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	04/20/2023

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BRIDGE AT GARDEN PLAZA	8614 W 10TH ST INDIANAPOLIS, IN 46234

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 18, 19, and 20, 2023 Facility number: 005616 Residential Census: 71 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 4, 2023.	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. A. Based on interview and record review, the facility failed to ensure 1 of 7 residents reviewed for quality of care was free from neglect after she was found unresponsive, not breathing, and changing color due to an acute change of condition, and nursing left her alone for an undetermined amount of time, before calling for help and/or initiating cardiopulmonary resuscitation (CPR) per her advance directive wishes resulting in a delay in CPR and the resident died (Resident 74). B. Based on interview, and record review, the facility failed to identify and assess a resident	R 0052	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 affected by the deficient practice;** Nursing progress notes were reviewed by the Resident Care Director to ensure no additional residents in similar	06/30/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marque McKinnor	Executive Director	05/15/2023

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	after a fall during a facility activity outing which resulted in increased severe pain and a transfer to the Emergency Department (ER) where it was determined she had sustained a burst fracture of her L-a (lumbar spine) for 1 of 7 residents reviewed for quality of care (Resident 59). Findings include: A. On 4/19/23 at 10:00 a.m., Resident 74's closed record was reviewed. She had diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD- a medical condition that can cause airflow blockage and breathing-related problems), heart failure, and pneumonia. Completed and discontinued physician's orders were reviewed on the electronic medical record, but lacked documentation of her advance directive wishes. A Physician's Order for Scope of Treatment, (POST) form was dated 8/29/22. Resident 74 selected and signed her wishes to remain a full code status with full interventions. A nursing progress note, dated 1/4/23 at 1:44 a.m., indicated, Qualified Medication Aide (QMA) 11 came to the first-floor nurses' station and informed writer QMA 20 that Resident 74 was not breathing and her lips were turning blue. QMA 20 grabbed the nurse phone and called 911 on the way to the resident's apartment. Resident 74 was observed sitting in her recliner and was not breathing. There was clear emesis noted on her chest. CPR was initiated by QMA 20 until Emergency Medical Services (EMS) arrived and took over. EMS worked on Resident 74 for approximately 45 minutes then pronounced her dead at 12:59 a.m.		instances were found to have been affected by this deficient practice. **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 this deficiency. To identify other residents having the potential to be affected by the same deficient practice, an in-service will be completed by the Resident Care Director on the Emergency Preparedness policy to all Nursing personnel. Nursing and non-personnel will be educated on the importance of adhering to the Emergency Preparedness protocols for both within the community and for external events to ensure resident safety. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All Nurse personnel and/or non-Nursing personnel will complete the Emergency Preparedness protocol during associate training upon hire. The Resident Care Director or designee will audit mandatory completion of training programs on	

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	A nursing progress note, dated 1/4/23 at 1:49 a.m., indicated around 11:52 p.m., QMA 11 went to give Resident 74 a 12:00 a.m. medication and checked to see if her oxygen was on. QMA 11 returned to the nurses' station when Resident 74 pressed her call light pendant and requested cough syrup since she was coughing. QMA 11 told Resident 74, "give me a minute to check for as needed cough medication," but when she returned, (an undetermined amount of time later), she found Resident 74, "was not breathing well and her skin has started changing. I ran downstairs to call for help." QMA 20 came and performed CPR until EMS arrived. During an interview on 4/19/23 at 12:53 p.m., the Director of Nursing (DON) indicated she was not at the facility when Resident 74 passed away. The above nursing progress notes were reviewed with her at that time. The DON indicated when a resident was not breathing or in distress she expected nursing staff to stay with the resident while they immediately called for assistance. They could use their own phone, the nursing phone, the resident phone, push the resident call pendant, or use the room pull chord. During an interview on 4/19/23 at 3:15 p.m., with the Executive Director (ED), and Director of Assisted Living (DAL) Present, the ED indicated when someone was found unresponsive staff should immediately call 911, make sure they knew what the code status of that individual was, and perform CPR if a full code. During an interview on 4/20/23 at 9:56 a.m., Certified Nursing Aide (CNA) 21 indicated if she found a resident unresponsive, she would stay with the resident and immediately call for help		a monthly basis to ensure compliance. In the event of a discrepancy, the Resident Care Director or designee is notified and an investigation is conducted immediately and corrected in accordance with the policy. **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 Resident Care Director will complete 50% resident chart audit for the next 4 weeks, then 25% for 4 weeks to ensure each new resident associate has been educated on the Emergency Preparedness protocols and a signed form is on file to confirm this action has been completed. The completion of the Emergency Preparedness training will be added to the Employee Orientation checklist for documentation required upon hire and tracked during the monthly Quality Management Performance Improvement meeting.	

