STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT GARDEN PLAZA	8614 W 10TH ST, INDIANAPOLIS, , 46234

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 13 and 14, 2024. Facility number: 005616 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 22, 2024.	R 0000		
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the	R 0120	All current employees shall receive and complete six (6) hours of Dementia specific training. Inservice records shall be maintained and shall include time, date and location of in-service, instructor name and title, learner name, and program content. All current employees shall receive and complete three (3) hours of Dementia specific training annually	10/04/2024

	needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.		thereafter. In-service records shall be maintained and shall include time, date and location of in-service, instructor name and title, learner name, and program content. All newly hired employees shall receive and complete six (6) hours of Dementia specific training during orientation. In-service records shall be maintained and shall include time, date and location of in-service, instructor name and title, learner name, and program content. All newly hired employees shall receive and complete three (3) hours of Dementia specific training annually thereafter. In-service records shall be maintained and shall include time, date and location of in-service, instructor name and title, learner name, and program content. The community leadership team has received education on the State requirements as it relates to specific Dementia training for all current and newly hired employees. The community shall ensure ongoing compliance through an audit or New Hire Orientation and Online Training Records submitted monthly following the QMPI process monthly for a period of 3 months.	

R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure residents' environments remained free from the potential for accidents and failed to follow facility policy to ensure bedrails were applied with physician's orders in place, routinely assessed, and routinely inspected to ensure continued safe operating condition for 2 of	R 0148	The Resident Care Director and/or designee shall evaluate each resident that currently has bedrails in their home environment. This shall include Resident #60 and #3. If determined appropriate, the Community policy shall be followed which shall include the following: ensuring physician orders are in place indicating the bed rail is used for repositioning/transferring assistance, side rail evaluation/assessment, and Maintenance Dept personnel safety check to ensure the bedrails are safe and secure. All residents with bed rails shall have a quarterly evaluation/assessment for the continued appropriate use of bed rails and monthly Maintenance Dept. personnel checks to ensure all bedrails are safe and secure. The Resident Care Director and/or designee shall evaluate each resident that is new to the community with a new order for bedrails in their home environment. If determined appropriate, the Community policy shall be followed which shall include the following: ensuring physician orders are in place indicating the bed rail is used for repositioning/transferring assistance, side rail evaluation/assessment quarterly thereafter, and Maintenance Dept personnel safety check to ensure	10/04/2024

	2 residents reviewed for bedrails (Resident 3 and 60). Findings include: On 8/13/24 at 10:27 a.m., Resident 60's room was observed. He had bilateral half side rails installed to his bed. On 8/13/24 at 1:12 p.m., Resident 3 was observed laying in his bed with his eyes closed. He had bilateral half side rails installed that were loose and wobbled when used. On 8/14/24 at 10:30 a.m., Resident 60's medical record was reviewed. He received hospice services and had diagnoses which included, but were not limited to, Alzheimer's disease (a degenerative brain disease which affects memory and cognition), heart failure, and restlessness. His record lacked a physician's order for bilateral side-rails. The most recent bed-rail assessment was dated 10/19/23. There were no quarterly assessments for January 2024, April 2024, or July 2024. On 8/14/24 at 10:45 a.m., Resident 3's medical record was reviewed. He had diagnoses which included, but were not limited to, history of a stroke, insomnia (trouble falling and		the bedrails are safe and secure. The community leadership team has received education on the State requirement as it relates to the policy and practices in the use of bedrails and safety in the home environment. The community shall ensure ongoing compliance through audit, submitted monthly to the Quality Management Performance Improvement Committee (QMPI) monthly x 3 months.	

staying asleep), hemiplegia/hemiparesis (weakens/paralysis) of left dominant side, and visual loss of his left eye.

His record lacked a physician's order for bilateral side-rails.

His most recent quarterly side-rail assessment was dated 7/29/24. The assessment asked if the Resident was visually challenged, and the answer was coded "no."

On 8/14/24 at 10:58 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, "Restrains and Bed Rail Use," dated 5/20/23. The policy indicated, " ...Quarter and half rails may be utilized for bed mobility only. All residents utilizing quarter or half rails for bed mobility will have a physician order that the device is used for repetitioning/transferring assistance. A quarterly bed rail assessment will be completed by the RCD [Residential Care Director] or designee. Maintenance will install and do a monthly safety check on the devices to ensure they are secure ...."

