Jason Wafford

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

05/08/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPL				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI		00	COMPL 04/15/	
			D. W1			04/13/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
BICKFOF	RD OF CARMEL				EL, IN 46033		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00							
2.ag. 00	This visit was for th IN00456021 and IN	ne Investigation of Complaints 100456858.	R 0	000			
	Complaint IN00456 the allegations were	021-No deficiencies related to cited					
	-	858-State deficiencies related to ited at R0052, R0091 and					
	Survey date: April 1	15, 2025					
	Facility number: 01	3217					
	Residential Census:	44					
	These deficiencies r accordance with 410	reflect State findings cited in 0 IAC 16.2-5.					
	Quality review was	completed on April 23, 2025.					
R 0052	410 IAC 16.2-5-1.	2(v)(1-6)					
	Residents' Rights	- Offense					
Bldg. 00	review, the facility of a diagnosis of deme physical abuse from for 2 of 2 residents of deficient practice reharassed and assault occasions without the interventions or activation.	on, interview and record failed to ensure a resident with entia (Resident C) was free of another resident (Resident B) reviewed for abuse. This sulted in Resident C being ted by Resident B on several ne facility initiating new ions to prevent further abuse.	R 00	052	R052 Residents' Rights – Offe What corrective actions will be accomplished for those resider found to have been affected by deficient practice? Resident B is being assessed other facilities to relocate. Resident B and C service plathave been updated with interventions to prevent harassment and assault 4/29/2 How the facility will identify other residents having the potential to	nts y the d by ins	04/28/2025
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	SNATURI	Ξ	TITLE		(X6) DATE

Any defiency statement 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 disclodays 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.

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 1 of 17

Administrator

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLI	ETED
			B. W	ING		04/15/	2025
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			EAST 116TH STREET		
BICKEO	RD OF CARMEL				EL, IN 46033		
BICKFOR	ND OF CARIVIEL			CARIVIE	EL, IN 40033		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of Health, a concern	n was expressed regarding an			be affected by the same defici	ent	
	_	Residents B and C. The email			practice and what corrective a	ction	
		B had physically assaulted			will be taken		
	Resident C. The incident was at least the second				· Director of Health and Wellne	ess	
	incident involving those two residents. A family				will complete an audit of all		
	member had also witnessed Resident B's				residents with history of		
	aggression and reported it to the staff. Despite all				resident-to-resident altercation	n and	
		apparent action had been			ensure service plans have bee	en	
	taken, and Resident	B remained at the facility.			updated with interventions.		
					· The Director of Health and		
		incident (FRI) indicated, on			Wellness will provide an in-sei	rvice	
	11/2/24 at 1:30 p.m			to caregivers on watching for			
	Resident C grinding his teeth. Resident B went up				behaviors and when to report		
	to Resident C, put his hands around Resident C's				management by 5/15/25		
	neck, and pushed hi	im. The staff intervened.			· Divisional Director of Health		
					Wellness will provide training		
		ncident (FRI) indicated, on			assessments and service plan		
		., a family member reported			development to the Director of		
		er to Resident C, pushed him			Health and Wellness by 5/15/2		
		n shook Resident C's Broda			What measures will be put into		
		nember indicated Resident B			place or what systemic change		
		y Resident C. The incident			the facility will make to ensure		
		mory care unit. The residents			that the deficient practice does	s not	
	were separated.				recur.		
					· Divisional Director of Operati		
		incident (FRI) indicated, on			will re-educate Executive Dire	ctor	
		m., a family member reported			on residents' right ensuring		
		dent C in the head. There were			interventions and actions are		
		y Resident B hit Resident C in			initiated to prevent further abu		
	the head. The reside	ents were separated.			· Director of Health and Wellne	ess	
	1 751 11 1				will monitor current resident		
		rd for Resident C was reviewed			monthly for 3 months and ann		
		o.m. The diagnoses included,			for any behaviors or pursuing	other	
		l to, dementia, macular			residents.		
		natic brain injury and			How the corrective actions will		
	post-traumatic stres	s aisorder.			monitored to ensure the defici		
	TEI .	· 1 C D · 1 · C			practice will not recur, what qu		
		ervice plans for Resident C,			assurance program will be put	into	
	dated 3/4/25, indica				place.		
	non-ambulatory, red	quired safety checks from the			· Divisional of Health and Well	iness	

