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

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00428410 and IN00428097. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00419622 completed on October 30, 2023. 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. Complaint IN00419622 - Not corrected. Unrelated deficiency is cited. Survey date: February 15, 16 and 19, 2024. Facility number: 013217 Residential Census: 48 These State Residential Findings are 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 (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.			

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

Jamie Langhans | Divisional Director of Health & Operations | 03/18/2024

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.

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

(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
	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) 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	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 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	04/05/2024

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

(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
	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 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		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. 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. All residents that meet the following criteria will be included in Wanderguard monitoring system: ALL Residents with GDS of 4 or greater and new admissions with a MMSE of 15 or less (until 30- day assessment with GDS completed) Any resident noted as unsafe to be outside the Branch unattended 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	

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

(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
	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. 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.		plan. Divisional Director of Health & Operations will continue to monitor on routine visits to ensure compliance. By what date the systemic changes will be completed by April 5, 2024.	

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

(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
	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 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.			

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

(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
	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. This citation relates to Complaint IN00428097.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18)			

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

(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
	years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation, interview and record review, the facility failed to report to the Indiana Department of Health, in a timely manner, an elopement incident and an incident of finding drug paraphernalia and an unidentified white powder in the facility for 2 of 2 incidents reviewed for reporting. (Resident C and 3) Findings include: 1. The area around the facility was observed on 2/15/24 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. 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.	R 0090	The rule is not met as evidenced by the facility failed to report to the Indiana Department of Health, in a timely manner, an elopement incident and an incident of finding drug paraphernalia and an unidentified white powder in the facility for 2 of 2 incidents reviewed for reporting. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Elopement incident was reported on 2/17/24 Drug paraphernalia incident was reported on 2/16/24 How the facility will identify other	04/05/2024

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

(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
	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. During an interview, on 2/15/24 at 3:01 p.m., the Director of Nursing indicated the Divisional Director of Health and Operations told her the report was not completed on Resident C, it was an oversight. At the time, the Director of Nursing indicated she could not access the portal to file the report. During a telephone interview, on 2/15/24 at 3:44 p.m., LPN 5 indicated an aid the heard door alarm and told him. He went outside looking for him, 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. 2. During an interview, on 2/15/24 at 2:55 p.m., Resident 3 indicated she was to move into her apartment on Saturday (2/11/24) but there was a "bit of a problem." Her son found a "crack" pipe in her room on Saturday. It was taken to the Family Advocate, and it was handled.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken Health and Wellness Director/Designee will complete an audit of UOR reports back to January 1, 2024 to ensure that all unusual occurrences meeting reporting guidelines have been reported. 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 all unusual occurrences that directly threatens the welfare, safety, or health of a resident is reported within 24 hours of becoming aware of the occurrence. Director and Health and Wellness Director will be re-educated completing and submitting state reportable for all unusual occurrences. 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 review state	

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

(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
	A facility statement, undated, was received from the Director of Nursing on 2/16/24 at 12:48 p.m. The statement indicated, on February 11th, a notification was made by the Executive Director and the Family Advocate during a family member's walk through of an apartment, what appeared to be a crack pipe in a cabinet was found in the locked apartment. After a discussion with the Executive Director, it appeared to belong to the Maintenance Coordinators because he was repairing the apartment for a new resident. Additional paraphernalia was found in the Maintenance Coordinators workspace. The employee was suspended immediately, pending an investigation, and asked to meet offsite to discuss the pending investigation. He denied any of the paraphernalia was his. He also said the stick which was in the box was his and he used it for crushing up and snorting Adderall, for which he had a prescription. He was asked to take a drug test and the appointment information was given to him. He indicated he did not have his phone and had to go home and get it first. The employee did not show up for the drug test, nor had he reached out. Within an hour or two, the Maintenance Coordinator contacted the Executive Director and told him he was not taking a drug test. He was notified that his employment with the facility was terminated immediately. The statement did not have a date or any identifiable information as to who wrote the statement. There was no other documentation to show that an investigation related to the incident involving the pipe or white powder had been started or the police were notified of the pipes or the white powder. The facility was unable to provide the incident		reportables for next 6 months prior to submission. Divisional Director of Health & Operaions will audit state reportables on routine visits.	

