STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/19/2021

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 Complaints IN00359801 and IN00359416. Complaint IN00359801 - Substantiated. State deficiencies related to the allegation are cited at R0052. Complaint IN00359416 - Substantiated. State deficiencies related to the allegation are cited at R0052. Survey dates: August 18 and 19, 2021 Facility number: 013217 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on August 24, 2021.	R 0000		
R 0052	Residents' Rights - Offense	R 0052	Bickford of	09/04/2021

	410 IAC 16.2-5-1.2(v)(1-6) (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 observation, interview and record review, the facility failed to ensure a resident with a diagnoses of dementia was free from neglect when she exited an alarmed door on the memory care unit and wandered 0.6 miles from the facility and had fallen at the side of a road and obtained a skin tear for 1 of 4 residents reviewed for neglect (Resident B). Finding includes: During a walk through of the facility, with Maintenance Staff 4 on 08/18/21 beginning at 10:30 a.m., it was noted on the Memory Care unit, there was a door leading to the outside of the facility. Lettering on the door indicated to push until alarm sounded and the door could be opened in 15 seconds. This door was located at the end of a hall, not observable from all		Carmel Survey dates: August 18 & 19, 2021 Complaint #: IN00359416 IN00359801 Finding: Facility failed to ensure a resident with a diagnosis of dementia was free from neglect when she exited an alarmed door on the memory care unit and wandered 0.6 miles from the facility and had fallen at the side of a road and obtained a skin tear. <u>Plan of Correction</u> . All direct care staff employed at time of surveyed event in-serviced by Registered Nurse Coordinator (RNC) on unwitnessed door alarm and missing resident	

	areas of the unit, in close proximately to a room titled "195" and opened to a parking area. Access to 116th street was unobstructed. There were no cameras observed at the exit. Per Maintenance Staff 4, there were no cameras in the facility. He indicated he checked the door alarms weekly and the wander guards/cut bands (a bracelet which would set off an alarm when in close proximately to alarmed doors) every morning. On 08/18/21 at 11:00 a.m., the route taken by Resident B was observed. The road, 116th Street, has four lanes of traffic moving from east to west. On the south side of the road, there was a side walk which did follow the road over the bridge to Trails End Drive. Trails End Drive was assessable by a right turn only, and descends downward to a narrow road. Tall weeds were observed at the top and bottom of the downgrade with trees in-between. There was one traffic signal at River Road, prior to the bridge. During a telephone interview with a witness, on August 18, 2021 at 10:55 a.m., she indicated she was driving west on 116th street and observed an elderly woman with a stooped posture, using a walker, walking on the bridge, at approximately 8:00 p.m. She		policy. . Facility Director, RNC, or other designated community leader will educate and ensure understanding in the form of signed off unwitnessed door alarm policy for all new employees prior to first unsupervised shift. . Facility Director, RNC, or other designated branch leader will educate and ensure understanding in the form of signed off missing resident policy prior for all new employees to first unsupervised shift. . Quarterly elopement drills will be conducted on each shift; 12 drills annually. . Results of elopement drills will be reviewed for 100% compliance, any failed drilled will be re—conducted within 24 hours. The facility will conduct these drills for the term of 1 year (4 quarters).	

	indicated she took the first left turn safely, which was in the facility parking lot. At the facility, she observed a person standing at the edge of the parking lot, on a cell phone and waiving her arms. She approached the person, who was wearing a facility shirt, and attempted to explain her observation of the woman, but was told "we have it under control". The witness, who identified herself as a Registered Nurse, indicated she felt they did not know where Resident B was at that time. By the time the witness turned around in the front area of the facility, a large vehicle shot out of the parking lot and turned right on 116th Street, the witness followed. She indicated there was a road, to the right, east of the bridge, called Trails End, when she turned onto the road she observed a walker upside down in tall grass, but she was unable to see the elderly woman. The large vehicle had come to a stop, it was left running and both the driver and passenger doors were left open. She indicated there was also a couple (male and female) which had stopped and the man was leaning over the resident trying to help her up when the staff members approached. The resident was found laying in the tall grass, her oxygen had been disconnected. The witness indicated the staff members "yanked" the woman		. Cut band monitoring system device and software to be updated. . All elopements will be documented in the resident’s progress notes, detailing the events, interventions, and outcomes. . A thorough investigation of the elopement will be completed by the branch designated leader, who will perform a root cause analysis, identifying system risks and failures and opportunities for improvement and retraining. . A Divisional Directors will review all documentation for compliance and completeness during onsite branch visits. Date of Compliance: September 4, 2021	

up, from the ground. She suggested a call be placed to 911, but the staff reconnected the resident's oxygen, rushed her into their vehicle and put the walker into the back door of the vehicle. At this time, the oxygen was disconnected again and was put the back on the resident. She indicated she did contact the police to file a report and have the resident checked on.