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 2 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
			B. W	ING		04/15/	/2025
		<u> </u>		CTREET 4	ADDRESS CITY STATE ZIR COR	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
DIOKEOL					AST 116TH STREET		
BICKFOR	RD OF CARMEL			CARME	EL, IN 46033		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	staff four times per	shift, had advanced dementia,			to confirm Service plans are		
	and was quiet and r	reserved.			updated after any resident to		
	•				resident altercation.		
	The service plans did not include any staff						
	_	event Resident B from being					
	aggressive with Res	_					
	mbbracer o man restaum ev						
	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						
	_	dent C was grinding his teeth,					
	which upset Resident B and caused the behavior.						
	The residents were separated from one another.						
	The residents were separated from one another.						
	Δ nursing progress	note, dated 11/4/24 at 2:36					
		ident C was anxious and					
	1 ~	y house" after Resident B got					
		y house after Resident B got					
	into his face again.						
	A nurging progress	note, dated 11/21/24 at 10:43					
		hospice nurse wrote a new					
		C to receive Risperdal (an					
		tic medication) due to an					
	increase in grinding	g his teeth.					
		1 1 1 1 2 / 1 2 / 2 5 1 5 1 5					
		note, dated 2/12/25 at 2:15					
		ident C had been grinding his					
		t due to his medication being					
		edication would not arrive until					
	this evening.						
	l	1 . 10/00/07					
		note, dated 3/20/25 at 10:59					
		3/15/25 at 10:00 a.m., a staff					
		e nurse they had observed					
	•	esident B) hit Resident C in the					
	head with his hand.	Resident B also was cursing					
	and yelling at Resid	dent C. Resident C was					
ļ	removed from the a						
	The progress notes	did not indicate any staff					

State Form Event ID: 0ILI11 Facility ID: 013217 If continuation sheet Page 3 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	B. WING			
	PROVIDER OR SUPPLIER		5829 E	ADDRESS, CITY, STATE, ZIP COD EAST 116TH STREET EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETIC DATE	ON
	aggressive with Res	vent Resident B from being sident C except for separating n incident had already				
	on 4/15/25 at 3:51 p but were not limited	rd for Resident B was reviewed o.m. The diagnoses included, Ito, dementia, multiple strokes, ajury from a car accident.				
	dated 12/2/24, indic independent with traindependently with received safety chec	out an assistive device, cks four times a shift, had mild ically disruptive, and was				
	-	id not include any staff vent Resident B from being ident C				
	p.m., indicated at 9: physically abusing observed approachi quietly on the coucl After a verbal excha	note, dated 11/2/24 at 2:16 00 a.m. Resident B was seen Resident C. Resident B was ng Resident C who was sitting n on the memory care unit. ange, Resident B grabbed the e throat and yelled at him.				
	p.m., indicated at 2: Resident B was with resident. Resident E punched him. Two residents. The Exec	note, dated 11/2/24 at 2:29 00 p.m., right after lunch, nessed approaching the same 3 grabbed Resident C's arm and staff members separated the utive Director (ED) and the s Director (HWD) were				
	A nursing progress	note, dated 11/2/24 at 4:03				

Event ID: 0ILI11 Facility ID: 013217 Page 4 of 17 State Form If continuation sheet

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/15/2025	
	PROVIDER OR SUPPLIER	2	5829 E	ADDRESS, CITY, STATE, ZIP COD EAST 116TH STREET EL, IN 46033	
(X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF p.m., indicated 911 sent out to the hosp behaviors. The poli Technician (EMT) evaluated Resident not need to be sent remained in the fac A nursing progress p.m., indicated Res another resident's fa morning. This after the other resident w onto the floor with	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION was called to have Resident B ital due to his aggressive ce and Emergency Medical arrived at the facility and B. Resident B indicated he did out for an evaluation, so he ility. The ED was notified. note, dated 11/3/24 at 2:52 ident B was observed in ace and yelled at him this noon, he grabbed the recliner was sitting in and shoved it the resident sitting in it. The	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	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				