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	using her phone or even the resident's phone in the room if needed. She indicated she was CPR certified so as she waited for help she would get the resident onto the floor and continue to watch to see if the resident stopped breathing which if that occurred she would immediately initiate CPR. During an interview on 4/20/23 at 9:58 a.m., QMA 7 indicated if she found a resident unresponsive, she would immediately notify the nurse and stay with the resident. If the resident was a full code status, then CPR should be initiated immediately if the resident stopped breathing and did not have a pulse. The fastest way to check for the code status would be the computer because it pulled up right under their picture on their profile as a physician order. When asked how she would call for help, she pulled a phone out of her pocket and indicated all nursing staff were provided a nursing phone, but if for some reason it was not on her, she could use the resident's emergency call pendant, or call light in the room. During an interview on 4/20/23 at 11:36 a.m., QMA 11 indicated, when she came on to her shift the day of the incident, everything was normal. She went to check on the resident's who used supplemental oxygen like she always did, and everything was OK with Resident 74 at that time. Resident 74 asked for her inhaler. "By the time I got back she wasn't responding like before, I saw that I did not have my jacket with my phone," so she left and ran downstairs to get help. She found QMA 20 and explained what happened. QMA 20 told her to call 911 and wait outside for EMS. When QMA 11 was asked if she was CPR certified, she indicated she was. When asked if she should have stayed with the resident to determine if she was breathing or had a pulse and needed CPR, she indicated, "everything just			

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	happened so fast and I ran to get help." On 4/20/23 at 12:15 p.m., the DON provided a copy of both QMA 11 and QMA 20's CPR certification cards. The DON indicated they were both CPR certified and appropriate to provide CPR in the event it would be required. Policies and procedures related to; acute change of resident condition, advance directives, CPR, and emergency response were requested on, 4/19/23 at 9:00 a.m., 11:45 a.m., and 3:15 p.m. On 4/20/23 at 9:06 a.m. and 12:02 p.m. Although no policies or procedures were provided, the ED provided pieces of the facilities Resident Admission Packet as follows: a. Page 38 Appendix H- Advance Directive Acknowledgement (a signature page for the resident and/or their representative to sign as evidence they were advised of the right to self-determination of their medical treatment and availability of advance directive). b. A blank copy of a templated letter sent to Healthcare Providers as a pre-admission physical exam and assessment which indicated, " ...Our licensure requirement mandates we obtain healthcare provider and clinical information prior to admission of resident's to our community. Our information needs have been consolidated to the attached forms please complete the attached forms to ensure the following: ...Code status ...." c. Appendix F- Resident Rights ... " ...you have the right to be informed, and participate in, your treatment. This includes the right to ... f. receive the services and/or items included in the plan of care ... you have the right to be treated with respect and dignity, including, a. the right to be			

