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	03/12/2024

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 Investigation of Complaint IN00429284. Complaint IN00429284-State deficiencies related to the allegations are cited at R0052. Survey dates: March 11 and 12, 2024 Facility number: 013217 Residential Census: 41 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review completed on March 20, 2024.	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 ensure a dependent resident with Lewy Bodies Dementia was free from neglect for 1 of 3 residents being reviewed for neglect (Resident B) which resulted in Resident B not being put in bed all night, she got up off her reclining couch, fell, and lay stuck under her bed for an undetermined amount of time. Using the reasonable person concept, it is likely that this would lead to recurrent fear and anxiety of being forgotten or neglected.	R 0052	R052 – Residents' Rights - Offense The rule is not met as evidenced by the facility failed to ensure a dependent resident with Lewy Bodies Dementia was free from neglect for 1 of 3 residents being reviewed for neglect which resulted in Resident B not being put in bed all night, she got up off	04/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie Langhans	Divisional Director of Health & Operations	03/30/2024

Any defiencystatement 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 disclo days 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.

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	Finding includes: A document titled, "Intake Information," dated 2/25/24, provided by the Indiana Department of Health indicated there was a concern regarding Resident B who had Lewy Body Dementia. Resident B was found on the floor under her bed on 2/21/24 at approximately 7:40 a.m. An anonymous person informed the facility they did not believe she had been put to bed the night before and she got up by herself, fell, then crawled under her bed. They believed the facility did not complete the every two hour checks as they were supposed to according to the resident's service plan. Resident B's record was reviewed on 3/11/24 at 12:26 p.m. Diagnoses included, but were not limited to, Lewy Bodies Dementia, Neurocognitive disorder with Lewy Bodies, dementia and depression. The resident's service assessment, dated 1/25/24, indicated Resident B required an assist of one for morning and bedtime care. The fall risk assessment section indicated the staff were to perform every two to three hour checks for Resident B's safety. A nursing progress note, dated 2/21/24 at 7:20 a.m., indicated when staff entered Resident B's room they found her lying on her back halfway under the bed. She was unable to verbalize how she got to the floor. The skin on the back of her head was red in color. She was transferred to the Emergency Room for evaluation and treatment. On 3/11/24 at 1:20 p.m., with the Area Health and Wellness Director in attendance an observation of		her reclining couch, fell, and lay stuck under her bed for an undetermined amount of time. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident B has given a 30-day notice to move out of the facility 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 service plans to ensure detailed cares and personalized interventions are listed for all residents, including those with Lewi Bodies Dementia. 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 and Director of Health and Wellness will be responsible for ensuring that residents are free from neglect. 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, including the importance of task	

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	Resident B's apartment was completed. Her bed with bilateral full set of full side rails was observed in the first room as you walked into the apartment. The bed was made with the bedrail towards the door in a downward position and the bedrail by the wall in an upward position. There was a small camera on the kitchen counter pointing directly to the bed. When a person entered the room a blue light was triggered to come on. If the resident's door was opened, the blue light was not triggered to come on. In the second room she had a couch. During an interview on 3/11/24 at 1:47 p.m., LPN 1 indicated the night shift on 2/20/24, the aide who took care of Resident B "peeked in on" her every two hours, but she did not check and change her as they were not supposed to do per the family request. During a phone interview on 3/11/24 at 2:06 p.m., CNA 5 indicated she took Resident B to the restroom after dinner then asked her family member if they wanted her put to bed or placed on the couch. They indicated on the couch that they "had it from there," so she assumed they placed the resident in bed. When a different family member of Resident B told staff they "had it from there," the other family member would place the resident to bed. The nurse gave the resident her medication as CNA 5 was leaving the room. CNA 5 did not go check on her the rest of the night. During a phone interview on 3/12/24 at 4:16 a.m., CNA 4 indicated she did not provide any ADL care to the resident during the night shift of 2/20/24, including incontinence checks per the family request. However, she did open the resident's door and "peek in" on her every two hours as her service plan indicated the CNAs were to do. She indicated her last two hour check		sheet education and review. Health & Wellness Director will provide an in-service to all staff on resident rights including the right to be free of neglect for all residents, including those with Lewi Bodies Dementia, the task of reviewing and being familiar with all residents care needs and the use of task sheets. Executive Director or Director of Health and Wellness will audit task sheets weekly for four weeks to ensure cares are being completed according to service plans. 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 admission service plans to ensure that all residents with dementia, including Lewi Bodies Dementia, have interventions in place to keep them free from neglect. Divisional Director of Health & Operations will audit task sheets on routine visits to ensure cares are being completed according to service plans. By what date the systemic changes will be completed by 4/30/24	