During an interview on 8/14/24 at 11:20 a.m., the Maintenance Director indicated, she did complete routine safety checks

	for things such as hot water temperatures, extension cords and throw rugs, but she did not do checks of bedrails. The facility policy was reviewed with the Maintenance Director and she indicated, she was not aware the Maintained department was supposed to conduct monthly safety checks for bedrails and thought the Nursing Department might. During an interview on 8/14/24 at 11:37 a.m., the Director of Nursing (DON) indicated, she completed initial and quarterly bed rail assessments, but the Maintenance Department was supposed to conduct safety checks. The DON did not know that the Maintenance Director (or designee) had not been aware of the safety check requirements. Based on observation, interview, and record review, the facility failed to ensure residents' environments remained free from the potential for accidents and failed to follow facility policy to ensure bedrails were applied with physician's orders in place, routinely assessed, and routinely inspected to ensure continued safe operating condition for 2 of 2 residents reviewed for bedrails (Resident 3 and 60). Findings include:			

	On 8/13/24 at 10:27 a.m., Resident 60's room was observed. He had bilateral half side rails installed to his bed. On 8/13/24 at 1:12 p.m., Resident 3 was observed laying in his bed with his eyes closed. He had bilateral half side rails installed that were loose and wobbled when used. On 8/14/24 at 10:30 a.m., Resident 60's medical record was reviewed. He received hospice services and had diagnoses which included, but were not limited to, Alzheimer's disease (a degenerative brain disease which affects memory and cognition), heart failure, and restlessness. His record lacked a physician's order for bilateral side-rails. The most recent bed-rail assessment was dated 10/19/23. There were no quarterly assessments for January 2024, April 2024, or July 2024.			

	On 8/14/24 at 10:45 a.m., Resident 3's medical record was reviewed. He had diagnoses which included, but were not limited to, history of a stroke, insomnia (trouble falling and staying asleep), hemiplegia/hemiparesis (weakens/paralysis) of left dominant side, and visual loss of his left eye. His record lacked a physician's order for bilateral side-rails. His most recent quarterly side-rail assessment was dated 7/29/24. The assessment asked if the Resident was visually challenged, and the answer was coded "no." On 8/14/24 at 10:58 a.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, "Restrains and Bed Rail Use," dated 5/20/23. The policy indicated, " ...Quarter and half rails may be utilized for bed mobility only. All residents utilizing quarter or half rails for bed mobility will have a physician order that the device is used for repetitioning/transferring assistance. A quarterly bed rail assessment will be completed by the RCD [Residential Care Director] or designee. Maintenance will install and do a monthly safety check on the devices to ensure they are			

	secure ...." During an interview on 8/14/24 at 11:20 a.m., the Maintenance Director indicated, she did complete routine safety checks for things such as hot water temperatures, extension cords and throw rugs, but she did not do checks of bedrails. The facility policy was reviewed with the Maintenance Director and she indicated, she was not aware the Maintained department was supposed to conduct monthly safety checks for bedrails and thought the Nursing Department might. During an interview on 8/14/24 at 11:37 a.m., the Director of Nursing (DON) indicated, she completed initial and quarterly bed rail assessments, but the Maintenance Department was supposed to conduct safety checks. The DON did not know that the Maintenance Director (or designee) had not been aware of the safety check requirements.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:	R 0217	Resident #74 and #75 have been discharged and records closed. The Resident Care Director and/or designee shall evaluate each current resident record for most recent service plan signatures and if missing, shall ensure signatures from appropriate individuals related to each resident are obtained,	10/04/2024

	(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were signed according to policy for 2		according to community policy. The Executive Director, Resident Care Director and/or designee shall ensure signatures from appropriate individuals related to each resident are obtained once reviewed, according to community policy. The community leadership team has received education on the State requirements as it relates to the community policy and practices involving the required resident service plans signatures. The community shall ensure ongoing compliance through audit, submitted monthly to the Quality Management Performance Improvement Committee (QMPI) monthly X 3 months.	

	of 2 closed records reviewed (Residents 74 and 75). Findings include: 1. On 8/14/24 at 1:10 p.m., Resident 75's record was reviewed. Her service plan, dated 9/21/23, was not signed by the Director of Nursing (DON) or the resident or responsible party. Her service plan, dated 2/20/24, was signed by the DON, but not by the resident or responsible party. 2. On 8/14/24 at 1:20 p.m., Resident 74's record was reviewed. Her service plan, dated 9/7/23, was signed by the Director of Nursing (DON), but not by the resident or responsible party. Her service plan, dated 3/14/24, was signed by the DON and the resident's responsible party. On 8/14/24 at 1:31 p.m., the DON indicated they followed the service plan process policy. A current policy titled, "Service Plan Process," dated 5/10/24, was provided by the DON, on 8/14/24 at 1:31 p.m. A review of the policy indicated, " ...Resident Care Director, Wellness Director, or designee ensures the original, revised			

