STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BLOOM AT EAGLE CREEK	5045 W 52ND ST INDIANAPOLIS, IN 46254

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00409427. Complaint IN00409427 - State deficiencies related to the allegations are cited at R0052. Survey date: June 7, and 8, 2023 Facility number: 003915 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 16, 2023.	R 0000	R 0000 Submission of this response and Plan of Correction is not a legal admission that the deficiency exists or, that the statement of deficiencies was correctly cited, and is not to be construed as an admission against any interest by the residence, or any employees, agents, or other individuals who drafted or who may be discussed in the response or Plan of correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (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 management and oversight of a resident with exit seeking behaviors, resulting in the elopement of a confused resident who then wandered approximately 2 miles away from the	R 0052	R 0052 What corrective actions will be accomplished for those residents found to have been affected by the	06/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Helga Bradley	Executive Director	06/27/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	facility and was missing for several hours for 1 of 3 residents reviewed for wandering and exit seeking behaviors (Resident B). Findings include: A confidential interview during the survey indicated, on 5/15/23 at 5:00 p.m., Resident B was found to be missing from the facility and eventually located at 9:45 p.m. at a gas station 2 miles from the facility. An Indiana State Department of Health Survey Report System report, dated 5/15/23 at 7:30 p.m., indicated upon evening rounds staff found Resident B missing. Staff searched inside and outside of the facility and the resident could not be located. Family and police were notified. Resident was located and returned to the facility, then discharged to the family member who took her to a local hospital where she was admitted. Resident B's record was reviewed on 6/7/23 at 11:52 a.m. Resident B's profile indicated she was admitted on 5/3/23, and had diagnoses to included, but were not limited to, Alzheimer's disease. An Admission Agreement for Resident B, effective date 5/1/23. The agreement indicated, " ...5.12 Staff: Company shall provide staff twenty-four [24] hours a day, to provide supervision of, and assistance to, Resident. Such supervision and assistance shall be for the safety of all residents and assistance to residents during an emergency ...5.13 Supervision: Company shall provide care and supervision subject to the terms of this Agreement to the extent that such services are in accordance with Resident's Assessment/Service Plan and law and included in		deficient practice: Resident B discharged from Bloom at Eagle Creek on 5/15/2023. 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 residing in the community have the potential to be affected. What measures will be put in place or what systematic changes the facility will make to ensure that the deficient practice does not recur: The Executive Director and Wellness Director reviewed Bloom Policy and Procedure on Admission, Mini Mental Assessment, Elopement Assessment, and Resident Rights. All residents have had a Mini Mental Assessment and Elopement Assessment completed on 5/26/2023 and care plans have been updated as needed. All associates have received education/training on Resident Rights, and Elopement Policy and Procedure. How the corrective actions will be monitored to ensure the deficient practice will not recur what quality assurance program will be put in place: Resident clinical assessments will be reviewed weekly by Executive Director or designee. By what date the systemic	

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	the Service Rate...." A progress notes for Resident B, dated 5/4/23 at 10:00 p.m., indicated the resident was exit seeking during the latter part of the shift and redirected back to her room. A progress notes for Resident B, dated 5/5/23 at 10:00 p.m., indicated the resident continued to exit seek. Resident was redirected, offered fluids, and offered to watch television. Will continue to monitor. An Elopement Risk Evaluation, signed and dated 5/3/23, indicated the resident score below 24 on the Folstein Mini Mental Exam which indicated possible cognitive impairment. The resident had a history of wandering, resident made personal choices that may increase the risk of elopement (for example, frequently opened doors to other resident apartments, bathrooms, exhibited searching behaviors, packing, etc.). Resident B experienced the frequent and urgent need to use the toilet, especially at night, and had difficulty finding the bathroom. Resident B expressed a desire to leave the community. A Service Plan/Care Plan for Resident B, dated 5/5/23, unsigned by the resident, family responsible party, or a staff member indicated the resident needed support on a daily basis as she did not understand why she was in the facility, was looking for her mother, and paced the halls daily. The resident exhibited some difficulty in decision making, and required cues as she had difficulty remembering and using information. Resident B could ambulate as much and as often as she wanted with a steady gait, but she needed assistance of one person outside for safety. The resident had been observed up during the night		changes will be completed: June 21, 2023	

