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	04/15/2025

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00456021 and IN00456858. Complaint IN00456021-No deficiencies related to the allegations were cited.. Complaint IN00456858-State deficiencies related to the allegations are cited at R0052, R0091 and R0217. Survey date: April 15, 2025 Facility number: 013217 Residential Census: 44 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 23, 2025.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dementia (Resident C) was free of physical abuse from another resident (Resident B) for 2 of 2 residents reviewed for abuse. This deficient practice resulted in Resident C being harassed and assaulted by Resident B on several occasions without the facility initiating new interventions or actions to prevent further abuse. Findings include: In an anonymous email, to the Indiana Department	R 0052	R052 Residents' Rights – Offense What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident B is being assessed by other facilities to relocate. · Resident B and C service plans have been updated with interventions to prevent harassment and assault 4/29/25 How the facility will identify other residents having the potential to	04/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Wafford	Administrator	05/08/2025

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	of Health, a concern was expressed regarding an incident involving Residents B and C. The email indicated Resident B had physically assaulted Resident C. The incident was at least the second incident involving those two residents. A family member had also witnessed Resident B's aggression and reported it to the staff. Despite all these incidents, no apparent action had been taken, and Resident B remained at the facility. A facility reported incident (FRI) indicated, on 11/2/24 at 1:30 p.m., Resident B was annoyed by Resident C grinding his teeth. Resident B went up to Resident C, put his hands around Resident C's neck, and pushed him. The staff intervened. A facility reported incident (FRI) indicated, on 3/11/25 at 9:01 a.m., a family member reported Resident B went over to Resident C, pushed him in the head, and then shook Resident C's Broda chair. The family member indicated Resident B was not provoked by Resident C. The incident happened in the memory care unit. The residents were separated. A facility reported incident (FRI) indicated, on 3/20/25 at 10:01 a.m., a family member reported Resident B hit Resident C in the head. There were no triggers as to why Resident B hit Resident C in the head. The residents were separated. 1. The clinical record for Resident C was reviewed on 4/15/25 at 4:05 p.m. The diagnoses included, but were not limited to, dementia, macular degeneration, traumatic brain injury and post-traumatic stress disorder. The most current service plans for Resident C, dated 3/4/25, indicated Resident C was non-ambulatory, required safety checks from the		be affected by the same deficient practice and what corrective action will be taken · Director of Health and Wellness will complete an audit of all residents with history of resident-to-resident altercation and ensure service plans have been updated with interventions. · The Director of Health and Wellness will provide an in-service to caregivers on watching for behaviors and when to report management by 5/15/25 · Divisional Director of Health and Wellness will provide training on assessments and service plan development to the Director of Health and Wellness by 5/15/25 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. · Divisional Director of Operations will re-educate Executive Director on residents' right ensuring interventions and actions are initiated to prevent further abuse. · Director of Health and Wellness will monitor current resident monthly for 3 months and annually for any behaviors or pursuing other residents. 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 of Health and Wellness	

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	staff four times per shift, had advanced dementia, and was quiet and reserved. The service plans did not include any staff interventions to prevent Resident B from being aggressive with Resident C. A nursing progress note, dated 11/4/24 at 11:27 a.m., indicated on 11/2/24 at 1:27 p.m., Resident C was choked and pushed by Resident B in the common area. Resident C was grinding his teeth, which upset Resident B and caused the behavior. The residents were separated from one another. A nursing progress note, dated 11/4/24 at 2:36 p.m., indicated Resident C was anxious and indicated "this is my house" after Resident B got into his face again. A nursing progress note, dated 11/21/24 at 10:43 a.m., indicated the hospice nurse wrote a new order for Resident C to receive Risperdal (an atypical antipsychotic medication) due to an increase in grinding his teeth. A nursing progress note, dated 2/12/25 at 2:15 p.m., indicated Resident C had been grinding his teeth the entire shift due to his medication being out of stock. His medication would not arrive until this evening. A nursing progress note, dated 3/20/25 at 10:59 a.m., indicated on 3/15/25 at 10:00 a.m., a staff member notified the nurse they had observed another resident (Resident B) hit Resident C in the head with his hand. Resident B also was cursing and yelling at Resident C. Resident C was removed from the area. The progress notes did not indicate any staff		to confirm Service plans are updated after any resident to resident altercation.	

