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	10/02/2023

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

(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 Complaint IN00417988. Complaint IN00417988 - State deficiencies related to the allegations are cited at R241 and R295. Survey date: October 2, 2023. Facility number: 005616 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 5, 2023.	R 0000		
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure staff administered medications to residents from the pharmacy packets with the label that matched the physician order, without contamination, and in the correct medication form for 3 of 5 residents reviewed for medication administration (Residents E, F, and D). Findings include:	R 0241	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **What corrective action(s) will be accomplished for those residents found to have been**	11/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marque McKinnor	Executive Director	10/23/2023

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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	On 10/2/23 at 12:43 p.m., Qualified Medication Aide (QMA) 5 provided Resident E with acetaminophen ES (extra strength) (pain relief) from the packet indicating give 2 tablets three times a day (TID), carbidopa levodopa (for Parkinson's disease) 50-200 mg ER (extended release) from the packet indicating give 1 tablet TID, and gabapentin (for nerve pain) 600 mg, from the packet labeled give TID. QMA 5 opened the physician's order and enlarged the print to be viewed as the same size as the entire computer screen. She was observed very up close squinting at the pharmacy packet to read it. When asked questions regarding the medication she referred to the enlarged computer screen. She was observed to drop the gabapentin 600 mg on top on the medication cart. She picked it up with her bare hands, placed it in the medication cup, and provided the medication for the resident. On 10/2/23 at 12:52 p.m., QMA 5 provided Resident F with acetaminophen 650 mg from the packet labeled to give TID. QMA 5 opened the physician's order and enlarged the print to be viewed as the same size as the entire computer screen. She was observed very up close squinting at the pharmacy packet to read it. When questioned from the pharmacy packet only she indicated it exactly read, "Tylenol 500 mg as needed (PRN)." When questioned further, she indicated the word, "pain," was PRN. She did not note the label on the blister packet indicated to provide TID. The order in the computer indicated to give once daily. She indicated she needed her glasses because the print was, "too tiny." After retrieving her prescription glasses, she indicated the pharmacy packet indicated acetaminophen 650 mg for pain and the computer order was the correct one. Resident F indicated she only		**affected by the deficient practice;** QMA #5 in which the deficiency was observed has received in-service education regarding policies, procedures and practices related to safe medication administration. The Director of Resident Care (RCD) has observed QMA #5 with a return demonstration of a competent medication administration pass. Additionally, a Medication Administration Audit has been completed by the RCD for Residents E, F and D without adverse findings. **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;** All residents that receive medications administered by care staff have the potential to be affected by deficient practice. Personnel responsible for administering medication have been observed by the RCD/designee with a return demonstration of a competent medication administration pass. Upon hire and no less than annually thereafter, all personnel responsible for medication administration be observed by the RDC/designee demonstrating safe and competent medication administration.	

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	received acetaminophen once a day. On 10/2/23 at 3:24 p.m., QMA 6 provided Resident D with acetaminophen 500 mg from the packet labeled to give twice a day (BID). QMA 6 indicated this resident needed her medications crushed because she needed assistance with eating. She was unable to show any documentation of a crush order. She provided Resident D's medications in applesauce. On 10/2/23 at 3:15 p.m., the Director of Nursing (DON) indicated staff should not have provided a medication that had been dropped on the medication cart, staff should have been able to compare the pharmacy medication packet with the physician's order, medication should have been provided from the correct blister pack. On 10/2/23 at 3:56 p.m., the DON indicated if a resident needed their medications crushed, there should have been a physician's order for it. A current policy titled, "Medication Management," dated 8/22/22, was provided by the Executive Director (ED), on 10/2/23 at 4:10 p.m. A review of the policy indicated, " ...Healthcare provider orders are required for all resident Medications. The Resident Care Director is responsible for ensure oversight and supervision for following physician orders. Note: State Regulations supersede company policy ...Medications dropped on the floor are disposed in appropriate non-retrievable container ...." This State Residential Finding relates to Complaint IN00417988.		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Personnel responsible for administering medication have received in-service education from the RCD/designee regarding policies, procedures and practices related to safe medication administration. Upon hire and annually thereafter, the RCD/designee shall ensure all personnel responsible for administering medication will review policies, procedures and practices related to safe medication administration. **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;** The RCD/designee shall perform 5 (five) random audits of medication administration by responsible personnel weekly for a period of 4 weeks to ensure to safe medication administration practices. Findings shall be documented and submitted to the Quantity Committee using the QA tool entitled “Nursing-Medication Administration Shadowing”. If 95% threshold of medication administration compliance	