	Service Plan with appropriate signatures (resident (if able) / family / responsible party / ED / RCD/WD and any other staff that attend) is filed in the resident record ...." Based on interview and record review, the facility failed to ensure service plans were signed according to policy for 2 of 2 closed records reviewed (Residents 74 and 75). Findings include: 1. On 8/14/24 at 1:10 p.m., Resident 75's record was reviewed. Her service plan, dated 9/21/23, was not signed by the Director of Nursing (DON) or the resident or responsible party. Her service plan, dated 2/20/24, was signed by the DON, but not by the resident or responsible party. 2. On 8/14/24 at 1:20 p.m., Resident 74's record was reviewed. Her service plan, dated 9/7/23, was signed by the Director of Nursing (DON), but not by the resident or responsible party. Her service plan, dated 3/14/24, was signed by the DON and the resident's responsible party. On 8/14/24 at 1:31 p.m., the			

	DON indicated they followed the service plan process policy. A current policy titled, "Service Plan Process," dated 5/10/24, was provided by the DON, on 8/14/24 at 1:31 p.m. A review of the policy indicated, " ...Resident Care Director, Wellness Director, or designee ensures the original, revised Service Plan with appropriate signatures (resident (if able) / family / responsible party / ED / RCD/WD and any other staff that attend) is filed in the resident record ...."			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure kitchen staff wore hair restraints according to policy for 3 of 3 kitchen observations. Findings include:	R 0273	Lead Cook #11 and Cook #5 have received counseling regarding the need to wear hair restraints as it relates to State and local sanitation and safe food handling standards as well as community policy. All Dietary community members have received education regarding the need to wear hair restraints as it relates to State and local sanitation and safe food handling standards as well as community policy. The community leadership team has received education regarding the need to wear hair restraints as it relates to State and local sanitation and safe food handling standards as well as community policy.	10/04/2024

	During an interview, on 8/13/24 at 9:41 a.m., the Dietary Manager (DM) indicated the kitchen served 72 residents. On 8/13/24 at 9:42 a.m., Lead Cook 11 was observed in the kitchen with a beard cover on, but not covering his mustache. He indicated he was working on breading and frying chicken for lunch. On 8/13 24 at 10:08 a.m., Lead Cook 11 was observed frying chicken for lunch. On 8/13/24 at 2:28 p.m., Cook 5 was observed only wearing a baseball cap, his hair under the baseball cap was uncovered. He had a full beard and was not wearing a beard cover. He was observed working with cooked pasta. He indicated he came in around 12:00 to 12:30 p.m. On 8/13/24 at 2:31 p.m., Cook 5 was observed wearing a face mask. It was pulled down and his mustache was exposed. He was observed wearing disposable gloves and scooping out handfuls of cooked pasta into another container. On 8/14/24 at 9:45 a.m., Cook 11 was observed in the kitchen preparing cucumber sandwiches, he was not wearing a beard cover. He wore a baseball cap, his hair under the baseball cap was uncovered. Lead Cook 5 was observed		The community shall ensure ongoing compliance through audit, submitted monthly to the Quality Management Performance Improvement (QMPI) monthly X 3 months.	

wearing a beard cover, but it was pulled down to his chin, exposing his beard and mustache. He was observed pouring loaded baked potato soup into a stainless steel container.

During an interview, on 8/14/24 at 9:59 a.m., the DM indicated she would gently remind Cook 11 and Lead Cook 5 to wear their beard covers.

A current policy, titled, "Department Expectations," dated 2/16/24, was provided by the DM, on 8/14/24 at 10:18 a.m. A review of the policy, indicated, " ...Hair nets. Associates working in production, dish room and serving kitchens will wear a hair covering which covers all unpinned hair at all times ...Facial hair must also be covered with a net.

Based on observation, interview, and record review, the facility failed to ensure kitchen staff wore hair restraints according to policy for 3 of 3 kitchen observations.

Findings include:

During an interview, on 8/13/24 at 9:41 a.m., the Dietary Manager (DM) indicated the kitchen served 72 residents.

On 8/13/24 at 9:42 a.m., Lead Cook 11 was observed in the

kitchen with a beard cover on, but not covering his mustache. He indicated he was working on breading and frying chicken for lunch.

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On 8/13/24 at 2:31 p.m., Cook 5 was observed wearing a face mask. It was pulled down and his mustache was exposed. He was observed wearing disposable gloves and scooping out handfuls of cooked pasta into another container.

On 8/14/24 at 9:45 a.m., Cook 11 was observed in the kitchen preparing cucumber sandwiches, he was not wearing a beard cover. He wore a baseball cap, his hair under the baseball cap was uncovered. Lead Cook 5 was observed wearing a beard cover, but it was pulled down to his chin, exposing his beard and mustache. He was observed pouring loaded baked potato soup into a stainless steel

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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