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	interventions to prevent Resident B from being aggressive with Resident C except for separating the residents after an incident had already occurred. 2. The clinical record for Resident B was reviewed on 4/15/25 at 3:51 p.m. The diagnoses included, but were not limited to, dementia, multiple strokes, and a tragic brain injury from a car accident. The most current service plans for Resident B, dated 12/2/24, indicated Resident B was independent with transfers, ambulated independently without an assistive device, received safety checks four times a shift, had mild dementia, was physically disruptive, and was uncooperative and resistant to care. The service plans did not include any staff interventions to prevent Resident B from being aggressive with Resident C A nursing progress note, dated 11/2/24 at 2:16 p.m., indicated at 9:00 a.m. Resident B was seen physically abusing Resident C. Resident B was observed approaching Resident C who was sitting quietly on the couch on the memory care unit. After a verbal exchange, Resident B grabbed the other resident by the throat and yelled at him. A nursing progress note, dated 11/2/24 at 2:29 p.m., indicated at 2:00 p.m., right after lunch, Resident B was witnessed approaching the same resident. Resident B grabbed Resident C's arm and punched him. Two staff members separated the residents. The Executive Director (ED) and the Health and Wellness Director (HWD) were notified. A nursing progress note, dated 11/2/24 at 4:03			

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	p.m., indicated 911 was called to have Resident B sent out to the hospital due to his aggressive behaviors. The police and Emergency Medical Technician (EMT) arrived at the facility and evaluated Resident B. Resident B indicated he did not need to be sent out for an evaluation, so he remained in the facility. The ED was notified. A nursing progress note, dated 11/3/24 at 2:52 p.m., indicated Resident B was observed in another resident's face and yelled at him this morning. This afternoon, he grabbed the recliner the other resident was sitting in and shoved it onto the floor with the resident sitting in it. The incident was reported the HWD and ED. A nursing progress note, dated 11/4/24 at 11:20 a.m., indicated the Emergency Medical Technician (EMT) and the police refused to take Resident B to the hospital and indicated the facility had accepted him, his behaviors, and he did not appear to be a threat. Staff would keep both residents separated as much as possible. A nursing progress note, dated 11/4/24 at 11:31 a.m., indicated Resident B was upset with Resident C for grinding his teeth, went up to him and placed his hands around Resident C's neck to choke him. The staff removed the residents from harm and ensured both were separated and safe. A nursing progress note, dated 11/12/24 at 2:17 p.m., indicated Resident B came out of his room and walked into the common area. He saw another male resident which he did not want to be near and yelled "get out of here. I don't want you in here." The other male resident was just sitting on the couch watching TV. A staff member informed Resident B if he did not want to be near the other male resident, he could go back to his room. He			

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	refused and sat in the recliner across from the other male resident. The resident did not say anything further. He only sat and stared at the other male resident. After a few minutes, Resident B walked back to his room. A nursing progress note, dated 11/13/24 at 2:31 p.m., indicated Resident B walked into the common area and sat next to another male resident. Staff attempted to direct him to another chair, but he refused. He sat down, started stabbing a plastic knife into the arm of his chair, and stated "I'm going to get him" while staring at the other male resident. A staff member was able to remove the plastic knife from Resident B. When Resident B was asked to please move away from the other male resident, he refused, was restless in his chair, tapped his feet and changed positions. Resident B was given an as needed Ativan (an anti-anxiety medication) as ordered by the physician, which was effective. He then went to breakfast and walked back to his room. The Health and Wellness Director was notified. A nursing progress note, dated 11/15/24 at 3:09 p.m., indicated Resident B was upset with the same resident today which he was usually upset with. A nursing progress note, dated 1/17/25 at 10:15 a.m., indicated Resident B was very aggressive with another resident for no reason. He began to yell at the other resident, then he pushed him. A nursing progress note, dated 2/4/25 at 3:47 p.m., indicated the Health and Wellness Director discussed Resident B's prior episodes of being violent with another resident with the psychiatric Nurse Practitioner (NP).			

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	A nursing progress note, dated 3/11/25 at 1:20 p.m., indicated a family member witnessed Resident B go up to another resident, he pushed the resident's head back, and shook his Broda chair. The aggressive behavior by Resident B was an unprovoked incident. A nursing progress note, dated 3/20/25 at 10:57 a.m., indicated Resident B hit another resident on the head with his fist and yelled and cursed at the other resident. The resident was moved from the area. A nursing progress note, dated 3/21/25 at 11:58 a.m., indicated information was sent to a geriatric psychiatric hospital for placement due to the on-going physical aggression towards another resident. A nursing progress note, dated 3/21/25 at 4:14 p.m., indicated the geriatric psychiatric hospital had a bed available on Monday (3/24/25). A nursing progress note, dated 3/25/25 at 11:44 a.m., indicated Resident B was verbally aggressive towards staff and another resident. A nursing progress note, dated 3/27/25 at 9:33 a.m., indicated the psychiatric hospital denied Resident B due to an insurance denial. He would remain on the facility psychiatric schedule. His recent aggression was just discussed with the psychiatric NP without any changes in his orders. A nursing progress note, dated 4/12/25 at 9:36 p.m., indicated Resident B showed signs of increased anger towards a specific resident. During an observation, on 4/15/25 at 11:25 a.m., Resident B and Resident C were observed sitting			