The record for Resident B was reviewed on 8/18/21 at 2:06 p.m. Diagnoses included, but were not limited to, dementia, seizure disorder and anxiety.

There was no documentation found in the chart, regarding the resident getting out of the facility on 07/29/21.

A facility document, titled "Unusual Occurrence Report," indicated "...Date...7/29/21...Time...appro x 730...8p...Who Responded...staff...Witnesses: none...Occurrence...Elopement. ..Location...side of back parking lot off Mary B (name of memory care unit)...Event...Elopement Unknown-Security System Failure...."

During an interview, on 08/18/21 at 2:34 p.m., CNA 1 indicated Resident B had expressed, all shift, she wanted to go home. CNA 1 was in another resident's

room at about 7:45-8:00 p.m., when she heard an alarm sound. She did ask LPN 3 about the alarm and the nurse indicated it was another resident who had gotten too close to the door. CNA 1 indicated it was a male resident who was always trying to get out of the door. The last time CNA 1 observed Resident B was at approximately 7:30 p.m. CNA 1 went to retrieve the resident to prepare her for bed but the resident was not at the table. She notified the nurse she was unable to locate Resident B. The facility received a phone call about an older woman walking down the street. She went to look for the resident, enlisted the assistance of another staff member (CNA 2) who was outside on break and went to find the resident. CNA 1 was not able to say how long the resident had been out of the facility. She indicated the resident was located. The resident had fallen and was down on the ground when they found her. They assessed the resident for injury, put the resident in the vehicle and returned her to the facility where she was assessed by a nurse. CNA 1 was unable to say how far the resident had wandered from the facility to the side street she was located on.

During an interview, on 08/18/21 at 2:55 p.m., the Director of

Health Services (DHS) indicated Resident B was assessed for injury upon return to the facility. The assessment included vital signs and a head to toe skin observation. Resident B did have a wanderguard/cut band in place and the facility should have a report indicating what time the alarm sounded. Resident B was out of the facility 10, 12, maybe 15 minutes.

During an interview, on 08/19/21 at 8:53 a.m., the DHS indicated Resident B was on a secured memory care unit when she eloped. The resident was moved to memory care on 07/24/21 related to resident often asking where she needed to go. The facility felt the smaller distance to move about would minimize her discomfort as she had chronic obstructive pulmonary disease (COPD-obstruction of the airway and discomfort with breathing). The DHS indicated she did not observed exit seeking behaviors but Resident B did tend to hang around by the door.

During a telephone interview, on 08/19/21 at 1:26 p.m., LPN 3 indicated she was working as the nurse on the memory care unit the evening Resident B eloped from the building. She heard the alarm sound and responded. A male resident was standing by the door. She

informed the resident he could not be back by the door and she reset the alarm and returned to her duties. A few minutes later she was informed a resident was missing. The CNA assigned to Resident B was looking for the resident but could not locate her. The CNA left to look for Resident B and the resident was located by the bridge on 116th Street. Resident B did return to the facility with a skin tear, which LPN 3 described as not big but not small and required "a couple" steri strips, but she was unable to recall if she had measured the area. She indicated the origin of the skin tear was unknown, but the resident did not have it prior to exiting the building. LPN 3 indicated she did not know what the facility procedure was for a missing resident, however she did start a head count of the residents on the unit and when she was informed Resident B was missing, she did not complete it. In this type of situation when the alarm sounds someone was to go check the source, and she did. She found a male resident by the door and thought he had set if off. There were three residents which set off the alarms every shift. She would not have known if more than one resident was missing at the time as she did not finish the head count. She was unable to say how many times the alarm sounded on the shift, if it

was like any other shift it went off several times. She placed the time of the incident at about 8:00 p.m. LPN 3 indicated the door, which leads out of the facility, said to push on the door, alarm will sound, door will open, "Some of those residents can read".