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 5 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/15/2025		
	PROVIDER OR SUPPLIER			5829 E	DDRESS, CITY, STATE, ZIP COD AST 116TH STREET L, IN 46033		
BICKFOF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR refused and sat in the other male resident. anything further. He other male resident. B walked back to his A nursing progress p.m., indicated Resicommon area and seresident. Staff attem chair, but he refused stabbing a plastic knand stated "I'm goin the other male resident to remove the plastic Resident B was ask the other male residents chair, tapped his chair, tapped his	note, dated 11/13/24 at 2:31 ident B walked into the at next to another male upted to direct him to another d. He sat down, started unife into the arm of his chair, up to get him" while staring at ent. A staff member was able to knife from Resident B. When ed to please move away from ent, he refused, was restless in a feet and changed positions.	F			ATE	(X5) COMPLETION DATE
	anti-anxiety medical physician, which we breakfast and walke and Wellness Direct A nursing progress p.m., indicated Resisame resident today with. A nursing progress a.m., indicated Resisuith another resident yell at the other resident yell at the other resident yell at the A nursing progress indicated the Health discussed Resident	en an as needed Ativan (an tion) as ordered by the as effective. He then went to ed back to his room. The Health tor was notified. Inote, dated 11/15/24 at 3:09 ident B was upset with the which he was usually upset Inote, dated 1/17/25 at 10:15 dent B was very aggressive at for no reason. He began to ident, then he pushed him. Inote, dated 2/4/25 at 3:47 p.m., and Wellness Director B's prior episodes of being a resident with the psychiatric					
	Nurse Practitioner (NP).					

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 6 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 04/15/2025		
	PROVIDER OR SUPPLIER		5829 E	ADDRESS, CITY, STATE, ZIP COD EAST 116TH STREET EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	p.m., indicated a far Resident B go up to the resident's head be chair. The aggressiv an unprovoked incident A nursing progress	note, dated 3/20/25 at 10:57				
	the head with his fis	dent B hit another resident on at and yelled and cursed at the resident was moved from the				
	a.m., indicated inforpsychiatric hospital	note, dated 3/21/25 at 11:58 rmation was sent to a geriatric for placement due to the ggression towards another				
	p.m., indicated the g	note, dated 3/21/25 at 4:14 geriatric psychiatric hospital on Monday (3/24/25).				
		note, dated 3/25/25 at 11:44 dent B was verbally aggressive nother resident.				
	a.m., indicated the p Resident B due to a remain on the facilit recent aggression w	note, dated 3/27/25 at 9:33 osychiatric hospital denied in insurance denial. He would try psychiatric schedule. His as just discussed with the out any changes in his orders.				
	p.m., indicated Resi	note, dated 4/12/25 at 9:36 dent B showed signs of ards a specific resident.				
		on, on 4/15/25 at 11:25 a.m., ident C were observed sitting				

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 7 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING			COMPLETED 04/15/2025		
	ROVIDER OR SUPPLIER	2		5829 E	DDRESS, CITY, STATE, ZIP COD AST 116TH STREET L, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the table from each	ble. They were sitting across other. Resident B was nt C was unable to ambulate or					
	5 indicated every tin table, Resident B sa hit Resident C in the the common area for came back, she four C in the head with I two and immediatel Wellness Director. I knew to initiate who Resident C was to so the only resident, R Resident B had indice, but he would not like the resident. During an interview 6 indicated wherever Resident B sat at the the only resident that and physically assaurecently. The only it when Resident C was to so Sometimes it worker.	me she sat Resident C at a at by him. The day Resident B he head (3/20/25), she had left or a brief minute and when she had Resident B hitting Resident his hands. She separated the dy reported it to the Health and The only intervention she hen Resident B "picked" on he heart them. Resident C was he he had not like Resident B sought out. Cated he did not like Resident give a reason why he did not he same table. Resident C, then he had hit Resident C was hat Resident B had sought out halted. He had hit Resident C intervention the staff used had his behavior and sought out he had sometimes it did not.					
	Resident C in the co	o wherever the staff had taken ommon area. y, on 4/15/25 at 12:34 p.m.,					
	Resident C indicate	d he was hit on the head " who sat across from him at					
		y, on 4/15/25 at 12:37 p.m., d he did not get along with					

