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	02/19/2024

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 a Post Survey Revisit (PSR) to the Investigation of Complaint IN00419622 completed on October 30, 2023. This visit was in conjunction with the Investigation of Complaints IN00428410 and IN00428097. Complaint IN00419622 - Not corrected. Complaint IN00428410 - State deficiencies related to the allegations are cited at R0090. Complaint IN00428097 - State deficiencies related to the allegations are cited at R0052 and R0154. Survey date: February 15, 16 and 19, 2024. Facility number: 013217 Residential Census: 48 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on February 26, 2024.	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 protect a resident with dementia and a history of exit seeking behaviors, from neglect, when the resident exited the facility, without staff knowledge, and was found behind the facility in the middle of the night, on 2/2/24, and exited the facility again, without staff knowledge, on 2/4/24. (Resident C)	R 0052	R052 – Residents' Rights - The rule is not met as evidenced by the facility failed to protect a resident with dementia and a history of exit seeking behaviors, from neglect, when the resident exited the facility, without	04/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Finding includes: An Indiana State Department of Health Intake Information Form, dated 2/14/24, indicated a resident had eloped out of the community several times. During a random observation, on 2/15/24 at 9:40 a.m., Resident C was observed hanging around the main entrance. He indicated he wanted to leave. The resident was wearing nonskid shoes and did not require any assistive devices to ambulate. The clinical record for Resident C was reviewed on 2/15/24 at 10:20 a.m. The diagnoses included, but were not limited to, dementia, fall history, and atrial fibrillation. The service plan for Resident C, last updated on 12/8/23, indicated the resident had a change of condition for increased safety concerns and exit seeking behavior. Interventions put in place included to offer a bedtime snack, a movie to keep the resident in sight of the facility employee during sundowning times, after the movie if he refused to stay up front (in the front common area) walk him to his room to ensure he arrived there safely. He was known to lose his way and start looking for an exit home. Walk with him and talk with him about where he grew up, then safely make sure he ends the walk at his apartment door and then state, 'we have arrived'. The service plan indicated the resident was an elopement risk and a fall risk. A nursing progress note, dated 12/27/23 at 10:00 p.m., indicated at 3:30 p.m., the resident was exit seeking at the front door of the building. He was		staff knowledge, and was found behind the facility in the middle of the night, on 2/2/24, and exited the facility again, without staff knowledge on 2/4/24. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident C now has Wander Guard placed Resident C's service plan was updated with safety interventions Resident C's POA has given 30 day notice 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 Health & Wellness Director will audit all resident charts to ensure that any resident with exit seeking behaviors has Wander Guard in place. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Director and Director of Health and Wellness will be responsible for ensuring that residents are free from neglect.	

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	redirected back to the television area. Staff talked with the resident and offered a snack. At 4:10 p.m., the resident followed people out the front door. He was in sight of the staff and staff tried to redirect him back into the building and he did not want to come in. He was assisted back into the facility by staff. A nursing progress note, dated 1/1/24 at 11:00 p.m., indicated during dinner the resident tried four times to exit seek out the door of the dining room. Staff ensured he had a meal in front of him and a drink. Staff sat and talked with him, and the resident once again attempted to leave the building at 5:32 p.m. A nursing progress note, dated 1/3/24 at 12:40 p.m., indicated the resident was ambulating in the hallway wearing only his underwear. The resident stated he was going home. The resident was redirected back to his apartment. A nursing progress note, dated 1/8/24 at 12:30 a.m., indicated the resident was walking around and trying to open the side door by the dining room. He was redirected. A nursing progress note, dated 1/16/24 at 4:30 p.m., indicated the nurse heard the front door alarm and went to clear (stop) it. They observed the resident attempting to go out of the building. The resident was difficult to redirect. The nurse and the Executive Director tried to get the resident back inside without success. The Happiness Director came to assist and was successful in getting the resident back to his room safely. A nursing progress note, dated 1/26/24 at 9:30 a.m., indicated the resident tried escaping out the door three times and was redirected.		Director and Health and Wellness Director will be re-educated on Resident Bill of Rights Policy, stating residents have the right to be free of neglect. Health & Wellness Director will provide an in-service to all staff on resident rights including the right to be free of neglect. 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 & Operations will audit next 3 new admission charts to see that residents who qualify for wander guard monitoring have it in place, and that specialized interventions for residents with exit seeking behaviors are listed on service plan.	

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	A nursing progress note, dated 2/2/24 at 1:00 a.m., indicated the exit alarm went off. Staff went to assess the situation and discovered the resident had eloped outside of the building from the back door of the Assisted Living. The resident had made it down the hill. He was assisted back into the building and assessed for pain and injury. The resident denied having any pain. The resident sustained minor scratches to both lower extremities and his left index finger. The wounds were cleaned, and an antibiotic cream was applied to them. A nursing progress note, dated 2/4/24 at 11:00 a.m., indicated at 8:00 a.m., the resident was pushing on the exit door by room 108. He stated "I have to let the meter man in." He was redirected to his apartment. At 9:30 a.m., another resident notified the nurse the exit door by her apartment was sounding and she saw a man walk by her window. The resident was found walking on the sidewalk in front of the building. He was escorted back into the building and to his apartment. He was given a snack and a drink. The resident indicated to the writer he was helping someone unload their car. At 12:00 p.m., staff heard the exit door by room 128 sounding and found the resident standing outside the door. The resident came back into the building easily and was escorted to lunch. The area around the facility was observed, on 2/15/23 at 10:31 a.m., at the back of the facility was a steep downgrade of grass and dirt which went into an overgrown field. During an interview, on 2/15/24 at 12:13 p.m., the Director of Nursing indicated Resident C exited either door 8 or 7, on 2/4/24, and stayed on the			

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	property. Another resident notified staff he went out; she indicated the staff did not hear the door alarm as it was too "soft". He walked to the front of the property and was trying to help a new resident move in. During an interview, on 2/15/24 at 12:26 p.m., LPN 6 indicated she thought, on 2/4/24, Resident C exited at door 7, and walked around to the front of the property. During a telephone interview, on 2/15/24 at 3:44 p.m., LPN 5 indicated an aide the heard door alarm, on 2/2/24, and told him. He went outside looking for the resident, it was dark, and he was yelling out the resident's name. The resident was at the bottom of a slope, he had gone out the back door. He escorted the resident back into the building. Resident C looked confused, he assessed the resident, and he had minor scratches. At the time, the resident was wearing a regular shirt and shorts. LPN 5 indicated there was no snow, and it was not cold out. The elopement did occur on the night shift. A facility policy, titled "RESIDENT BILL OF RIGHTS-BFM ACKNOWLEDGEMENT (IN)," dated as last revised 03/2023 and received from the Director of Nursing on 2/16/24 at 12:18 p.m., did not include documentation regarding the resident's right to be free from neglect. A facility policy, titled "PP-60100-Abuse and Neglect (IN)," dated as last revised 04/2015 and received from the Regional Support Nurse on 2/19/24 at 9:59 a.m., included guidance for reporting abuse and neglect, but did not include documentation regarding the abuse and neglect prevention.			

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	This deficiency was cited on 10/30/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			