During an interview, on 08/19/21 at 2:19 p.m., CNA 2 indicated she was working on the assisted living area that evening and was going on her break when she was informed someone reported a resident walking on the street. She did not hear an alarm sound as she was not working on the memory care unit. CNA 1 was looking for the resident when the facility received a phone call about a resident walking on the street. They (CNA 1 and CNA 2) got in a vehicle and drove up 116th Street, past 2 stop signs. She indicated they had to make a u-turn and head back as she observed the walker upside down on Trails End, but not the resident. They would not have found the resident if she had not seen the walker. There were other people present. CNA 1 and CNA 2 lifted the resident and assessed her for injuries. The resident did have a skin tear. She indicated the resident was breathing funny. They did get the oxygen back on the resident. When CNA 2 asked Resident B what she was doing,

the resident told her she was going home, going to Wabash. They returned the resident to the facility.

A untitled facility report, provided by the Director of Health Services on 08/19/21 at 2:22 p.m., listed when wanderguard alarms set off the alarm system. There was no documentation from 11:53 a.m. to 10:39 p.m., on 07/29/21. During an interview, at that time, the Director of Health Services indicated there was a block of time missing from the report and the facility was checking on it. If both alarms went off they would have sounded like one alarm. A second report, titled (name of company), was also provided at that time. The report listed the times the door alarms were set off on the memory unit. The report indicated the alarm at the exit, located by B195, went off at 7:57 p.m., 8:10 p.m. and 8:19 p.m.

A facility policy, titled, "Unwitnessed Door Alarm," provided by the Director of Health Services on 08/18/21 at 1:01 p.m., indicated "...PERFORM VISUAL SEARCH INSIDE AND OUTSIDE OF DOOR AREA" The inside and outside area surrounding the door that caused the alarm must be visually searched immediately after an unwitnessed door

alarm...SILENCE ALARM: The door alarm shall be silenced only AFTER all employees on duty area aware of the unwitnessed door alarm and the appropriate search is initiated...ACCOUNT FOR ALL RESIDENTS: Staff shall account for all residents...."

This State Tag relates to Complaints IN00359801 and IN00359416.

Based on observation, interview and record review, the facility failed to ensure a resident with a diagnoses of dementia was free from neglect when she exited an alarmed door on the memory care unit and wandered 0.6 miles from the facility and had fallen at the side of a road and obtained a skin tear for 1 of 4 residents reviewed for neglect (Resident B).

Finding includes:

During a walk through of the facility, with Maintenance Staff 4 on 08/18/21 beginning at 10:30 a.m., it was noted on the Memory Care unit, there was a door leading to the outside of the facility. Lettering on the door indicated to push until alarm sounded and the door could be opened in 15 seconds. This door was located at the end of a hall, not observable from all areas of the unit, in close proximately to a room titled

"195" and opened to a parking area. Access to 116th street was unobstructed. There were no cameras observed at the exit. Per Maintenance Staff 4, there were no cameras in the facility. He indicated he checked the door alarms weekly and the wander guards/cut bands (a bracelet which would set off an alarm when in close proximately to alarmed doors) every morning.

On 08/18/21 at 11:00 a.m., the route taken by Resident B was observed. The road, 116th Street, has four lanes of traffic moving from east to west. On the south side of the road, there was a side walk which did follow the road over the bridge to Trails End Drive. Trails End Drive was assessable by a right turn only, and descends downward to a narrow road. Tall weeds were observed at the top and bottom of the downgrade with trees in-between. There was one traffic signal at River Road, prior to the bridge.

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facility parking lot. At the facility, she observed a person standing at the edge of the parking lot, on a cell phone and waiving her arms. She approached the person, who was wearing a facility shirt, and attempted to explain her observation of the woman, but was told "we have it under control". The witness, who identified herself as a Registered Nurse, indicated she felt they did not know where Resident B was at that time. By the time the witness turned around in the front area of the facility, a large vehicle shot out of the parking lot and turned right on 116th Street, the witness followed. She indicated there was a road, to the right, east of the bridge, called Trails End, when she turned onto the road she observed a walker upside down in tall grass, but she was unable to see the elderly woman. The large vehicle had come to a stop, it was left running and both the driver and passenger doors were left open. She indicated there was also a couple (male and female) which had stopped and the man was leaning over the resident trying to help her up when the staff members approached. The resident was found laying in the tall grass, her oxygen had been disconnected. The witness indicated the staff members "yanked" the woman up, from the ground. She suggested a call be placed to

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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