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 8 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 04/15/2025		
	PROVIDER OR SUPPLIER		5829 E	ADDRESS, CITY, STATE, ZIP COD EAST 116TH STREET EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION lived at the facility. He did not	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	like him because he was the man who sa lunch (Resident C). to "provoke" that m in the head and ther Resident B indicate aggravated him and in the head. During an interview ED indicated Residing pay for a stay at the previously stayed befacility. He did not Wellness Director in psychiatric hospital psychiatric service in psychiatric service i	lived at the facility. He did not was an "idiot." He indicated it across from him today at Resident B indicated he liked an, he was able to punch him a would sit and laugh at him. d Resident C did things which made him punch Resident C wo., on 4/15/25 at 12:50 p.m., the ent B's insurance would not psychiatric hospital where he efore he was admitted to the know if the Health and had attempted to find another. Resident B was seen by a chrough telehealth. There was ce which would come to the d treat residents face to face did not have enough end those services. If Resident in his medication cup, he he he he he had a traumatic brain hy Resident B did not attend care programming activities				
	and mainly stayed in the During an interview ED indicated he was behaviors document besides the ones who agency. He was not other behaviors. A current facility por Neglect," dated 2/20 on 4/15/25 at 5:30 p					

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 9 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		04/15/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD EAST 116TH STREET		
BICKEOE	RD OF CARMEL				EL, IN 46033		
DICKI OI	TO OF CARRIEL			CAINIL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	cted or exploited shall report					
	the information imp	nediately to the Branch					
	Executive Director or Health & Wellness						
	Directorare requir	red to be knowledgeable of the					
		ures regarding the prohibition					
	of mistreatment, neg	glect, and abuse of residents					
	and misappropriation	on of their property"					
	This citation relates	to Complaint IN00456858.					
R 0091	410 IAC 16.2-5-1.	3(h)(1-4)					
	Administration and Management -						
Bldg. 00	I ~						
Ŭ	Based on observation, interview and record		R 0	091	R091 Administration and		04/28/2025
		failed to ensure incidents of	100	0)1	Management - Noncompliance	<u> </u>	0 1/20/2023
	-	hly investigated in an effort to			· 0 residents were harmed by t		
	_	recations between 2 of 2			deficient practice.		
	_	for investigations of abuse.			What corrective actions will be		
	(Residents C and B)				accomplished for those reside		
		,			found to have been affected by		
	Findings include:				deficient practice?	,	
	C				· Investigation of the incident		
	In an anonymous er	nail, to the Indiana Department			completed 4/28/25.		
	_	n was expressed regarding an			· Audit will be completed of las	t 60	
		Residents B and C. The email			days to ensure all		
		B had physically assaulted			resident-to-resident altercation	s	
		eident was at least the second			have been thoroughly investig		
		hose two residents. A family			How the facility will identify oth		
		itnessed Resident B's			residents having the potential		
		orted it to the staff. Despite all			be affected by the same defici		
		apparent action had been			practice and what corrective a		
		B remained at the facility.			will be taken		
	,	,			· Executive Director and Director	tor	
	A facility reported i	incident (FRI) indicated, on			of Health and Wellness will be		
		., Resident B was annoyed by			responsible for investigating a		
	_	g his teeth. Resident B went up			resident to resident altercation	-	
		nis hands around Resident C's			What measures will be put into		
		im. The staff intervened.			place or what systemic change		
	, 1				the facility will make to ensure		
	A facility reported i	incident (FRI) indicated, on			that the deficient practice does	not	
			1		'		

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 10 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		04/15/2025
		1	CTDEE	Γ ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	₹		EAST 116TH STREET	
BICKEUE	RD OF CARMEL			MEL, IN 46033	
PICKEOF	AD OF CARRIEL		CARI	MLL, IN 40000	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		., a family member reported		recur.	
		ver to Resident C, pushed him		· Divisional Director of Health	and
		en shook Resident C's Broda		Wellness will re-educate	
	1	nember indicated Resident B		Executive Director and Director	or of
	_	by Resident C. The incident		Health and Wellness on the	
	happened in the memory care unit. The residents			Investigation process.	
	were separated.			How the corrective actions will	
		A facility and and incident (EDI) in light 4		monitored to ensure the defici	
		incident (FRI) indicated, on		practice will not recur, what qu	·
	3/20/25 at 10:01 a.m., a family member reported			assurance program will be pu	t into
	Resident B hit Resident C in the head. There were no triggers as to why Resident B hit Resident C in			place.	
		-		· Divisional of Health and Wel	
	the head. The residents were separated.			will review the investigation th	
	1 771 1' ' 1	16 P :1 .6		next three resident-to-residen	
		rd for Resident C was reviewed		altercation to ensure process	was
		p.m. The diagnoses included,		followed.	
		d to, dementia, macular			
	_	natic brain injury and			
	post-traumatic stres	ss disorder.			
	The most current se	ervice plans for Resident C,			
		ated Resident C was			
		quired safety checks from the			
	I	shift, had advanced dementia,			
	and was quiet and r				
	quiet unu i				
	2. The clinical reco	rd for Resident B was reviewed			
		p.m. The diagnoses included,			
		d to, dementia, multiple strokes,			
		njury from a car accident.			
	The most current se	ervice plans for Resident B,			
		cated Resident B was			
	independent with transfers, ambulated				
	independently with	out an assistive device,			
	received safety che	cks four times a shift, had mild			
	dementia, was phys	sically disruptive, and was			
	uncooperative and	resistant to care.			
	During an observat	ion, on 4/15/25 at 11:25 a.m.,			