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	at the same lunch table. They were sitting across the table from each other. Resident B was ambulatory. Resident C was unable to ambulate or stand up. During an interview, on 4/15/25 at 11:59 a.m., CNA 5 indicated every time she sat Resident C at a table, Resident B sat by him. The day Resident B hit Resident C in the head (3/20/25), she had left the common area for a brief minute and when she came back, she found Resident B hitting Resident C in the head with his hands. She separated the two and immediately reported it to the Health and Wellness Director. The only intervention she knew to initiate when Resident B "picked" on Resident C was to separate them. Resident C was the only resident, Resident B sought out. Resident B had indicated he did not like Resident C, but he would not give a reason why he did not like the resident. During an interview, on 4/15/25 at 12:02 p.m., CNA 6 indicated wherever the staff sat Resident C, then Resident B sat at the same table. Resident C was the only resident that Resident B had sought out and physically assaulted. He had hit Resident C recently. The only intervention the staff used when Resident B had his behavior and sought out Resident C was to separate the two residents. Sometimes it worked and sometimes it did not. Resident B would go wherever the staff had taken Resident C in the common area. During an interview, on 4/15/25 at 12:34 p.m., Resident C indicated he was hit on the head recently by "the guy" who sat across from him at the lunch table today (Resident B). During an interview, on 4/15/25 at 12:37 p.m., Resident B indicated he did not get along with			

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	one of the men who lived at the facility. He did not like him because he was an "idiot." He indicated it was the man who sat across from him today at lunch (Resident C). Resident B indicated he liked to "provoke" that man, he was able to punch him in the head and then would sit and laugh at him. Resident B indicated Resident C did things which aggravated him and made him punch Resident C in the head. During an interview, on 4/15/25 at 12:50 p.m., the ED indicated Resident B's insurance would not pay for a stay at the psychiatric hospital where he previously stayed before he was admitted to the facility. He did not know if the Health and Wellness Director had attempted to find another psychiatric hospital. Resident B was seen by a psychiatric service through telehealth. There was no psychiatric service which would come to the facility to assess and treat residents face to face because the facility did not have enough residents who needed those services. If Resident B saw any new pills in his medication cup, he would not take them. He had a traumatic brain injury which was why Resident B was placed in the memory care unit. Resident B did not attend any of the memory care programming activities and mainly stayed in his room. During an interview, on 4/15/25 at 3:15 p.m., the ED indicated he was not aware of the other behaviors documented in the progress notes besides the ones which were reported to the state agency. He was not informed by staff about the other behaviors. A current facility policy, titled "Abuse and Neglect," dated 2/2025 and provided from the ED on 4/15/25 at 5:30 p.m., indicated "... reasonable cause to believe that a resident is being, or had			

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	been, abused, neglected or exploited shall report the information immediately to the Branch Executive Director or Health & Wellness Director...are required to be knowledgeable of the policies and procedures regarding the prohibition of mistreatment, neglect, and abuse of residents and misappropriation of their property...." This citation relates to Complaint IN00456858.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance Based on observation, interview and record review, the facility failed to ensure incidents of abuse were thoroughly investigated in an effort to prevent further altercations between 2 of 2 residents reviewed for investigations of abuse. (Residents C and B) Findings include: In an anonymous email, to the Indiana Department of Health, a concern was expressed regarding an incident involving Residents B and C. The email indicated Resident B had physically assaulted Resident C. The incident was at least the second incident involving those two residents. A family member had also witnessed Resident B's aggression and reported it to the staff. Despite all these incidents, no apparent action had been taken, and Resident B remained at the facility. A facility reported incident (FRI) indicated, on 11/2/24 at 1:30 p.m., Resident B was annoyed by Resident C grinding his teeth. Resident B went up to Resident C, put his hands around Resident C's neck, and pushed him. The staff intervened. A facility reported incident (FRI) indicated, on	R 0091	R091 Administration and Management - Noncompliance · 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Investigation of the incident completed 4/28/25. · Audit will be completed of last 60 days to ensure all resident-to-resident altercations have been thoroughly investigated. 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 · Executive Director and Director of Health and Wellness will be responsible for investigating any resident to resident altercation. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not	04/28/2025