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

(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
	report filed with the Indiana Department of Health prior to the survey entry date. During an interview, on 2/15/24 at 3:01 p.m., the Director of Nursing indicated, on Friday (2/10/24), a new resident was coming to move into the facility. The Family Advocate showed Resident 3 and her son the apartment. Resident 3's son found a pipe in the room and took it to the Family Advocate. The facility personnel met with the Divisional Director of Health and Operations and the Executive Director investigated the incident. They found the employee who was prepping the room for the move in the Maintenance Coordinator and requested he take a drug test. He refused and quit. On 2/16/24 at 11:23 a.m., the incident report to the Indiana Department of Health was requested and the Director of Nursing indicated if it had not been provided then it probably was not done. During an interview, on 2/19/24 at 12:12 p.m., the Regional Support Nurse indicated the police were not contacted and the pipe was to be disposed of or put up. The employee was called, he denied it was his, and refused to take a drug test. During a telephone interview, on 2/19/24 at 1:15 p.m., the Family Advocate indicated a resident was moving into the facility. The resident and her son were in the room. They came to him and made him aware they had found a pipe in the room. He indicated there had been one or two people in the room, maintenance, or housekeeping. The housekeeper's reaction made him believe it was not her pipe. They searched the housekeeping and maintenance areas and found more stuff in the maintenance office, a pipe, and a crushed-up substance with a straw in it. To his knowledge,			

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

(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
	there had been no other employees in the resident apartment/room. The Maintenance Coordinator admitted to the white substance being his Adderall. He told them he crushed it to snort, but he did not admit to the pipes being his, he really did not know about the pipes. The second pipe was found by a baggie of white powder. The facility did not call the police. The Corporate Office told him not to because it was found in the room and not on a person. The white power and pipes were put in a locked closet in the hall, inside a cooler. The door was locked with a padlock. The Maintenance Coordinator did not show up for a drug test. The Family Advocate indicated the Maintenance Coordinator had called off 2/10/24 and had not been in the facility 2/10, 2/11 or 2/12/24. He did not know if a report was filed with the state. During an observation, on 2/19/24 at 1:34 p.m., with the Regional Support Nurse, the cooler was in a pad locked closet in a service hall. The cooler contained personal items from the maintenance office as well as two glass pipes with a long stem and round bulb, a plastic bag containing a white powder, a straw, and multiple torch lighters. One pipe was found to be clean and the other contained residue within the bulb. The items were locked back up and the Regional Support Nurse indicated she would contact Corporate for advice on what to do. A facility policy, titled "PP-31000-Incident and Accident Report (IN)," dated as last revised in 01-2018 and received from the Director of Nursing on 2/15/24 at 3:31 p.m., indicated "...incidents or accidents are to be reported and documented immediately after they occur...Incidents or accident can include but are not limited to...medication errors...Injuries...Resident falls or			

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

(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
	injuries...The Director and/or RN Coordinator shall...Investigate incidents or accidents...Document investigation and corrective action regard the incident or accident...Implement corrective action as appropriate...." This citation relates to Complaint IN00428410.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to have an employee fingerprint completed when the employee's Indiana State Police background check indicated inconclusive results and finger printing was recommended for 1 of 3 employees reviewed for employee records. (Maintenance Coordinator 4) Finding includes: A document, titled "STATE OF INDIANA INDIANA STATE POLICE," received from the Regional Support Nurse on 2/19/24 at 12:18 p.m., indicated the date of completion was 7/25/23 and the background report for Maintenance 4 was inconclusive. A fingerprint was recommended. During an interview, on 2/16/24 at 1:23 p.m., the Regional Support Nurse indicated the facility followed the state's regulations. During an interview, on 2/19/24 at 11:29 a.m., the	R 0116	The facility failed to have an employee fingerprint completed when the employee's Indiana State Police background check indicated inconclusive results and finger printing was recommended for 1 of 3. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Maintenance Coordinator 4 is no longer employed by Bickford Senior Living 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	04/05/2024

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

(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
	Regional Support Nurse indicated the Executive Director had background checks on all employees. During an interview, on 2/19/24 at 11:55 a.m., the Regional Support Nurse indicated the Executive Director informed her it had been completed and returned with driving issues/violations. During an interview, on 2/19/24 at 12:04 p.m., the Regional Support Nurse indicated no fingerprint report could be found for Maintenance Coordinator 4, it should have been completed. At that time, a policy was requested. During an interview, on 2/19/24 at 12:05 p.m., the Regional Support Nurse indicated the facility was unable to provide a policy and the facility followed the check list. A facility document, titled "PERSONNEL FILE CHECKLIST," dated as revised 06-2017 and received from the Regional Support Nurse on 2/19/24 at 12:05 p.m., indicated "...Background Check Results" was a part of the personnel file. At the time of receipt of the document, the Regional Support Nurse indicated everything listed was to be completed for a new hire/employee.		Director/Designee will audit all employee files to ensure that any employee with a fingerprint recommendation has been completed A copy of documentation will be kept in employee file 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 Health and Wellness Director will be responsible for ensuring that all employee Indiana State Police background checks indicate inconclusive results and fingerprinting is recommended that it is completed. Director and Health and Wellness Director will be re-educated on Personnel File Policy, which includes background check and any recommendation for fingerprints. 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 employee files to ensure that background checks and any	

