| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 08/14/2024 |

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

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: August 13 and 14, 2024.<br><br>Facility number: 005616<br><br>Residential Census: 72<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on August 22, 2024. | R 0000 | | |
| R 0120<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(e)(1-3)<br>Personnel - Noncompliance<br><br>Based on interview and record review, the facility failed to ensure staff received the minimum requirement of Dementia-specific training upon hire and on an on-going annual basis for 6 of 6 employees reviewed for dementia training. This deficient practice had the potential to effect 16 of 72 residents who resided in the facility with a diagnosis of Dementia.<br><br>Findings include:<br><br>On 8/13/24 at 1:00 p.m., 6 employee files were randomly selected for upon hire and ongoing in-service education and reviewed at that time.<br><br>Certified Nursing Aide (CNA) 13 was hired on 1/24/24. Only 1 hour of 6 required hours of dementia-specific training was on file for CNA 13.<br><br>Qualified Medication Aide (QMA) 8 was hired on | 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.<br><br>All current 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.<br><br>All newly hired employees shall | 10/04/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Marque McKinnor | Executive Director | 09/05/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 2/28/24. Only 1 hour of 6 required hours of dementia-specific training was on file for QMA 8.<br><br>Housekeeper (HK) 14 was hired on 5/29/25. Only 1 hour of 6 required hours of dementia-specific training was on file for HK 14.<br><br>Server 15 was hired on 12/16/05. Her file lacked documentation of the required 3 hours of annual dementia-specific training.<br><br>Concierge 17 was hired on 11/19/18. Her file lacked documentation of the required 3 hours of annual dementia-specific training.<br><br>QMA 17 was hired on 9/14/20. Her file lacked documentation of the required 3 hours of annual dementia-specific training.<br><br>During an interview on 8/13/24 at 1:45 p.m., the Business Office Assistant (BOA) indicated new staff only received one hour of dementia training upon hire, and she was unsure how many hours of dementia training was provided on an annual basis.<br><br>During an interview on 8/13/24 at 2:00 p.m., the BOA and Executive Director (ED) indicated after looking into the facilities "Upon-Hire" training and "Annual" training, the ED indicated it did not total 6 hours within the first 6 months of hire, and did not meet that minimum 3 hours requirement of annual in-service.<br><br>During an interview on 8/14/24 at 1:10 p.m., the Regional Nurse Consultant (RNC) indicated, she was unable to find a facility policy related to Residential Regulation requirements, but provided the facilities annual in-service schedule and a course list of an online training program utilized | | 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.<br><br>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.<br><br>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.<br><br>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. | |

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| | by the facility, but the documents did not indicated the appropriate hours of dementia-specific training. The RNC indicated in the absence of a policy, the facility should follow the Residential Regulations. | | | |
| R 0148<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(e)(1-4)<br>Sanitation and Safety Standards - Deficiency<br><br>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).<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>His record lacked a physician's order for bilateral side-rails. | 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.<br><br>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.<br><br>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.<br><br>The Resident Care Director and/or designee shall evaluate each resident that is new to the | 10/04/2024 |

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| | The most recent bed-rail assessment was dated 10/19/23. There were no quarterly assessments for January 2024, April 2024, or July 2024.<br><br>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.<br><br>His record lacked a physician's order for bilateral side-rails.<br><br>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."<br><br>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 ...."<br><br>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 | | community with a new order for bedrails in their home environment.<br><br>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 the bedrails are safe and secure.<br><br>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.<br><br>The community shall ensure ongoing compliance through audit, submitted monthly to the Quality Management Performance Improvement Committee (QMPI) monthly x 3 months. | |

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| | 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.<br><br>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<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br><br>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).<br><br>Findings include:<br><br>1. On 8/14/24 at 1:10 p.m., Resident 75's record was reviewed.<br><br>Her service plan, dated 9/21/23, was not signed by the Director of Nursing (DON) or the resident or responsible party.<br><br>Her service plan, dated 2/20/24, was signed by the DON, but not by the resident or responsible party.<br><br>2. On 8/14/24 at 1:20 p.m., Resident 74's record was reviewed.<br><br>Her service plan, dated 9/7/23, was signed by the Director of Nursing (DON), but not by the resident or responsible party. | R 0217 | Resident #74 and #75 have been discharged and records closed.<br><br>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, according to community policy.<br><br>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.<br><br>The community leadership team has received education on the State requirements as it relates to | 10/04/2024 |

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| | Her service plan, dated 3/14/24, was signed by the DON and the resident's responsible party.<br><br>On 8/14/24 at 1:31 p.m., the DON indicated they followed the service plan process policy.<br><br>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 ...." | | the community policy and practices involving the required resident service plans signatures.<br><br>The community shall ensure ongoing compliance through audit, submitted monthly to the Quality Management Performance Improvement Committee (QMPI) monthly X 3 months. | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br><br>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.<br><br>Findings include:<br><br>During an interview, on 8/13/24 at 9:41 a.m., the Dietary Manager (DM) indicated the kitchen served 72 residents.<br><br>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.<br><br>On 8/13 24 at 10:08 a.m., Lead Cook 11 was observed frying chicken for lunch.<br><br>On 8/13/24 at 2:28 p.m., Cook 5 was observed only | 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.<br><br>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.<br><br>The community leadership team has received education regarding the need to wear hair restraints as it relates to State and local | 10/04/2024 |

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| | 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.<br><br>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.<br><br>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 container.<br><br>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.<br><br>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. | | sanitation and safe food handling standards as well as community policy.<br><br>The community shall ensure ongoing compliance through audit, submitted monthly to the Quality Management Performance Improvement (QMPI) monthly X 3 months. | |