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	10/30/2023

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 Complaint IN00419622. Complaint IN00419622 - State deficiencies related to the allegations are cited at R0052. Survey date: October 30, 2023 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 November 6, 2023.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (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 protect a resident with dementia from neglect when the resident exited the facility, without staff knowledge, and was found walking on 116th Street on the city sidewalk, by an off-duty staff member for 1 of 3 resident reviewed for neglect. (Resident B) Finding includes:	R 0052	R0052 Residents' Rights – Offense Survey Event #DKWT11 The facility failed to protect a resident with dementia from neglect when the resident exited the facility, without staff knowledge, and was found walking on 116th Street on the city sidewalk by an off-duty staff	12/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie	Langhans, RN	12/07/2023

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	During an observation, on 10/30/23 at 8:47 a.m., Resident B was observed sitting in a chair at a table facing the main entrance door. He was dressed and had a bag. The resident indicated he was waiting on the bus to go to dialysis. The resident indicated he had left the facility to go for a walk, but now all the doors were locked, and he could not get out, but he did try the doors until he could find one which would open. He wanted to leave the facility. During a walkthrough of the facility, on 10/30/23 beginning at 9:16 a.m., the exits at the end of the halls were found to be armed to alarm when opened. The main entrance and west side entrance (employee entrance) were found to have a keypad which required a code to enter and exit the facility. The record for Resident B was reviewed on 10/30/23 at 11:14 a.m. Diagnoses included, but were not limited to, end stage renal disease (kidney failure) and dementia without a behavioral disturbance. Resident B admitted to the facility on 9/19/23. A service plan, dated 9/19/23, indicated to review/update the service plan every 180 days or with a significant change in condition, the resident was independent with mobility, was a fall risk, and occasionally used a walker due to sciatica nerve disorder. A Mini Mental State Examination (MMSE) was an assessment of cognitive function. A score of 25 or higher was classed as normal. A score below 24, was usually considered to be abnormal, indicating possible cognitive impairment. On 9/19/23, Resident B had a score of 19 out of 25.		member for 1 of 3 resident reviewed for neglect. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · Resident B still resides at Bickford of Carmel; no further incidents have occurred. · Service plan has been updated to reflect exit seeking behaviors and his cognitive level GDS 4. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · Service plans of residents with exit seeking behaviors will be reviewed to ensure individualized interventions are in place. · Service plans will be developed and implemented that include interventions for residents with exit seeking behaviors What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. · Executive Director/Health & Wellness Director to receive additional training by the Divisional Director of Health and Operations on the expectation that Service plans are developed and	

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	There was no elopement risk assessment found in the resident's record. A nursing note, dated 9/27/23 at 9:00 p.m., indicated the resident was very confused and was trying to exit seek most of the evening. A nursing note, dated 9/28/23 at 2:45 p.m., indicated the resident had been wandering the halls and standing at exit doors all shift. The resident did push open an exit door by the dining room prior to lunch but staff had "eyes on him" and were able to redirect him back in the door. A nursing note, dated 9/29/23 at 3:10 p.m., indicated the resident was in the doorway of another resident's room, raising his voice, and accusing the other resident's family of stealing his money and phone. The nurse was able to remove Resident B from the door way and toward his apartment. When the nurse tried to reorient the resident, he became louder and used profanity. The resident was directed back to his apartment. Later when the nurse returned to administer the resident's medications, the resident did not know how to operate the remote control, or which remote to use for his television. He also began to talk to the nurse about things which "did not make sense". A nursing note, dated 9/30/23 at 9:00 p.m., indicated from 3:00 p.m., to approximately 8:30 p.m., Resident B had been wandering the halls and going into other resident's apartments. Several residents came to the nurse stating they were afraid in their apartments. Resident B was very angry. Resident B also told the nurse "...I am going to bust out of here and get to a phone and call the police and tell them what all of you are		implemented to include individualized interventions to address exit seeking behaviors. Re-training will also cover Abuse and Neglect Policy · Executive Director and Director of Health & Wellness will be responsible for ensuring individualized service plan are developed and address the care needs of residents, including exit seeking behaviors. · Health & Wellness Director will conduct an in-service on interventions and supervision as identified on service plan for residents exhibiting exit seeking behaviors and abuse and neglect policy for all caregivers. · Residents with exit seeking behaviors will be discussed with Divisional Team during weekly care calls to ensure proper assessment and intervention development. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place · Divisional Director of Health and Operations will review service plans monthly for three months and then annually to ensure residents identified with exit seeking behaviors have appropriate interventions implemented in service plan.	