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	free from abuse, neglect ...." B. On 4/20/23 at 9:52 a.m., Resident 59's medical record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), hypertension (high blood pressure), and generalized anxiety disorder. She had a history of wedge compression fracture of T9 - T10 (thoracic vertebra 9 & 10), spondylopathies (disorders of the vertebra) of the cervical (neck) region, intervertebral disc disorders with radiculopathy (disease of the root of a nerve) lumbosacral (lower back) region, spinal stenosis (narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs) and a history of falling. Blood sugar (BS) results, dated 3/23/23 at 11:35 a.m., indicated Resident 59's blood sugar was 257. A nursing progress note, dated 3/23/23 at 12:08 p.m., indicated Resident 59 fell when she went grocery shopping. She stated she felt dizzy, "everything went blurry," and she couldn't control herself. She hit her head on the wall. Her vital signs (VS) were blood pressure (BP) 160/90, pulse (P) 64, (O2) saturation 99%, and temperature (T) 98 degrees Fahrenheit (F). Resident took 2 Tylenol and was resting. A nursing progress note, dated 3/24/23 at 11:01 a.m., follow-up to Resident 59's fall at the grocery store on 3/23/23. She had 2 bruises noted to left side of her face/cheek area. She had complained of mid-back pain. She declined an x-ray. She was given 2 PRN (as needed) Tylenol. VS were BP 149/78, R 18, O2 saturation 96% on room air, BS 348, insulin was given as ordered. A nursing progress note, dated 3/24/23 at 11:16 a.m., indicated called Resident 59's physician			

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	about her fall yesterday. She was complaining of mid-back pain today and not wanting to get out of bed. Tylenol was not effective for her pain. She had 2 bruises on her left cheek/face. Resident was acting mentally stable and did not want to go to the Emergency Room (ER). Physician indicated he wanted her to go to the ER for evaluation of back pain and because she hit her head. An ambulance was called for transport. A nursing progress note, dated 3/24/23 at 11:19 a.m., indicated nurse called 911 and resident was transported via ambulance around 15 minutes later to the local hospital. A nursing progress note, dated 3/26/23 at 11:11 a.m., indicated Resident 59 was admitted to the local hospital on 3/24/23 with an L1 (first lumbar vertebral body) fracture. She had surgery to repair it on 3/26/23. Resident 59's Service Plan indicated she at risk for falls. Complete a fall evaluation and assessment and make sure all staff members are aware of her risk for falls. On 4/20/23 at 10:40 a.m., Resident 59 neurological assessment documents (neuro check sheets) were requested. The facility did not provide them before exit. During an interview, on 4/20/23 at 11:14 a.m., the AL Activity Director indicated she did not know anything about Resident 59 falling at the grocery store on 3/23/23. The residents independently signed-up for an outing. She did not have any information about who went because at the end of the month the sign-up pages were shredded. She did not go with them on the outing. The bus driver did not mention anything about a resident			

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	falling. No staff person went in with the residents to assist them in any way. During an interview, on 4/20/23 at 11:30 a.m., the Bus Driver indicated Resident 59 told him she had fallen down in the store. She was wheeled out to the bus by a grocery store employee in a store wheelchair. He indicated he did not tell any staff person at the facility that Resident 59 had a fall. During an interview, on 4/20/23 at 3:23 p.m., the Grocery Store Manager indicated after reviewing the store's video from 3:23 p.m. the resident was observed falling near the front of the store at 10:26 a.m. She indicated to a store employee that she was hot and weak. Grocery Store Associate 10 helped her to check-out and wheeled her to the facility bus in a store wheelchair. She did not want to make a report of the fall at grocery store, she just did not want to miss the bus. A hospital note, dated 3/25/23 at 11:17 a.m., indicated neurosurgery was consulted for possible kyphoplasty (surgical filling of an injured vertebra to restore the original shape and gives relief from spinal compression and pain). On examination, patient complainted of uncontrolled, severe, non-radiating low back pain. Assessment plan was every 4 hour neuro checks. A hospital note, dated 3/25/23 at 3:57 p.m., indicated the History of Present Illness: Patient fell at grocery store 3 days ago. She stated that she started having worsening lower back pain since the fall. She was admitted to the hospital on 3/24/23 for her symptoms. The CT (computer tomography imaging) of her lumbar spine showed a burst fracture of L1 (spinal injury where the spine breaks in multiple directions). The x-ray showed moderate loss of the height of the L1			