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	3/11/25 at 9:01 a.m., a family member reported Resident B went over to Resident C, pushed him in the head, and then shook Resident C's Broda chair. The family member indicated Resident B was not provoked by Resident C. The incident happened in the memory care unit. The residents were separated. A facility reported incident (FRI) indicated, on 3/20/25 at 10:01 a.m., a family member reported Resident B hit Resident C in the head. There were no triggers as to why Resident B hit Resident C in the head. The residents were separated. 1. The clinical record for Resident C was reviewed on 4/15/25 at 4:05 p.m. The diagnoses included, but were not limited to, dementia, macular degeneration, traumatic brain injury and post-traumatic stress disorder. The most current service plans for Resident C, dated 3/4/25, indicated Resident C was non-ambulatory, required safety checks from the staff four times per shift, had advanced dementia, and was quiet and reserved. 2. The clinical record for Resident B was reviewed on 4/15/25 at 3:51 p.m. The diagnoses included, but were not limited to, dementia, multiple strokes, and a tragic brain injury from a car accident. The most current service plans for Resident B, dated 12/2/24, indicated Resident B was independent with transfers, ambulated independently without an assistive device, received safety checks four times a shift, had mild dementia, was physically disruptive, and was uncooperative and resistant to care. During an observation, on 4/15/25 at 11:25 a.m.,		recur. · Divisional Director of Health and Wellness will re-educate Executive Director and Director of Health and Wellness on the Investigation process. 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 of Health and Wellness will review the investigation the next three resident-to-resident altercation to ensure process was followed.	

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	Resident B and Resident C were observed sitting at the same lunch table. They were sitting across the table from each other. Resident B was ambulatory. Resident C was unable to ambulate or stand up. During an interview, on 4/15/25 at 11:59 a.m., CNA 5 indicated every time she sat Resident C at a table, Resident B sat by him. The day Resident B hit Resident C in the head (3/20/25), she had left the common area for a brief minute and when she came back, she found Resident B hitting Resident C in the head with his hands. She separated the two and immediately reported it to the Health and Wellness Director. The only intervention she knew to initiate when Resident B "picked" on Resident C was to separate them. Resident C was the only resident, Resident B sought out. Resident B had indicated he did not like Resident C, but he would not give a reason why he did not like the resident. During an interview, on 4/15/25 at 12:02 p.m., CNA 6 indicated wherever the staff sat Resident C, then Resident B sat at the same table. Resident C was the only resident that Resident B had sought out and physically assaulted. He had hit Resident C recently. The only intervention the staff used when Resident B had his behavior and sought out Resident C was to separate the two residents. Sometimes it worked and sometimes it did not. Resident B would go wherever the staff had taken Resident C in the common area. During an interview, on 4/15/25 at 12:34 p.m., Resident C indicated he was hit on the head recently by "the guy" who sat across from him at the lunch table today (Resident B). During an interview, on 4/15/25 at 12:37 p.m.,			

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	Resident B indicated he did not get along with one of the men who lived at the facility. He did not like him because he was an "idiot." He indicated it was the man who sat across from him today at lunch (Resident C). Resident B indicated he liked to "provoke" that man, he was able to punch him in the head and then would sit and laugh at him. Resident B indicated Resident C did things which aggravated him and made him punch Resident C in the head. During an interview, on 4/15/25 at 3:15 p.m., the ED indicated he was not aware of the other behaviors documented in the progress notes besides the ones which were reported to the state agency. He was not informed by staff about the other behaviors. He did not complete an investigation on any of the three resident-to-resident altercations which were reported to the Indiana Department of Health regarding Resident B and C. He indicated he should have completed the investigations. A current facility policy, titled "Abuse and Neglect," dated 2/2025 and provided by the ED on 4/15/25 at 5:30 p.m., indicated "...reasonable cause to believe that a resident is being, or had been, abused, neglected or exploited shall report the information immediately to the Branch Executive Director or Health & Wellness Director...are required to be knowledgeable of the policies and procedures regarding the prohibition of mistreatment, neglect, and abuse of residents and misappropriation of their property...Investigation Report." This citation relates to Complaint IN00456858.			
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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	04/15/2025

