picked him up and transported him to the hospital.

During an interview, on 3/19/26 at 11:58 p.m., the Executive Director (ED) indicated Resident B was approximately 20-30 miles from the facility. He was gone approximately 10 minutes before staff realized he was gone. It was one and one half hours before the facility found out where the resident was. An Emergency Medical Technician picked Resident B up somewhere between the facility and the hospital in Greenwood. The EMTs took Resident B to the hospital in Greenwood. Resident B would try to press on the exit doors, but he was easily

redirected. They re-educated him not to press on the exit doors. He was not placed in the memory care unit because he did not have a diagnosis of Alzheimer's disease or dementia, he had a learning disability, and there were no empty beds in their memory care unit. The facility had been trying to relocate the resident related to safety concerns but had not been able to find a facility to take him. The front door was always locked except when the fire alarm went off. The night Resident B left, a memory care resident had pulled the fire alarm in memory care. The staff completed their head counts after the fire alarm and had determined Resident B was missing. There was one nurse working on the assisted living side, which was where Resident B lived. She had to determine where the fire alarm was, so she could not make sure the doors on the first floor were secure. There were three CNAs upstairs who made sure the doors were kept secure and the residents were watched. The last time Resident B was seen by staff prior to the fire alarm going off was 6:50 p.m., when he was heading to his room to watch television.

During an interview, on 3/19/26 at 2:00 p.m., the ED indicated the resident's family had filled

	out the information on Resident B's face sheet and they were the ones who marked Resident B had a diagnosis of Alzheimer's disease and dementia. There had not been an official diagnosis given to him by a doctor for those two diseases. A current facility policy, titled "Elopement Prevention", dated May 2012, indicated "...If a resident is identified as being an elopement risk, a plan would be developed to determine the level of the resident's risk for elopement and implementation of risk-reducing interventions...a wander guard or other placement within or out of the community...." This citation relates to Intake 468317.			

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) DATE04/06/2026