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	vertebra. At this point, she was transferred to nearby trauma hospital for further care. A hospital note, dated 3/26/23 at 2:11 p.m., indicated Resident 59 was status post (patient experienced previously) kyphoplasty surgery on this date. During an interview, on 4/20/23 at 9:48 a.m., the Director of Nursing (DON) indicated Resident 59 should have had neuro checks after her fall and hitting her head. The neuro checks should have been charted and she should have been monitored after hitting her head. If there was no nurse in the facility, the protocol was if the resident falls and hits their head, they are to be sent out to the hospital. If there was only a QMA in building, she should have called the DON. A current policy titled, "Incident Report for Residents," dated 1/6/23, was provided by the DON, on 4/20/23 at 10:02 a.m. A review of the policy indicated, " ...Should a resident experience a fall or report they have had a fall, staff will provide or arrange for necessary emergency care and will follow up with necessary service plan updates ...Should the resident have trauma resulting in a deformity or hit, or report hitting their head, Executive Director, Resident Care Director of designee or care givers will summon emergency medical serves (call 911) ...."			
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			

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	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) 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			

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	available for inspection to any member of the public upon request Based on observation, interview, and record review, the facility failed to ensure an injury of unknown origin was reported to the Department of Health after a large and spreading bruise was noted on a resident's breast for 1 of 7 residents reviewed for quality of care (Resident 14). Findings include: On 4/18/23 at 12:27 p.m., Resident 14 was observed in the main dining room. She petite and pleasantly confused. She lightly pushed herself back and forth in her wheelchair which mimicked a rocking motion. She attempted to give her utensils, napkin, and cup of water to her tablemate. On 4/18/23 at 1:10 p.m., Resident 14's medical record was reviewed. She had resided in the facility since 2020 and had diagnoses which included, but were not limited to, vascular dementia, vitamin D deficiency, syncope and collapse. A nursing incident note, dated 1/28/23 at 12:32 p.m., indicated new bruising of an unknown origin was found noted to Resident 14's left breast tissue. Resident 14 was only alert and oriented to herself, and therefore was unable to say what happened. Large bruising was observed to the affected area which was dark purple in color and warm to touch. The area measured 10 inches long and 6 inches wide. Resident 14 did not give any indication of pain at the affected area. Additionally, light green/purplish bruising was noted down the left side of her iliac region, but it was unable to determine measurements due to faint discoloration. Notifications were made to the	R 0090	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 affected by the deficient practice;** A Resident assessment form has been completed for each resident during weekly showers to capture any marks or bruising of unknown source. Any injuries of an unknown source will be reported immediately to the Resident Care Director. **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 this deficiency. To identify other residents having the potential to be affected by the same deficient practice, an in-service has been completed by the Administrator with all Nursing personnel on reporting injuries of unknown source immediately to both the Resident Care Director and Administrator via the shower sheets. Upon notification, the Administrator will conduct an	06/30/2023

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	family, Nurse Practitioner and Executive Director (ED). On 1/30/23 at 1:54 p.m., a new order was received to obtain an X-ray of Resident 14's chest and abdomen related the new bruises. A nursing progress note dated 1/31/23 at 5:07 p.m., indicated, " ... new severe bruising of unknown origin to thoracic cavity reported ... Chest x-ray performed. Awaiting results ...." During an interview on 4/20/23 at 9:05 a.m., the ED indicated, injuries of unknown origin should be reported to the Indiana Department of Health (IDOH). At first, he thought only major accidents, fire and outbreaks were reported, but upon his further review, found that additionally, injuries like bruising of an unknown origin should also be reported to IDOH. He indicated, there was no specific policy, other than to follow the state regulations.		investigation and report the injury to the Department of Health using the standard reporting process. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Executive Director will receive an education from the Regional Director of Operation on timely reporting to the State. The Executive Director will manage the State reportable process to ensure adequate and timely reporting. All State reportables will be completed within 24 hours following the notification by Nursing personnel to the Executive Director. The Executive Director shall oversee and ensure that a comprehensive investigation of is conducted and corrective action is implemented, if necessary. The Executive Director will be responsible for maintaining records pertaining to State reportables. Once the State Reportable has been reported and completed, the record will be filed and maintained by the Administrator. **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;**	

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			The Executive Director will complete 100% of all State reportables including injuries of unknown sources to ensure timely resolution up to and/or including termination following investigation of associate if necessary. The Quality Management Performance Improvement tool entitled "Operations" will be reviewed monthly to ensure compliance.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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 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,			