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

(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
			fingerprint recommendations are completed and filed. Divisional Director of Health & Operations will audit employee files on routine visits.	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain sanitary and in good repair kitchens for 2 of 2 kitchens observed. (Assisted Living Kitchen and Memory Care Kitchen) Findings include: 1. During an observation, on 2/15/24 at 1:57 p.m., the Assisted Living Kitchen was observed to have multiple paper ketchup cups, a white glass desert cup, a Styrofoam cup, and pieces of food and debris under the steam table. The floor had a white powder between the stove and the fryer station. Food debris was on the floor under the stove, the food preparation island, and the fryer station. There were green peas smashed into the floor and the shelves of the steam table had a greasy, dirty film. One kitchen cabinet was missing a door. During an interview, on 2/15/24 at 1:57 p.m., Kitchen Staff 3 indicated he worked, from 5:00 a.m. to 5:00 p.m., and had not observed food left out when he came into work. The evening shift was responsible for cleaning the kitchen.	R 0154	R154 – Sanitation and Safety Standards – Deficiency The rule is not met as evidenced by the facility failed to maintain sanitary and in good repair kitchens for 2 of 2 kitchens observed (Assisted Living and Memory Care Kitchens) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The debris was cleaned under the steam table, floor, and under the stove, food preparation island and the fryer station The floor and steam table were cleaned. A door for the kitchen cabinet has been requested to be replaced How the facility will identify other residents having the potential to be affected by the same deficient	04/05/2024

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

(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
	2. During an observation, on 2/15/24 at 2:09 p.m., the Memory Care Kitchen was found to have two broken cabinet doors, a missing drawer front, and food debris on the floor. The microwave had deep fried pieces of food under the turn table and food up the walls. In the dining room, there was food on the tables, chairs, and floor. During an interview, on 2/15/24 at 2:13 p.m., QMA 2 indicated there were not enough staff on the unit to take care of the residents and clean the kitchen. She indicated there were 15 residents and three staff on the unit. During an interview, on 2/15/24 at 2:28 p.m., Resident D indicated the glasses were dirty at breakfast and she used a Styrofoam cup. No one washed the floors. During an interview, on 2/16/24 at 11:30 a.m., the Director of Nursing indicated the kitchen staff were responsible for cleaning the kitchen and nursing staff were to clean the dining room. During an interview, on 2/16/24 at 9:09 a.m., the Dietary Supervisor indicated if he had a dietary aide, it would be their responsibility to clean up the kitchen, he thought it was housekeeping's job, but he could sweep up. During an interview, on 2/19/24 at 9:09 a.m., the Regional Support Nurse indicated the facility did not have a kitchen cleaning policy, and she would provide the cleaning responsibility sheet. A facility document, titled "FAMILY AREA CLEANING SCHEDULE-NIGHT SHIFT-ASSISTED LIVING," dated as last revised 12/2013 and received from the Corporate Area Health and Wellness Director on 2/19/23 at 9:31		practice and what corrective action will be taken No other residents were affected by this deficiency. 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 Bread Basket Manager will be responsible for maintaining clean kitchen and dining areas, equipment and utensils. Bread Basket Manager and all cooks will be re-educated on kitchen safety and sanitation. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place Executive Director/Bread Basket Manager will do a walk through the kitchen and washing area daily to ensure areas are clean and free of debris 3 days per week times four weeks. Divisional Director of Health & Operations will walk through the kitchen to ensure safety standards are being met on routine visits.	

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

(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
	a.m., indicated "...KITCHEN...Counters, Island...Stove top, Shelf...Floors (Kitchen, Hallway)...DINING ROOM...Throw away debris, tidy daily, Deep clean areas...Wipe Chair Bases, Arms...Wipe Table Bases...." This citation relates to Complaint IN00428097.			