STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/01/2022

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 IN00375554. Complaint IN00375554 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey dates: March 30, 2022 and April 1, 2022 Facility number: 013217 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 8, 2022.	R 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 05/01/2022.**	
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	**What corrective action(s) will be accomplished for those residents found to**	05/01/2022

	(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 with a diagnosis of dementia was free from neglect when he wandered out of the facility and was found by the police in a residential neighborhood. The whereabouts of the resident were unknown for approximately 45 minutes. (Resident B) Finding includes: During an observation of Resident B's room, with the Maintenance Director, on March 30, 2022 at 10:25 a.m., the window was easily viewed from the entrance to the room. The window looked out over the west side parking area, which was set back from the main road, 116th Street and had multiple bushes (with no leaves) outside it. The window had locks/blocks on each side which allowed the window to open approximately 4-5 inches in an upward direction. The window measured 64 inches tall by 41		**have been affected by the deficient practice?** Resident B placed on 1-to-1 supervision until able to be evaluated by NP. NP evaluation resulted in medication adjustment. Window stop-lock mechanism lowered to allow window to only be raised to safe level. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

	inches wide and had the ability to open upward approximately 28 inches, without the blocks in place, as measured by the Maintenance Director. An attempt to disengage the window block, during the observation, was unsuccessful. During the observation, the Maintenance Director indicated he did not know how Resident B got the window open, someone must have moved the lock/blocks higher and the screen easily popped out. To disengage the lock/blocks they needed to be unscrewed. He indicated the lock/blocks may have been moved higher during COVID-19 visits from family or friends. During an observation of the area, on March 30, 2022 at 11:50 a.m., 116th Street was noted to have four lanes of traffic; two moving east and two moving west. Hazel Dell Parkway was also found to have four lanes of traffic; two moving north and two moving south. Each road had additional lanes at the round-a-bout.		Inspected each room on Memory Unit and secured each room window stop-lock mechanism to allow window to only be raised to safe level. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** -Facility-wide evaluation of residents per policy PP-60800, Resident Monitoring Device, to identify potential residents at risk and ensure appropriate interventions are in place. -Educate staff regarding high-risk residents and triggers for identifying high-risk residents. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** -Window audits to be completed on high-risk resident rooms to ensure stop-lock	

	The record for Resident B was reviewed on April 01, 2022 at 9:59 a.m. Diagnoses included, but were not limited to, dementia, post-traumatic stress disorder and macular degeneration (a disease which affects the central vision). A nursing note indicated staff was alerted, on March 15, 2022 at 4:06 p.m., the resident was to be returned to the facility. The next entry indicated the resident was returned to the facility at 4:15 p.m. The nursing notes also indicated Resident B had exited the facility previously, unattended, on June 15, 2021, and August 08, 2021. During an interview, on March 30, 2022 at 9:51 a.m., LPN 1 indicated she had just come on shift about 3:00 p.m., the day Resident B got out of the facility. She received report and counted the narcotics. She had not viewed the resident at this point in her day. At about 4:15 p.m., the police returned Resident B to the facility and she assessed his vital signs and his skin for any injuries. She indicated Resident B was dressed appropriately for the weather; she remembered it being a sunny, nice day. During an interview, on March 30, 2022 at 10:05 a.m., the		mechanism is placed to allow window to only be raised to safe level. Frequency to be: *5 times weekly for 4 weeks, then… *3 times weekly for 4 weeks, then… *Weekly for 4 weeks, then… *Monthly -Increase number of Missing Resident drills as follows: *One time weekly (alternate shift each week) for 4 weeks, then… *One time monthly (alternate shift each month) for 4 months, then… *Return to one time quarterly (alternate	

	Director of Nursing indicated the incident happened during shift change. Resident B exited the facility through the window in his room and staff had not realized he had left the facility. During an interview, on March 30, 2022 at 11:04 a.m., CNA 2 indicated on the day of the elopement, he arrived at the facility for his shift about 2:25 p.m., and reported to the memory care unit. He spoke with the off-going CNA and was updated on the events from her shift. He then went to speak with QMA 3. Resident B was observed to enter a room, of another resident, and staff redirected him. Resident B was then observed walking down the hall towards his room. CNA 2 then began to gather laundry from the resident's room. When he entered Resident B's room, to get his laundry, he did not notice the window and the resident was not in his room. He indicated it had been approximately five minutes since he had seen Resident B. He did not think it was odd the resident was not in his room as the resident liked to sit in the enclosed courtyard and it was a nice sunny day. He indicated Resident B also liked to walk around the unit. Resident B was most likely out of the facility went he went to check his laundry. CNA 2 indicated he thought it was about 3:20 p.m.,		shift each quarter) per facility policy	

when the facility received information Resident B was picked up by the police.

During an interview, on April 01, 2022 at 9:03 a.m., the Director of Nursing indicated there was no documented lock/block checks on Resident B's window.

During an interview, on April 01, 2022 at 8:59 a.m., the Director of Community Services indicated he did not receive the phone call from the police. The Administrative Assistant did and informed him. They both went to the memory care unit and he found the window open in Resident B's room.

During an interview, on April 1, 2022 at 9:05 a.m., the Administrative Assistant indicated she received a call from the police department informing her they had found a gentleman and asked if the facility was missing a resident. She indicated she did not know, put them on hold and went to the memory care unit with the Director of Community Relations. The staff search the unit. During the search, the Director of Community Relations found an open window in Resident B's room and the resident was unaccounted for at that time. She returned to the call and informed them the facility was missing a resident. The police informed her the

resident was found about one block away, northwest of the facility, in a residential housing area. She indicated she received the call at about 3:45 p.m. Resident B was returned to the facility, by the police, at about 4:15-4:30 p.m.

During an interview, on April 01, 2022 at 12:14 p.m., the Director of Nursing indicated Resident B was found in a residential neighborhood north and west of the facility. He had crossed both 116th Street and Hazel Dell Parkway.

A current facility policy, titled "RESIDENT RIGHTS," dated as revised in September 2014 and provided by the Director of Nursing on April 01, 2022 at 12:40 p.m., indicated "...Residents have the right to be free from...neglect ...."

This State Finding relates to Complaint IN00375554.

Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia was free from neglect when he wandered out of the facility and was found by the police in a residential neighborhood. The whereabouts of the resident were unknown for approximately 45 minutes. (Resident B)

Finding includes:

During an observation of Resident B's room, with the Maintenance Director, on March 30, 2022 at 10:25 a.m., the window was easily viewed from the entrance to the room. The window looked out over the west side parking area, which was set back from the main road, 116th Street and had multiple bushes (with no leaves) outside it. The window had locks/blocks on each side which allowed the window to open approximately 4-5 inches in an upward direction. The window measured 64 inches tall by 41 inches wide and had the ability to open upward approximately 28 inches, without the blocks in place, as measured by the Maintenance Director. An attempt to disengage the window block, during the observation, was unsuccessful.

During the observation, the Maintenance Director indicated he did not know how Resident B got the window open, someone must have moved the lock/blocks higher and the screen easily popped out. To disengage the lock/blocks they needed to be unscrewed. He indicated the lock/blocks may have been moved higher during COVID-19 visits from family or friends.

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PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		