STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/28/2025

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 27 and 28, 2025. Facility number: 005616 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 10, 2025.	R 0000		
R 0154	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(k) (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.	R 0154	R 154 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficient practice. The residents only ate popcorn when	10/03/2025

	Based on observation, interview, and record review, the facility failed to ensure a common use popcorn machine was properly and thorooughly cleaned after use and left sitting for days with old popcorn and the scoop uncleaned for 2 of 2 random observations. Findings include: On 8/27/25 at 10:00 a.m. the main dining room was observed. There was a popcorn machine with leftover popcorn in it and a scoop for dishing the popcorn left inside the container touching the popcorn. On 8/28/25 at 9:30 a.m. The popcorn machine was observed for a second time. The popcorn machine still had old popcorn and its scoop inside. During an interview on 8/28/25 at 10:30 a.m. the Regional Nurse Consultant (RNC) indicated the popcorn machine and any utensils used with it should have been cleaned after every use. She indicated she would have someone clean it immediately. The activities calendar indicated "Popcorn in the Café" was last scheduled on 8/22/25. On 8/28/25 at 10:05 a.m. the RNC provided a copy of a current facility policy titled, "Surface Cleaning and		it was originally served to them by Lifestyle's staff. No resident was served popcorn from this machine afterwards. 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; 100% of AL residents could be affected by this deficient practice if each residents partakes of the popcorn provided as part of activities. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Because we do make and serve popcorn from the popcorn machine at scheduled times for our Assisted Living residents, the Lifestyles Director in that program will be re-educated on the company's Surface Cleaning and Sanitizing Policy, particularly the requirement to clean the machine both at the beginning and the end of the task. How the corrective action(s) will be monitored to ensure the deficient practice will	

	Sanitizing," dated 10/17/13. This policy indicated, "... All work surfaces require both cleaning and sanitizing to meet local and state codes ...2. When to clean. Before beginning a task and after ending a task, completely washed her face with rag and soapy water. Then sanitize surface with product from the red bucket/sanitizer spray bottle ...." Based on observation, interview, and record review, the facility failed to ensure a common use popcorn machine was properly and thorooughly cleaned after use and left sitting for days with old popcorn and the scoop uncleaned for 2 of 2 random observations. Findings include: On 8/27/25 at 10:00 a.m. the main dining room was observed. There was a popcorn machine with leftover popcorn in it and a scoop for dishing the popcorn left inside the container touching the popcorn. On 8/28/25 at 9:30 a.m. The popcorn machine was observed for a second time. The popcorn machine still had old popcorn and its scoop inside. During an interview on 8/28/25 at 10:30 a.m. the Regional Nurse Consultant (RNC) indicated the popcorn machine and any utensils used with it		not recur, i.e., what quality assurance program will be put into place; and A running log will now be used to document the appropriate completion of the popcorn machine cleaning including date, time and person cleaning and sanitizing the machine both before and after using the machine for resident popcorn. See attached sample, please. This log will be maintained in the Lifestyle's office and be inspected at least once per month by the Executive Director for compliance. The Executive Director will document these inspections through personally signing the log after his/her monthly inspection of the log. Failure of Lifestyle's Director to properly follow this policy will result in action through progressive discipline up to and including possible termination. By what date the systemic changes will be completed. These system changes will be completed immediately but no later than PRIOR TO the	

	should have been cleaned after every use. She indicated she would have someone clean it immediately. The activities calendar indicated "Popcorn in the Café" was last scheduled on 8/22/25. On 8/28/25 at 10:05 a.m. the RNC provided a copy of a current facility policy titled, "Surface Cleaning and Sanitizing," dated 10/17/13. This policy indicated, "... All work surfaces require both cleaning and sanitizing to meet local and state codes ...2. When to clean. Before beginning a task and after ending a task, completely washed her face with rag and soapy water. Then sanitize surface with product from the red bucket/sanitizer spray bottle ...."		next planned use of the popcorn machine for activities - 10/3/2025.	
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use.	R 0301	R301 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No resident was directly affected by the deficient practice as the unlabeled insulin pen was immediately removed from the	09/26/2025