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	was between 5:00 and 5:30 a.m., the morning of 2/21/24, and the resident was in her bed every time she checked her since 11:00 p.m., when she came on duty. During a phone interview on 3/12/24 at 9:58 a.m., a family member indicated the camera in the resident's room was only armed to see when persons entered Resident B's room, not to see her crawling around on the floor, so that was why there was no video clips of her until 3:07 a.m. on 2/21/24. She triggered the camera to video tape her when she kicked over the nightstand because the nightstand was high enough to be in the cameras view to be triggered. When she was found by the staff members under the bed on the morning of 2/21/24, she had the same dress and socks on that she had on the day before and her bed was made. So, the family member knew no one put her to bed that night. The family member thought that the CNA thought was going to put Resident B to bed was a male. Therefore, he would not have put her to bed because her service plan indicated no male caregivers. The male family member was not physically able to assist Resident B and the facility knew he was unable to place her to bed. On 3/12/24 at 11:20 a.m., video clips and photographs were sent by a family member to a secure email and observed, which included, but were not limited to, the following video clips and photographs: On 2/20/24 at 6:20 p.m., a photograph showed the son-in-law exiting the resident's room. On 2/21/24 at 3:07 a.m., a video clip of Resident B was observed. She was lying under her made bed with black knee high socks on and a green dress			

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	on. Her shoes were off laying by her feet. She was under the bed to her knees, lying partially on her right side between the full size side rail and the head of the bed. The top of the full size side rail was laying on top of her left thigh, so the siderail was raised off the floor slightly. The living room light was on. The resident was kicking her legs up and knocked over her nightstand, which triggered the camera in her room to video tape her under the bed. There was no other video tapes to indicate when or how the resident got under the bed per a family member. On 2/21/24 at 7:21 a.m., a video clip was observed of two staff members entering Resident B's room and finding her lying on the floor under her bed. One staff member stayed with the resident, while the other staff member went to get additional help. On 2/21/24 at 7:22 a.m., a video clip was observed of five staff members talking about how to get the resident out from under the bed. On 2/21/24 at 7:26 a.m., a video clip was observed of a nurse assessing Resident B indicating the resident's head was "all red" on the back of her head. During an interview on 3/12/24 at 1:15 p.m., CNA 7 indicated she and another CNA found Resident B laying under her bed between 7:00 and 7:30 a.m. Resident B had the same clothes on from the day before. Her couch recliner was still in the reclined position and the staff thought she had gotten herself up out of the recliner and fell, then crawled under the bed. The head of the bed had to be lifted by her and LPN 8 and two other staff members pulled her out from under the bed. The head of the bed had to be lifted before the resident was able to be removed because her face			

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	was so close to the bottom of the bed the way she had her head turned. She was drooling and gurgling. During an interview on 3/12/24 at 1:25 p.m., LPN 8 indicated Resident B was found on the floor under the bed in the same clothes she and another aide dressed her in the day before. She and CNA 7 had to lift the head of the bed while other staff members pulled her out from under the bed because her head was hyperextended and between two bars on the bottom of the bed. There was no way the staff was able to pull her out from under the bed without her head getting caught between those two bars. The siderail on the door side of the room had to be raised to get her out from under the bed. No one knew how long she had been under the bed. Resident B's back of her head and her bottom had red marks on them. Using the reasonable person concept, it is likely that this would lead to recurrent fear and anxiety of being forgotten or neglected. This citation relates to Complaint IN00429284.			