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	doing to me...." A nursing note, dated 10/4/23 at 2:45 p.m., indicated Resident B was argumentative with staff in the morning. He was standing at the front door stating he was leaving. The resident attempted to walk out the front door when another resident was leaving the building for an appointment. Resident B was not easily redirected and continued to stand at the front door, he refused to move to another area. Resident B did pull up a chair to the door area and sat down. A nursing note, dated 10/5/23 at 10:00 p.m., indicated the staff had to continuously redirect Resident B from the doors which led out of the building. The resident was standing and looking out the doors and pushed on the handles. A nursing note, dated 10/10/23 at 12:30 p.m., indicated an off-duty nurse walked in the front door with Resident B. She told the nurse she had found him walking on 116th Street toward River Road. The resident was walking on the sidewalk. The resident did come back into the facility without any issues but became agitated when he was told he could not go out the front door and walk. The resident told LPN 3 he knew the code for the door. No alarms had sounded when he left the facility. The resident was observed in the dining room at about 12:15 p.m., after finishing his lunch. The staff had to sit near the exit and keep resident redirected. A nursing note, dated 10/10/23 at 6:00 p.m., indicated a wander guard (a device which would activate an alarm when a resident was close to, or tried to exit a door) was placed on the resident. The resident removed the device and told staff he threw it away.		By what date the systemic changes will be completed by December 8, 2023	

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	A nursing note, dated 10/11/23 at 2:00 p.m., indicated Resident B was restless and pacing in the hall by the front door. The staff attempted to redirect the resident, but the resident became agitated and began to yell at the staff. He continued to sit and/or stand around the door. When a staff member approached the resident, he threatened to punch her in the face. A nursing note, dated 10/13/23 at 7:30 p.m., indicated after returning from a visit out of the facility with his family, the resident was standing at the door with his coat on. The staff had to redirect him away from the door many times. The resident was exit seeking around other doors which led to the outside of the facility. A nursing note, dated 10/18/23 at 12:00 p.m., indicated the resident was confused about the time of day and thought he was late for his dialysis appointment. Staff attempted to show him the time. The resident argued with the staff, followed staff down the hall yelling at them, going to the front entrance, and standing in the doorway when visitors were attempting to enter the building. The resident was difficult to redirect away from the door. The resident did get picked up and transported to dialysis. A facility document, titled "Unusual Occurrence Report," dated 10/10/23, indicated Resident B eloped from the assisted living facility at 12:30 p.m. He was found outside off branch campus. The document indicated "Elopement Unknown-Security System Failure." The resident was not injured. The description of the incident indicated "...off duty facility nurse came into building with res [resident] @ 12:30. nurse stated she saw res walking down 116th on sidewalk			

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	towards River Rd. Res came with off duty nurse willingly but was easily agitated when he kept trying to go back outdoor. No door alarms sounded. Res stated to the nurse "I know the code". Director notified...." The following observations which may have contributed to the occurrence were confusion or increased confusion, agitation, or increased agitation and other. The option other was not filled in on the form. A facility document, titled, "Elopement," dated 10/11/23, indicated Resident B exited the facility using the front door. The alarm did not sound/activate. He was found walking on the sidewalk outside the branch. He returned/exited the facility at 12:36. The resident did not sustain any injuries. He did not have a history of elopement from the branch (facility). A wanderguard was placed upon his return but he removed it and hid it. The resident was put on frequent checks. The resident had no behavior issues prior to the elopement. There was no service plan found in the record to show the resident was re-evaluated after he walked out of the facility, on 10/10/23, without the staff's knowledge. During an interview, on 10/30/23 at 10:11 a.m., CNA 2 indicated Resident B got out at lunch, he put the code in the door and exited. A nurse saw the resident between the facility and River Road and brought him back into the facility. During an interview, on 10/30/23 at 10:25 a.m., Maintenance Staff 1 indicated the door codes had to be changed because Resident B would hang around by the main entrance and watch people.			