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Bldg. 00	Based on observation, interview and record review, the facility failed to ensure residents involved in physical alterations had service plans updated to identify and document the services to be provided by the facility for 2 of 2 residents reviewed for service plans. (Resident C and B) Findings include: In an anonymous email, to the Indiana Department of Health, a concern was expressed regarding an incident involving Residents B and C. The email indicated Resident B had physically assaulted Resident C. The incident was at least the second incident involving those two residents. A family member had also witnessed Resident B's aggression and reported it to the staff. Despite all these incidents, no apparent action had been taken, and Resident B remained at the facility. A facility reported incident (FRI) indicated, on 11/2/24 at 1:30 p.m., Resident B was annoyed by Resident C grinding his teeth. Resident B went up to Resident C, put his hands around Resident C's neck, and pushed him. The staff intervened. A facility reported incident (FRI) indicated, on 3/11/25 at 9:01 a.m., a family member reported Resident B went over to Resident C, pushed him in the head, and then shook Resident C's Broda chair. The family member indicated Resident B was not provoked by Resident C. The incident happened in the memory care unit. The residents were separated. A facility reported incident (FRI) indicated, on 3/20/25 at 10:01 a.m., a family member reported Resident B hit Resident C in the head. There were no triggers as to why Resident B hit Resident C in	R 0217	R217 Evaluation - Deficiency · One resident was affected by the deficient practice What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident's B and C service plans have been updated with interventions 4/29/25 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 · Director of Health and Wellness will complete an audit of all residents with history of resident-to-resident altercation and ensure service plans have been updated with interventions. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. · Divisional Director of Health and Wellness will re- educate Director of Health and Wellness on triggers for reassessment and Service plan updates. 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 Wellness will review all service plans of residents that have been	04/28/2025

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	the head. The residents were separated. 1. The clinical record for Resident C was reviewed on 4/15/25 at 4:05 p.m. The diagnoses included, but were not limited to, dementia, macular degeneration, traumatic brain injury and post-traumatic stress disorder. The most current service plans for Resident C, dated 3/4/25, indicated Resident C was non-ambulatory, required safety checks from the staff four times per shift, had advanced dementia, and was quiet and reserved. The service plans did not include any staff interventions to prevent Resident B from being aggressive with Resident C. 2. The clinical record for Resident B was reviewed on 4/15/25 at 3:51 p.m. The diagnoses included, but were not limited to, dementia, multiple strokes, and a tragic brain injury from a car accident. The most current service plans for Resident B, dated 12/2/24, indicated Resident B was independent with transfers, ambulated independently without an assistive device, received safety checks four times a shift, had mild dementia, was physically disruptive, and was uncooperative and resistant to care. The service plans did not include any staff interventions to prevent Resident B from being aggressive with Resident C During an observation, on 4/15/25 at 11:25 a.m., Resident B and Resident C were observed sitting at the same lunch table. They were sitting across the table from each other. Resident B was ambulatory. Resident C was unable to ambulate or		in a resident-to-resident altercation to ensure intervention have been added to prevent further abuse for the next seven months.	

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	stand up. During an interview, on 4/15/25 at 11:59 a.m., CNA 5 indicated every time she sat Resident C at a table, Resident B sat by him. The day Resident B hit Resident C in the head (3/20/25), she had left the common area for a brief minute and when she came back, she found Resident B hitting Resident C in the head with his hands. She separated the two and immediately reported it to the Health and Wellness Director. The only intervention she knew to initiate when Resident B "picked" on Resident C was to separate them. Resident C was the only resident, Resident B sought out. Resident B had indicated he did not like Resident C, but he would not give a reason why he did not like the resident. During an interview, on 4/15/25 at 12:02 p.m., CNA 6 indicated wherever the staff sat Resident C, then Resident B sat at the same table. Resident C was the only resident that Resident B had sought out and physically assaulted. He had hit Resident C recently. The only intervention the staff used when Resident B had his behavior and sought out Resident C was to separate the two residents. Sometimes it worked and sometimes it did not. Resident B would go wherever the staff had taken Resident C in the common area. During an interview, on 4/15/25 at 12:34 p.m., Resident C indicated he was hit on the head recently by "the guy" who sat across from him at the lunch table today (Resident B). During an interview, on 4/15/25 at 12:37 p.m., Resident B indicated he did not get along with one of the men who lived at the facility. He did not like him because he was an "idiot." He indicated it was the man who sat across from him today at			

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	lunch (Resident C). Resident B indicated he liked to "provoke" that man, he was able to punch him in the head and then would sit and laugh at him. Resident B indicated Resident C did things which aggravated him and made him punch Resident C in the head. During an interview, on 4/15/25 at 12:50 p.m., the ED indicated he was not aware of the other behaviors documented in the progress notes besides the ones which were reported to the state agency. He was not informed by staff about the other behaviors. This citation relates to Complaint IN00456858.			