	(F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observations and interview, the facility failed to store an insulin pen appropriately in the 100 hall medication cart for 1 of 3 carts observed. Findings include: On 8/27/25 at 11:50 a.m., during a medication cart review, it was noted there was an insulin pen of Tresiba located in the cart with no name or date on it. On 8/27/25 at 11:50 a.m., QMA 5 ndicated she would take care of the insulin pen. A policy titled, "Medication Package and Storage" was provided by the Executive Director (ED) on 8/28/25 at 10:33 a.m. It indicated, " ...Discontinued medications are removed from the medication cart, given to the Resident Care Director for return to family/responsible party, pharmacy provider or destroyed		cart and dated and labeled by the QMA. 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; If this deficient practice happens on a recurring basis, any resident receiving medications from staff could potentially be affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Resident Care Director will re-educate all QMA’s on the proper procedures for both labeling and dating medications properly per the Century Park Medication Package and Storage policy. How the corrective action(s) will be monitored to ensure the deficient practice will	

	...." Based on observations and interview, the facility failed to store an insulin pen appropriately in the 100 hall medication cart for 1 of 3 carts observed. Findings include: On 8/27/25 at 11:50 a.m., during a medication cart review, it was noted there was an insulin pen of Tresiba located in the cart with no name or date on it. On 8/27/25 at 11:50 a.m., QMA 5 ndicated she would take care of the insulin pen. A policy titled, "Medication Package and Storage" was provided by the Executive Director (ED) on 8/28/25 at 10:33 a.m. It indicated, " ...Discontinued medications are removed from the medication cart, given to the Resident Care Director for return to family/responsible party, pharmacy provider or destroyed ...."		not recur, i.e., what quality assurance program will be put into place; and The Resident Care Director and Resident Care Coordinator will conduct weekly cart audits to ensure the deficient practice does not recur. Cart audits are and will remain a regular part of the Care Department's QMPI Program. By what date the systemic changes will be completed. All QMA's will be required to attend the above referenced education the week of September 22. Each associate will sign an attestation that they received and understood the education regarding the deficient practice. Deployment of cart audits will continue on an ongoing basis with any deficiencies to be addressed immediately by the Resident Care Director. QMA's unable to follow the proper procedures will be subject to progressive discipline up to and	

			potentially including termination.	
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. A. Based on interview and record review, the facility failed to ensure a comprehensive infection surveillance program was in place to track resident infections and antibiotic use. This deficient practice had the potential to effect 73 of 73 residents who resided in the facility at risk for infections. B. Based on observation and interview, the facility failed to use standard precautions when administering eye drops for 1 of	R 0407	R407 - A What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident Care Director will implement the policies and procedures contained in the Infection Control Manual including Surveillance of Infections. 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; 100% of AL residents are potentially affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does	10/10/2025

	5 residents observed (Resident 9). Findings include: A. On 8/27/25 at 2:00 p.m., the Infection Control and Prevention binder was reviewed, but did not include a list of active resident infections. On 8/28/25 at 9:00 a.m., the Regional Director of Clinical Services (RDCS) indicated she did not know if there were any line listings or trending infection data, but the Director of Nursing (DON) monitored resident progress notes daily. On 8/28/25 at 10:00 a.m., the RDCS indicated upon double checking, it did not appear that any infection listing, tracking, or tend identification had been done by the previous DON. Since the current DON had just recently started work, the DON had not had a chance to work on it, so no current infection surveillance could be produced. On 8/28/25 at 10:10 a.m., the RDCS provided a list of residents with infections which was reviewed and revealed: There were 24 Residents with active infections: 14 infections were urinary tract infections (UTIs), 4 were respiratory tract infections (RTIs), and 6 other varying types of infection (cellulitis, diverticulitis, chronic		not recur; Regional Director of Resident Care will provide continuing education to the Resident Care Director regarding company policies around infection control monitoring and prevention. This education will occur on or before October 1, 2025. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Regional Care Director conducts monthly audits of community performance on care standards including infectious disease monitoring and prevention. Any deficiencies discovered are communicated both to the Resident Care Director and the Executive Director for review and action. By what date the systemic changes will be completed.	

	osteomyelitis, and lymphadenitis). On 8/28/25 at 10:30 a.m., the RDCS provided a copy of current facility policy titled, "Infection Control Manual, Chapter 2: Surveillance of Infections," dated 5/2015. The policy indicated, "Surveillance of infections includes such activities as entering residents' infection on Line Listing and determining if the infections meet the McGreer definitions for infections; calculating the monthly infection rate; knowing the infections to report as required by law; and investigating an outbreak ..." The policy went on to give detailed definitions and instructions for the surveillance and monitoring of UTS and RTIs. B. On 8/27/25 at 1:00 p.m. a record review was completed for Resident 9). She had the following diagnoses which included, but were not limited to glaucoma and arthritis. During a medication administration observation on 8/27/25 at 11:34 a.m., QMA 5 administered eye drops to Resident 9 without wearing any gloves. First, brimonidine solution was administered to both eyes without the use of gloves. Next, after waiting 5 minutes between eye drops,		Systemic changes will be in place by October 1, 2025 following education of the Resident Care Director on the company Infection Control Manual. R407 - B What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The QMA noted in the deficiency was given education regarding the use of gloves when administering eye drops – completed on 8/27/2025. 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; 100% of AL residents could potentially be affected by this deficient practice so the Resident Care Director will readminister the Med Administration Observation (see attached) to all care staff who administer medications to residents. What measures will be put into place or what systemic changes the facility will	