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	During an interview, on 10/30/23 at 10:54 a.m., the Corporate Support Nurse indicated Resident B had a Global Deterioration Scale (GDS-an assessment tool used to provide an overview of the stages of cognitive functioning for residents with degenerative dementia) score which indicated the resident was able to leave the facility on his own. Resident B failed his first Mini Mental State Examination with a score of 19. She believed a nurse was in her car when the nurse observed the resident out of the facility. The resident could leave the facility if he wanted, it was in his resident rights. Resident B was to have his next GDS assessment at 30 days from admission. During a telephone interview, on 10/30/23 at 11:59 a.m., LPN 3 indicated on the day Resident B left the building it was lunch time, he was in the dining room and staff were working in the dining room. The resident had finished eating and left the dining room. A nurse brought him into the facility and indicated she found him walking on 116th street toward the bridge. There were no alarms sounding. The resident said he knew the code to get out the main doors. The staff attempted to place a wander guard, but the resident removed it. He was assessed for injury and put on 15-minute checks. A couple days later the wander guard was attempted again but the resident did not want the wanderguard. The codes to the doors were changed. During a telephone interview, on 10/30/23 at 2:15 p.m., LPN 4 indicated she was getting into her car to go home when she looked and saw Resident B at the end of the property on 116th Street. He was walking on the city sidewalk. She did not observe him leave the building. She indicated it was about 12:30 p.m. The resident did hesitate to return to the building, but she was able to convince him to			

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	enter with her. During a telephone interview, on 10/30/23 at 2:30 p.m., the daughter of Resident B indicated he did wander at home, and she felt his dementia did worsen living home alone. He would go out and forget where he was going. The resident was admitted to an independent living facility, and he did walk out of the facility at about 2:00 a.m. Since it was an independent living facility, the residents were allowed to come and go as they wanted. He exited the building because he thought he had dialysis. He was locked out of the facility and could not get back in. He was also admitted to an assisted living facility, and he walked out of that building between 1:30 a.m., and 2:00 a.m. He thought he had a dialysis appointment. Staff found him standing, outside, at the awning/car port area. She indicated he had mood issues and would swing back and forth. He had a temper and could get vicious. If he was not in control, he would get agitated/aggressive. He wanted to get out of the facility, and he complained every day about it. He did hang around the entrance/exit doors watching people, maybe he wrote down the code (to the door). During an interview, with the Corporate Support Nurse present, on 10/30/23 at 2:51 p.m., the Director of Nursing indicated she was not aware of Resident B's history prior to his admit to the facility. The last facility only sent his face sheet, orders, medication and treatment record, code status etc. She did ask if the resident had behaviors, but the facility he came from did not provide any information. When she had the interview/assessment, the daughter felt the resident was confused after dialysis, but no other behavior information was shared. The resident did want to go out to the store, walk around outside			

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	and did go into the courtyard, but after walking in the area he would get bored. The facility did receive a report about a week after he admitted to the facility from the dialysis provider, the resident was aggressive with them. The daughter did not disclose information about the resident walking out of the other two facilities in the middle of the night. The resident did watch the door and they have had to tell people to hide the code when they punched it in. There was also another resident, who was independent and drove, which would yell out the key code. During an interview, with the Director of Nursing present, on 10/30/23 at 2:51 p.m., the Corporate Support Nurse indicated technically any assisted living resident could leave the facility if they did not have a wander guard or were not an elopement risk, but Resident B was an elopement risk per the records (progress notes) she had reviewed. A facility policy, titled "Resident Monitoring Device, Panic Button," dated as last revised October 2014 and received from the Corporate Support Nurse on 10/30/23 at 11:52 a.m., indicated "...A resident shall wear a monitoring device at all times if he/she meets the trigger mechanisms...these triggers are...Wandering (leaving residence or entering other's apartment) ...." A facility policy, titled "Resident Bill of Rights (IN)," dated as last revised September 2014 and received from the Corporate Support Nurse on 10/30/23 at 11:52 a.m., indicated "...Residents have the right to be free of...neglect...." This State Residential finding relates to Complaint IN00419622.			

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