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			/competency is not achieved, an action plan shall be developed and resubmitted to the Quality committee towards safe medication administration remediation.	
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to ensure a resident who self-administered medications was able to administer medications safely, did not have additional medications in her room, had a current self-medication administration assessment, and ensure the medications were secure (Resident B). Findings include: On 10/2/23 at 10:38 a.m., Resident B indicated staff always brought her 2 Tylenol, but she only needed one and that upset her. One Tylenol tablet was observed in a plastic bowl on the table next to her recliner. There were 3 medication containers in the bowl with the Tylenol tablet, two were dorzolamide-timolol maleate ophthalmic 22.6 milligrams (mg)/6.8 mg with 2 different expiration dates. They had blue lids and were for eye pressure. No instructions were observed on the containers. She indicated she could not read the bottles and went by the color of the lids to give herself the eye drops. She indicated one time she couldn't find the container with the blue lid, so	R 0295	**R-0295 -** Based on observation, interview, and record review, the facility failed to ensure a resident who self-administered medications was able to administer medications safely, did not have additional medications in her room, had a current self-medication administration assessment, and ensure the medications were secure (Resident B). ***Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.*** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	11/20/2023

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	she got another container of the medication, from a drawer in her bedside table. She did not know which container to put back in the drawer because she couldn't read the expiration dates. The other container in the bowl was Latanoprost 0.005%, with instructions to instill 1 drop in left eye in the evening. She indicated she knew it had a white lid, but did not know what it was for, but used it at noon, it was for her left eye only. She indicated she had an eye drop medication, she did not know the name, and had dropped it on the floor and could not find it. It had a green lid, but did not know what it was for, but it was for her left eye only, at bedtime. The label indicated Rhopressa ophthalmic solution with instructions to give 1 drop in left eye in the morning. She indicated her, "left eye was dead," and could only see a little out of her right eye. She needed to go by the color on the eye drop lids to know when to take them because she could not see. She indicated she did not know want the medication were used for. On 10/2/23 at 11:05 a.m., Certified Nursing Aide (CNA) 4 entered her room and asked if she wanted to go to lunch. The resident indicated she had dropped an eye drop medication and would the CNA look for it. CNA 4 found the green lid medication and put it on the table beside the recliner. Resident B indicated today was darker than usual. CNA 4 indicated today was not a dark day. The resident's room was observed to be bright and sunny. Resident B indicated she usually got around her room by, "furniture surfing" (moving around from furniture to furniture to get to a different place). She was observed to stand up from her recliner, CNA 4		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The RCD/designee evaluated the abilities of Resident B for self -administration of medications, contacted her PCP regarding the evaluation findings and received new orders regarding the self -administration of Resident B's medications. Her service plan has been updated to align with her care needs as it relates to her medication self- administration abilities and the tasks involved for care assistance. The ED/RCD have inspected Resident B's room to ensure the security and safety of medications stored. **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;** All residents have the potential to be affected by these deficiencies. The RCD/designee has evaluated the abilities of all residents identified for self -administration of medications, and ensured accurate orders are in place from their PCP's regarding the self -administration of medications. The RCD/designee has reviewed each Service Plan (SP) of residents identified to self-	

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	brought her walker to her, but it was just out of her reach. Resident B was observed to wave her arm around trying to find it. She was unable to find it, so CNA 4 brought it closer and helped her arm to it. Resident B indicated she was not ready to go to lunch yet and CNA 4 left. On 10/2/23 at 11:08 a.m., Resident B abandoned her walker and used her bed to find the bedside table. She opened the drawer and brought out different medications. A large bottle of Tylenol, refresh eye drops (noted to have a white lid), and several bottle of prescription eye drops were observed. She indicated the facility staff would not give her Tylenol in the afternoon, so she kept a bottle they did not know about. She indicated she did not know the names of the medications because she could not see the labels. On 10/2/23 at 2:31 p.m., Resident B's record was reviewed. She moved in on 9/30/21. Her diagnoses included, but were not limited to, blindness in one eye and low vision in the other eye, aphakia of unspecified eye (eyes lens missing resulting in difficulty seeing things clearly: problems with color vision, blurry vision, difficulty focusing, trouble seeing items up close), bilateral (both eyes) severe open-angle glaucoma progressive loss of peripheral vision and central visual vision), major depressive disorder, generalized anxiety disorder, dementia (progressive brain dysfunction), mild cognitive impairment (trouble thinking). Her electronic physician orders included, but were not limited to: a. Tylenol 500 mg (for pain) extra strength, give 2 tablets by mouth one time a day. b. Buspirone 5 mg (for anxiety disorder), give 1		administer medications to ensure that each aligns with their care needs as it relates to their medication self- administration abilities and the tasks involved for care assistance. The ED/RCD have inspected all the rooms of residents identified to self-administer medications to ensure the security and safety of medications stored. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** RDC/ designee will provide in-service education to responsible personnel on the importance of; 1 Obtaining the self-administration assessment upon admission, every six months and during a change in condition. 2 Ensuring each resident's SP aligns with their care needs as it relates to their medication self-administration abilities and the tasks involved for care assistance. 3 Inspecting all the rooms of residents identified to self-administer medications to ensure the security and safety of medications stored. **How the corrective action(s) will be monitored to ensure the**	