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	and staff was to redirect her to her apartment if needed. A progress notes for Resident B, dated 5/8/23 at 10:00 a.m., indicated the resident was wandering around the common area, carrying items such as a lamp and picture. The resident indicated she was cleaning out her room. There were two (2) episodes of this behavior. A progress notes for Resident B, dated 5/9/23 at 12:00 a.m., indicated the resident was exit seeking at the rear exit door. Resident had come out of the laundry room with a basket and bags of clothes. Writer had asked where the resident was going, and resident stated she was going home. A progress notes for Resident B, dated 5/9/23 at 10:00 p.m., indicated the resident continued to exit seek, was redirected back to her room. A progress notes for Resident B, dated 5/10/23 at 9:30 a.m., the resident was in the hallway trying to get staff to assist her in moving out. A progress notes for Resident B, dated 5/13/23 at 6:00 p.m., indicated the resident had managed to get out the front door when visitors came in, another resident alerted staff saying resident had headed to parking lot and was called back to a rocker by peers. The resident was redirected into the building and asked, "why can't I just leave?" The Administrator and Wellness Director asked the staff member to ask the family member to pick up the resident. The family member indicated, "I took her there because she was not safe in her own home. Physician also stated resident not safe in her home." Family member to came on Mother's Day Sunday and took her out. Family tried to convince her to stay at the apartment in the			

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	facility. A progress notes for Resident B, dated 5/13/23 at 7:00 p.m., indicated resident was in the back of facility walking around building after she went out the smoker's door. Staff returned her to the facility and brought her upstairs to the nursing office. Vital signs were taken and included: temperature 97.9 Fahrenheit (F), pulse 81, respirations 18, and blood pressure 187/102 (normal 120/80). A progress note for Resident B, dated 5/14/23 at 12:30 p.m., indicated the resident asked staff where there were bags to put her clothes in. On a progress note for Resident B, dated 5/15/23 at 9:00 p.m., Qualified Medication Aide (QMA) 11 documented at 7:15 p.m., she saw Resident B in her room. Approximately 10 minutes later she went back to the resident's room, and she was not there. QMA 11 and staff immediately searched inside and outside the building and could not find the resident. The Wellness Director and Resident B's family member were notified. The resident was found later. A progress note for Resident B, dated 5/15/23 at 9:45 p.m., indicated resident was found and was being checked out by Emergency Medical Services (EMS). No injuries were noted. Resident was to be escorted via cop car back to the facility. A progress note for Resident B, dated 5/15/23 at 10:15 p.m., indicated the resident returned to facility. Police officers released the resident to the family member. Writer suggested she be taken to hospital for further evaluation and treatment. The resident's record lacked documentation the physician and resident representative were			

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	consistently made aware of the resident's daily exit seeking behaviors, that she had left the facility unsupervised twice on 5/13/23, or that elopement interventions were implemented. An Elopement Identification page, undated, had a picture of Resident B, her name, hair color, race, age, and sex. Last time and place resident was seen was 6:00 p.m. in the dining room at the facility. Distinguishing characteristics included glasses. Other pertinent information indicated resident responded to her middle name, her family member's name, and had memory problems. During an interview on 6/7/23 at 10:23 a.m., Resident B's family members indicated the resident had been admitted to the facility because she was unsafe to stay at home alone any longer, but she had no history of wandering off. The Administrator had told them the facility did not have a dementia care unit, but the resident would be safe as the staff would watch her and not let her out of the building. After Resident B had eloped on 5/15/23, the family was told by the Maintenance Supervisor that he had seen the resident out by the road on 5/13/23 and took her back inside. On 5/13/23 staff had called the family member and reported the resident was having exit seeking behaviors and wanted him to come pick her up but he was out of town. The staff later called back and said she could stay, and they would secure the doors. The family member indicated on 5/15/23 they got a call asking about Resident B's cellphone, there was no mention of the resident being gone. When they arrived at the facility, they saw police cars and were notified the resident had come up missing around 5:00 p.m. The resident was located at 9:45 p.m. by police at a gas station on 34th			

