STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD OF CARMEL	5829 EAST 116TH STREET, CARMEL, , 46033

(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 Complaint IN00463510. Complaint IN00463510-State deficiencies related to the allegations are cited at R0052. Survey date: July 31, 2025 Facility number: 013217 Residential Census: 49 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 7, 2025.	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	R052 Residents' Rights – Offense The facility failed to ensure a resident was free from neglect, when a resident with a diagnosis of dementia wandered away from the facility, without	09/01/2025

(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 resident with a diagnosis of dementia wandered away from the facility, without staff knowledge, for 1 of 1 resident reviewed for elopement. (Resident B) This deficient practice resulted in Resident B being found by law enforcement near a busy four lane highway.

Findings include:

A facility reported incident (FRI), dated 7/19/25, indicated on 7/18/25, Resident B exited the campus without notifying staff at approximately 6:00 p.m., by following another assisted living resident out the door. He was brought back to the facility later by his family and the authorities.

The clinical record for Resident B was reviewed on 7/31/25 at 2:45 p.m. The diagnoses included, but were not limited to, dementia.

A service plan, dated 5/15/25, indicated Resident B ambulated

staff knowledge for 1 of 1 resident reviewed for elopement.

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

· Resident B still resides at Bickford of Carmel; no further incidents have occurred.

· Service plan has been updated to reflect exit seeking behaviors and his cognitive level GDS 4.

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

· Service plans of residents with exit seeking behaviors will be reviewed to ensure individualized interventions are in place.

· Service plans will be developed and implemented that include interventions for residents with exit seeking behaviors

What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

· Executive Director/Health & Wellness Director to receive

	independently without the use of assistive devices. He required an escort to meals and activities and verbal assist with evacuation from the building. He required occasional help due to forgetfulness and difficulty concentrating. He was disoriented to person, place, and time. He had memory and severe cognitive impairment. He had trouble finding his words and required occasional help with prompting to make his needs known. A nursing progress note, dated 7/19/25 at 12:09 p.m., with a revision date of 7/31/25 at 12:56 p.m., indicated Resident B exited the facility behind Resident C on 7/18/25 around 6:00 p.m. He was brought back to the facility by his family and the police. A wanderguard bracelet was placed on the resident. He was not on the grounds of the facility property. During a phone interview, on 7/31/25 at 1:11 p.m., the Administrator indicated Resident C went for a walk in the evenings. When he went for his evening walk, on 7/18/25 at approximately 6:00 p.m., Resident B followed him out the door. Resident C did not know Resident B was behind him because of his hearing problem. CNA 5 seen Resident C and Resident B in the lobby, she went to do something, and		additional training by the Divisional Director of Health and Operations on the expectation that Service plans are developed and implemented to include individualized interventions to address exit seeking behaviors. Re-training will also cover Abuse and Neglect Policy · Executive Director and Director of Health & Wellness will be responsible for ensuring individualized service plan are developed and address the care needs of residents, including exit seeking behaviors. · Health & Wellness Director will conduct an in-service on interventions and supervision as identified on service plan for residents exhibiting exit seeking behaviors and abuse and neglect policy for all caregivers. · Residents with exit seeking behaviors will be discussed with Divisional Team during weekly care calls to ensure proper assessment and intervention development. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place · Divisional Director of Health and Operations will review service plans monthly for three months and then annually to	

	when she came back, they were both gone. She looked around the lobby of the facility, but she did not see Resident B. She assumed he had gone back to his room, but she never went to his room to make sure he was there. Resident C was also gone, but CNA 5 knew he walked in the evening, so she assumed he was on his evening walk. During an observation, on 7/31/25 at 3:00 p.m., Resident B was observed to have a wanderguard bracelet on his right ankle under his sock. He was disoriented to person, place, and time. He had trouble finding his words and when he spoke, his conversation was unintelligible. During an interview, on 7/31/25 at 3:40 p.m., Resident C indicated he took walks during the day after lunch. He knew the code to the front door, so he let himself outside. He always pulled the door closed and looked to make sure there was no one behind him. He would not let any other residents out the front door. He did not know how Resident B was possibly behind him the day he exited the facility. During an interview, on 7/31/25 at 3:41 p.m., CNA 5 indicated, on 7/18/25 after dinner, Resident B was trying to pick up		ensure residents identified with exit seeking behaviors have appropriate interventions implemented in service plan. By what date the systemic changes will be completed by September 1, 2025	

	the dishes with her and another CNA. He was re-directed back to his room, and she thought he had gone. She went to the laundry room to do some laundry. When she came out of the laundry room at approximately 6:00 p.m., she observed Resident C entering the door code for a female resident, who was in a wheelchair and was not supposed to be going outside alone. She stopped Resident C, re-directed him to his room, and took the female to her room. She notified QMA 3 of the situation. The night before she had observed Resident C entering the door code so Resident B could get through the secured door. She stopped Resident C and Resident B stayed on 1-on-1 for the rest of the night. The only thing she was able to figure out was while she was in the laundry room, Resident C must have let Resident B out the front door. She and the other CNA thought he had gone to his room, but neither one of them went to check on him. On 7/18/25 at 8:30 p.m., Resident B's son and daughter in law brought him back to the facility and indicated the police picked him up on 96th street near the Car Max. The police found him, and he gave the police his daughter-in-law's name, and they called her. Google Map was used to			

measure the mileage for how far the resident had walked from the facility. He was found near the Car Max on 96th Street, which was three miles away from the facility.

During an interview, on 7/31/25 at 4:00 p.m., QMA 3 indicated she was back in the memory care unit when Resident B was brought back to the facility by his family, which was at approximately 9:00 p.m.

A current facility policy, dated 12/2024, and provided by email from the Administrator on 7/31/25 at 2:23 p.m., indicated "...Incidents and accidents can include but are not limited to...Resident elopements...The Executive Director shall notify...State Ombudsman...."

This citation relates to Complaint IN00463510.

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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 SIGNATURE	TITLE	(X6) DATE