dorzol/timolol 22.3-6.8mg/ml (milligrams/milliliters) was administered without wearing gloves.

On 8/27/25 at 12:00 p.m., during a interview, the Regional Clinical Director (RCD) indicated she would correct the QMA with education. The RCD indicated there was no specific policy addressing the use of gloves while administering eye drops.

On 8/27/25 at 12:30 p.m., during a interview, QMA 5 indicated she was nervous at the time of the eye drop administration.

A. Based on interview and record review, the facility failed to ensure a comprehensive infection surveillance program was in place to track resident infections and antibiotic use. This deficient practice had the potential to effect 73 of 73 residents who resided in the facility at risk for infections.

B. Based on observation and interview, the facility failed to use standard precautions when administering eye drops for 1 of 5 residents observed (Resident 9).

Findings include:

A. On 8/27/25 at 2:00 p.m., the Infection Control and Prevention binder was reviewed, but did not include a list of active resident

make to ensure
that the deficient practice does not recur;

Per company policy,
this Med Administration Observation is conducted quarterly to check for compliance with all medication administration standards by all associates who
administer medication.

How the corrective
action(s) will be monitored to ensure the deficient practice will not recur,
i.e., what quality assurance program will be put into place; and

The Executive
Director and the Regional Director of Care Services will review the results of
both the Med Administration Observation mentioned above as part of the Resident Care portion of the QMPI meeting.

By what date the
systemic changes will be completed.

Deployment of the
Med Administration Observation for all associates who administer medications to residents will be completed by October 10, 2025 and will then be completed
quarterly.

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On 8/28/25 at 9:00 a.m., the Regional Director of Clinical Services (RDCS) indicated she did not know if there were any line listings or trending infection data, but the Director of Nursing (DON) monitored resident progress notes daily.

On 8/28/25 at 10:00 a.m., the RDCS indicated upon double checking, it did not appear that any infection listing, tracking, or tend identification had been done by the previous DON. Since the current DON had just recently started work, the DON had not had a chance to work on it, so no current infection surveillance could be produced.

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There were 24 Residents with active infections: 14 infections were urinary tract infections (UTIs), 4 were respiratory tract infections (RTIs), and 6 other varying types of infection (cellulitis, diverticulitis, chronic osteomyelitis, and lymphadenitis).

On 8/28/25 at 10:30 a.m., the RDCS provided a copy of current facility policy titled, "Infection Control Manual, Chapter 2: Surveillance of Infections," dated 5/2015. The

policy indicated, "Surveillance of infections includes such activities as entering residents' infection on Line Listing and determining if the infections meet the McGreer definitions for infections; calculating the monthly infection rate; knowing the infections to report as required by law; and investigating an outbreak ..." The policy went on to give detailed definitions and instructions for the surveillance and monitoring of UTS and RTIs.

B. On 8/27/25 at 1:00 p.m. a record review was completed for Resident 9). She had the following diagnoses which included, but were not limited to glaucoma and arthritis.

During a medication administration observation on 8/27/25 at 11:34 a.m., QMA 5 administered eye drops to Resident 9 without wearing any gloves. First, brimonidine solution was administered to both eyes without the use of gloves. Next, after waiting 5 minutes between eye drops, dorzol/timolol 22.3-6.8mg/ml (milligrams/milliliters) was administered without wearing gloves.

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A. Based on interview and record review, the facility failed to ensure a comprehensive infection surveillance program was in place to track resident infections and antibiotic use. This deficient practice had the potential to effect 73 of 73 residents who resided in the facility at risk for infections.

B. Based on observation and interview, the facility failed to use standard precautions when administering eye drops for 1 of 5 residents observed (Resident 9).

Findings include:

A. On 8/27/25 at 2:00 p.m., the Infection Control and Prevention binder was reviewed, but did not include a list of active resident infections.

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the time of the eye drop administration.

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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 SIGNATUREDan Fink	TITLEExecutive Director	(X6) DATE09/22/2025