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	street and Georgetown Rd which was between 2 to 2 ½ miles from the facility. An unidentified lady at the gas station first remembered seeing the resident around 7:00 p.m. The resident told her she thought she was lost. Police and an ambulance were called to check her out. Upon being returned to the facility, the resident indicated she was exhausted, she was "foggy", and stumbling a little. The administrative staff refused to allow the resident back into the facility, took her vital signs while she was sitting on the porch, and family was told they had to find somewhere else for her to go. The facility never explained to them how the resident got out of the facility. The family member indicated they were concerned also with the timing of the incident and when Resident B went missing on 5/15/23. They were originally told the resident was last seen at 5:00 p.m. Then they overheard the staff telling the police she went missing at 6:00 p.m. But the family was there at 6:00 p.m. and the resident was not in her room. Facility staff then pushed back the time to 7:00 p.m. The family member indicated the police were upset the facility waited 2 hours to report the resident gone. During an interview on 6/7/23 at 3:06 p.m., a detective with the Indianapolis Metropolitan Police Department (IMPD) indicated the police department were notified of a missing resident on 5/15/23 at 8:14 p.m. and were told the resident had been missing for 4 -5 hours before they were called. The report gave no indication how the resident got out of the facility, but they were told staff were doing dinner rounds and passing medications and she was found to be gone. A peer on scene said Resident B was going back home. The detective indicated he was unsure who			

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	called an ambulance to the gas station, but EMT's checked the resident out and said there were no injuries. The resident was taken back to the facility by a police officer. Staff at the facility refused to let the resident back into the facility and told her family member to take her to the hospital as she needed a more secured facility. The gas station was 2 miles away when searched on Google maps. Per police body camera video, facility staff were recorded as repeatedly changing the time of the incident when giving statements to the police and family. The detective indicated the facility should have called them as soon as the resident was observed to be missing, there were procedures for missing persons, especially for older folks with dementia. "They were lucky to have found her safe." On 6/7/23 at 3:20 p.m., the smoking area behind the facility near the employee parking lot was observed. The exit door was opened using a keypad security code. The smoking area chairs were accessed by ambulating down the sidewalk approximately 50 feet. The Maintenance Supervisor indicated in his opinion Resident B could not have worked the keypads on the back or front doors as staff would take her out to sit on front porch. His guess was another resident went out to smoke, and Resident B went with them. He had not seen the resident outside on the weekend before she eloped, he'd have brought her back inside. During an interview on 6/7/23 at 3:31 p.m., QMA 9 indicated she routinely worked the evening shift on the first floor, although she was not on duty on 5/15/23 when Resident B eloped. The resident had displayed exit seeking but no other behaviors. Staff monitored the resident, but she could not verbalize other interventions put into place to			

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	prevent the resident from elopement. More cognitively alert residents were given the codes to unlock the front and back doors, and they would go outside independently to sit on the porch. Resident B would not have been given the code to the exit doors. In her opinion, the resident most likely got outside by following another resident out the door. During an interview on 6/7/23 at 3:41 p.m., Licensed Practical Nurse (LPN) 10 indicated, there was an elopement binder that was usually kept in the nurse's station, but the Wellness Director must have taken it to the office that day. Indicated to her knowledge there were no current residents in the facility that were considered elopement risks, most recently Resident B ran off and her family member took her out. Resident B had not been in the facility long, had been exit-seeking, she remembered where she lived and was obsessed with going home. Indicated staff had been diligent about watching the resident, she had to figure possibly a visiting family member let her out the door. No further interventions verbalized that had been put into place to prevent the resident from getting out of the facility without staff knowledge. During an interview on 6/8/23 at 10:56 a.m., the Community Relations Director indicated Resident B had first been referred, reviewed, and accepted for admission in February 2023. Due to financial reasons the resident was not admitted to the facility until 5/3/23. The first day of admission was the resident's best day, after that she began to wander why she was there and was exit seeking. Indicated he was not for sure how the resident got out of the facility but had go guess she went out with another resident.			