State Form Event ID: 0IL11 Facility ID: 013217 If continuation sheet Page 11 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/15/	ETED
	PROVIDER OR SUPPLIER	<u>.</u>		5829 E	DDRESS, CITY, STATE, ZIP COD AST 116TH STREET L, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	at the same lunch ta the table from each ambulatory. Reside stand up.	ident C were observed sitting ble. They were sitting across other. Resident B was nt C was unable to ambulate or					
	5 indicated every tintable, Resident B sahit Resident C in the the common area for came back, she four C in the head with I two and immediatel Wellness Director. I knew to initiate who Resident C was to set the only resident, Resident B had indicated to the same and the same area.	y, on 4/15/25 at 11:59 a.m., CNA me she sat Resident C at a at by him. The day Resident B he head (3/20/25), she had left or a brief minute and when she had Resident B hitting Resident his hands. She separated the hy reported it to the Health and The only intervention she hen Resident B "picked" on he parate them. Resident C was he esident B sought out. Cated he did not like Resident a give a reason why he did not					
	6 indicated wherever Resident B sat at the the only resident the and physically assar recently. The only in when Resident B has Resident C was to a Sometimes it worked Resident B would g Resident C in the contract						
	Resident C indicate recently by "the guy the lunch table toda	7, on 4/15/25 at 12:34 p.m., d he was hit on the head 7" who sat across from him at y (Resident B). 7, on 4/15/25 at 12:37 p.m.,					

State Form Event ID: 0ILl11 Facility ID: 013217 If continuation sheet Page 12 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u> CO			TE SURVEY PLETED 5/2025				
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL			5829 E	STREET ADDRESS, CITY, STATE, ZIP COD 5829 EAST 116TH STREET CARMEL, IN 46033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
	one of the men who like him because he was the man who sa lunch (Resident C). to "provoke" that m in the head and ther Resident B indicate aggravated him and in the head. During an interview	d he did not get along with blived at the facility. He did not was an "idiot." He indicated it at across from him today at Resident B indicated he liked an, he was able to punch him a would sit and laugh at him. d Resident C did things which made him punch Resident C							
	behaviors documen besides the ones whagency. He was not other behaviors. He investigation on any resident-to-resident reported to the India regarding Resident	ted in the progress notes ich were reported to the state informed by staff about the did not complete an							
	Neglect," dated 2/2/4/15/25 at 5:30 p.m to believe that a res abused, neglected o information immed Director or Health a required to be know procedures regarding mistreatment, negle misappropriation of Report."	olicy, titled "Abuse and 025 and provided by the ED on ., indicated "reasonable cause ident is being, or had been, r exploited shall report the intely to the Branch Executive & Wellness Directorare reledgeable of the policies and leg the prohibition of ct, and abuse of residents and their propertyInvestigation to Complaint IN00456858.							
R 0217	410 IAC 16.2-5-2(Evaluation - Defic	e)(1-5)							

State Form Event ID: 0ILl11 Facility ID: 013217 If continuation sheet Page 13 of 17