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	tablet by mouth two times a day. c. Escitalopram oxalate 10 mg (for major depressive disorder), give 1 tablet by mouth in the morning. Her Self-Administration of Medication Evaluation, dated 1/8/23, indicated the evaluation determined the amount of assistance required by a resident with medications. The assessment was to be completed every 6 months and when a significant change occurs in resident's mental or physical condition. The areas checked were resident could independently demonstrate ability to open dosage packaging and administer drops and ointments. Resident understands and states indications for medications, instructions for use, common side effects, and proper storage and requirements. Therefore, the resident was able to independently self-administer medications. The areas not checked as competent were able to read and understand labels and check dosage against dosage on prescription. No further medication self-assessment evaluations were provided. Her September Medication Administration Record (MAR) indicated she did not receive: a. Atorvastatin calcium (for hyperlipidemia) tablet 40 mg, give 1 tablet by mouth at bedtime, on 9/18, 9/19, and 9/20/23. b. Cholestyramine (for hyperlipidemia) light packet 4 grams (g), give 1 packet by mouth in the morning, on 9/20/23. c. Escitalopram oxalate (for depression) oral tablet 10 mg, give 1 tablet by mouth in the morning, on 9/18 through 9/21/23. d. Famotidine (for gastroesophageal reflux disease) oral tablet 20 mg, give 1 tablet by mouth in the morning, on 9/18 through 9/21/23. e. Namenda (for dementia) ER 7 mg, give 1 capsule by mouth in the morning, on 9/18 through 9/21/23.		**deficient practice will not recur *I.e.,* what quality assurance program will be put into place;** The RCD/designee shall conduct 4 (four) random self -administration evaluations of residents identified for appropriateness in self-administration of medications weekly for a period of four (4) weeks, as well as reviewing their orders and SP for accuracy in aligning with support needs. The ED/RCD shall randomly inspect 4 (four) rooms of residents that self-administer medications to ensure the security and safety of medications stored for a period of four (4) weeks. Findings will be documented and submitted to the Quality committee using the Quality Management Performance Improvement tool entitled "Resident Care" to ensure compliance. If the desired threshold is not achieved in each category, an action plan will be developed towards safe medication administration and storage remediation.	

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	f. Wellbutrin XL tablet ER 300 mg, give 1 tablet by mouth in the morning, on 9/18 through 9/21/23. The Full Resident Care Evaluation, dated 6/29/23, indicated the resident required qualified staff to follow physician orders and provide her medications. Her Service Plan for medication management, dated 6/5/23, indicated she would receive her medications safely and as prescribed. On 10/2/23 at 2:30 p.m., the DON indicated for resident's who self-administer their own medications, it was all or nothing. But, the previous DON had let some residents do partial medication self-administrations. The current DON indicated she had no idea who was doing partial self-medication administration because they were not documented correctly with self-administration assessments. She indicated Resident B was blind and should not be self-administering any medications. Her quarterly self-administration assessment should have been completed in April; it was a quarterly assessment. The Tylenol and Refresh eye drops should not have been in her room. On 10/2/23 at 3:15 p.m., the DON indicated she removed all the medications from Resident B's room, including the prescription eye drops and all the back-up eye drops, Tylenol, and Refresh eye drops. The DON indicated she had contacted the resident's physician and it was agreed that her new self-administration assessment indicated she was no longer able to provide her own medications. She indicated she would also call the family and request they no longer bring her any medications.			

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	A current policy, titled, "Self-Administration of Medications," dated 8/22/22, was provided by the ED, on 10/2/23 at 4:10 p.m. A review of the policy indicated, " ...A physician's order is required for resident to self-administer medications. Criteria for Resident to Self-Administer Medications: Read and understand labels ...Check dosage against dosage on prescription ...Administer drips and ointments ...Understand indication of use and medication name ...Understand instruction for use ...Understand common side effects ...Physician Orders: Physician Orders are obtained specific orders to self-administration of medications ...Storage: Residents are required to store medications in a locked/secured cabinet/area ...Self-Administration List. Resident Care Director maintains a current list of residents with self-medication orders form [sic] in Resident Care area ....Medication List. MAR ...lists all prescribed medications and reflects residents who self-medicate ...Confirmation. The Service Plan reflects self-administration of medications. A resident Self Administration Assessment is completed by a Licensed Nurse ...per the community regulatory requirement to confirm the resident's competence to self-administer medication. The resident's physician is notified for concerns of changes in the resident's ability to Self-Administer medications. Associates will communicate observations, concerns related to Self-Administration of medications immediately to the Resident Care Director ...." A current policy, titled, "Resident Rights," dated 1/4/22, was provided by the ED, on 10/2/23 at after entrance conference. A review of the policy indicated, " ...changes in services provided by the facility, including but not limited to changes in charges for any or all services. Exceptions to this notice are: ...change in the resident's medical			

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	acuity that result in a documented-decline in condition that constitute an increase in care necessary to protect the health and safety of the resident ...." This State Residential Finding relates to Complaint IN00417988.			