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	During an interview on 6/8/23 at 11:36 a.m., the Wellness Director indicated, it was her responsibility to review the clinical information and then confer with the Administrator to make decisions for new resident admissions. Resident B had been exit seeking from admission, interventions in place included having her family member come one time to see if he could calm her down. There had been a discussion with the family member about placing the resident into a secured memory care facility, but the family member was unsure. Within 24 hours of admission the Wellness Director had completed an assessment and instructed the staff to get a picture of the resident as she was concerned about elopement due to the resident packing daily, and she thought her deceased husband lived across the road. Wellness Director indicated she tried to keep Resident B busy during the day, but trying to involve her in activities did not work as the resident was not interested. There were no evening activities for intervention, and staff said the resident would sleep a couple of hours then be back up and wander. Resident B had sundowning, but it was "like 24 hours a day." Staff were not able to confine the resident to the facility as she walked around, and although there was a code on the doors that she could not work, it was assisted living and others would let her in and out. The Wellness Director indicated, on 5/15/23 around 6:30 p.m., QMA 11 had called her to report she could not find Resident B. QMA 11 indicated staff had already looked in the building and outside on the grounds, anywhere that was unlocked. The Wellness Director indicated she came to the facility, had staff contact the family member to see if he had come and picked up the resident and not signed her out, had them call 911,			

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	she contacted additional staff to help, and re-initiated search of all areas to include locked areas. Wellness Director indicated she had called and spoken with the family around 6:30 p.m. - 7:00 p.m. The Administrator and management then showed up to help with the search. Resident B was found and returned to the facility somewhere around 10:00 p.m. - 10:30 p.m. The Wellness Director indicated she was not sure how Resident B got out as there were no cameras, but another resident who sat on the front porch indicated he was being a gentleman and let her out to sit on the porch, saw her go for a walk, and he did not tell anyone. The Wellness Director acknowledged, upon review of the resident record, there was no documentation to indicate a preventive elopement plan had been put into place. During an interview on 6/8/23 at 12:20 p.m., the Area Director of Operations indicated he was at the facility on 5/15/23 to help with the search for Resident B. Sometime after 7:00 p.m., he had received a call from the Administrator and told Resident B was missing. The Administrator indicated the facility had initiated the elopement process, he advised staff to search the facility again to include locked rooms, have a person do a parameter search, then advised staff to start driving and do neighborhood checks with 2 associates. The Administrator had already called the department heads to come in and help and made copies of Resident B's elopement sheet with her picture. When he arrived at the facility, he first drove through neighborhoods nearby without success, and 2 squad cars were already at the facility. A police officer had called the station about doing a silver alert, which required a detective to come to the facility to upload a picture. The Area Director of Operations left the facility driving, and somewhere between 9:15 p.m.			

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	and 9:30 p.m. when he turned onto 34th and Georgetown Rd he saw an ambulance sitting in the parking lot of a gas station. He pulled in and parked to block the ambulance, knocked on the ambulance doors, told them he thought his resident was in the ambulance, informed them police were at the facility getting ready to put out a silver alert, he put a paramedic on the phone with police at the facility, and a decision was made to release the resident to the police at the gas station. Resident B was brought back to the facility by the police. His understanding was a lady working at the gas station had called the paramedics. Regarding the family and police having different reported times of the resident missing and notifying the police, he did not have an explanation, but indicated that the 1st hour after an elopement was always the most crucial. After reviewing Resident B's record, he indicated there were no elopement interventions documented. On 6/8/23 at 2:50 p.m., the Area Director of Operations provided an Elopement Prevention policy, dated May 2012, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy: 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 ...3. Residents 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 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, i.e., a wander guard or other placement within or out of the community."			

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	This State tag relates to Complaint IN00409427.			