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
			B. WING			04/15/2025	
				GTDFFT	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					EAST 116TH STREET		
BICKFOR	RD OF CARMEL			CARM	EL, IN 46033		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)	16	DATE
Bldg. 00							
	Based on observation	on, interview and record	R 0217		R217 Evaluation - Deficiency		04/28/2025
		failed to ensure residents	10217		· One resident was affected by the		0 20. 2020
	-	l alterations had service plans		deficient practice			
		and document the services to		What corrective actions wil		1	
	-	facility for 2 of 2 residents			accomplished for those reside		
		e plans. (Resident C and B)			found to have been affected by		
					deficient practice?	,	
	Findings include:				· Resident's B and C service p	lans	
	i mamga maraaa.				have been updated with	iai io	
	In an anonymous en	nail to the Indiana Department			interventions 4/29/25		
	In an anonymous email, to the Indiana Department of Health, a concern was expressed regarding an				How the facility will identify oth	or	
	incident involving Residents B and C. The email				residents having the potential		
	indicated Resident B had physically assaulted			be affected by the same			
	Resident C. The incident was at least the second			practice and what corrective			
	incident involving those two residents. A family				will be taken	Clion	
	member had also witnessed Resident B's				· Director of Health and Wellne	200	
	aggression and reported it to the staff. Despite all				will complete an audit of all	555	
	these incidents, no apparent action had been				residents with history of		
	taken, and Resident B remained at the facility.				resident-to-resident altercation	and	
	and resident D remained at the facility.				ensure service plans have bee		
	A facility reported incident (FRI) indicated, on				updated with interventions.	511	
	11/2/24 at 1:30 p.m., Resident B was annoyed by			What measures will be put in		,	
	Resident C grinding his teeth. Resident B went up			place or what systemic chang			
	to Resident C, put his hands around Resident C's			the facility will make to ensur			
	-		that the deficient practice do				
	neck, and pushed him. The staff intervened.				•	STIOL	
	A facility reported incident (FRI) indicated, on			recur. · Divisional Director of Health and		and	
	3/11/25 at 9:01 a.m., a family member reported				Wellness will re- educate Director		
	Resident B went over to Resident C, pushed him				of Health and Wellness on triggers for reassessment and Service plan		
	in the head, and then shook Resident C's Broda					pian	
	chair. The family member indicated Resident B		updates.		L		
	was not provoked by Resident C. The incident			How the corrective actions			
	happened in the memory care unit. The residents			monitored to ensure the deficient			
	were separated.				practice will not recur, what qu	•	
	A C:11:4-				assurance program will be put	into	
	A facility reported incident (FRI) indicated, on		place				
	3/20/25 at 10:01 a.m., a family member reported		· Divisional Director of Health and				
		dent C in the head. There were	Wellness will review all service				
	no triggers as to why Resident B hit Resident C in				plans of residents that have be	een	

State Form Event ID: 0ILI11 Facility ID: 013217 If continuation sheet Page 14 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 04/15/2025				
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 5829 EAST 116TH STREET CARMEL, IN 46033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	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.			in a resident-to-resident alterd to ensure intervention have be added to prevent further abus the next seven months.	een			
	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.							
	dated 12/2/24, indic independent with traindependently with received safety chec	out an assistive device, cks four times a shift, had mild ically disruptive, and was						
	_	id not include any staff vent Resident B from being sident C						
	Resident B and Res at the same lunch ta the table from each	ion, on 4/15/25 at 11:25 a.m., ident C were observed sitting ble. They were sitting across other. Resident B was nt C was unable to ambulate or						

State Form Event ID: 0ILI11 Facility ID: 013217 If continuation sheet Page 15 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 00 COMPLETED B. WING 04/15/2025			LETED			
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL				STREET ADDRESS, CITY, STATE, ZIP COD 5829 EAST 116TH STREET CARMEL, IN 46033					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	5 indicated every tin table, Resident B sa hit Resident C in the the common area for came back, she four C in the head with he two and immediatel Wellness Director. I knew to initiate who Resident C was to so the only resident, R Resident B had indice, but he would not like the resident. During an interview 6 indicated wherever Resident B sat at the the only resident that and physically assaure cently. The only in when Resident B had Resident C was to so sometimes it worked Resident B would greatent B would greatent B would greatent C in the company in the company in the properties of the men who like him because he would be a sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the company in the sident B indicate one of the men who like him because he in the com	y, on 4/15/25 at 12:34 p.m., d he was hit on the head " who sat across from him at							

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 16 of 17

PRINTED: 05/12/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/15/2025		
NAME OF PROVIDER OR SUPPLIER BICKFORD OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP COD 5829 EAST 116TH STREET CARMEL, IN 46033				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	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.						

State Form Event ID: 01L111 Facility ID: 013217 If continuation sheet Page 17 of 17