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	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. Based on record review and interview, the facility failed to provide required dementia training for its employees for 9 of 9 employees reviewed for initial and annual dementia training (LPN 5, QMA 11, QMA 12, Server 13, Cook 14, Dishwasher 15, Maintenance Assistant 16, Housekeeper 17, and QMA 18). Findings include: 1. On 4/18/23 at 2:00 p.m., LPN 5's employee file was reviewed. Her hire date was 8/5/19. Her employee file lacked documentation of receiving state required dementia training. 2. On 4/18/23 at 2:03 p.m., QMA 8's employee file was reviewed. Her hire date was 10/26/22. Her employee file lacked documentation of receiving state required dementia training. 3. On 4/18/23 at 2:15 p.m., QMA 12's employee file was reviewed. Her hire date was 3/22/2023. Her employee file lacked documentation of receiving state required dementia training. 4. On 4/18/23 at 2:26 p.m., Server 13's employee file was reviewed. Her hire date was 10/19/222. Her	R 0120	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 affected by the deficient practice;** All Nursing personnel and/or non-Nursing personnel will complete the required minimum 6-hour Dementia education and training program within 6 months of initial employment. **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;** The Business Office Director or designee will conduct an audit of Dementia training quarterly to ensure compliance.	06/30/2023

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	employee file lacked documentation of receiving state required dementia training. 5. On 4/18/23 at 2:33 p.m., Cook 14's employee file was reviewed. His hire date was 3/23/22. His employee file lacked documentation of receiving state required dementia training. 6. On 4/18/23 at 2:45 p.m., Dishwasher 15's employee file was reviewed. His hire date was 3/8/23. His employee file lacked documentation of receiving state required dementia training. 7. On 4/18/23 at 3:01 p.m., Maintenance Assistant 16's employee file was reviewed. His hire date was 12/21/22. His employee file lacked documentation of receiving state required dementia training. 8. On 4/18/23 at 3:10 p.m., Housekeeper 17's employee file was reviewed. Her hire date was 2/14/23. Her employee file lacked documentation of receiving state required dementia training. 9. On 4/18/23 at 3:20 p.m., QMA 18's employee file was reviewed. Her hire date was 8/20/20. Her employee file lacked documentation of receiving state required dementia training. During an interview with the ED (Executive Director) on 4/19/23 at 2:32 p.m., he indicated he could not provide dementia training for the employees. No policy was provided.		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All Nursing personnel and/or non-Nursing personnel will complete required minimum 6 hour Dementia education and training program within 6 months of initial employment and 3 hours annually thereafter to meet the needs of cognitively impaired residents and to gain understanding o the current standards of care for residents with dementia. The Resident Care Director or designee will audit mandatory completion of training programs on a monthly basis to ensure compliance. If a count discrepancy occurs following hire or thereafter, the Resident Care Director or designee is notified and an investigation is conducted immediately and corrected in accordance with the policy. **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 Executive Director will be responsible for checking the education and training program application weekly for 3 months, then monthly. The Quality	

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			Management Performance Improvement tool entitled Quality Management Performance Improvement tool entitled "Associate Education & Training Program Tracking" to ensure compliance. If 100% of the threshold is not achieved, an action plan will be developed.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (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 when bedrails were applied but not monitored or maintained in a safe operating condition for 4 of 11 residents reviewed for bedrails, (Residents 14, 13, 30, and 42). Findings include:	R 0148	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 affected by the deficient**	06/30/2023

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	On 4/18/23 at 12:27 p.m., Resident 14 was observed in the main dining room. She was petite and pleasantly confused. She lightly pushed herself back and forth in her wheelchair which mimicked a rocking motion. She attempted to give her utensils, napkin and cup of water to her tablemate. On 4/18/233 at 1:00 p.m., after lunch, Resident 14 was observed as she laid flat in her bed. Her eyes were closed and she appeared to be asleep. There were bilateral half side rails installed to the bed and both observed to be ill-fitted. They leaned away from the bed which created a noticeable gap between the rail and the mattress, and the rails wobbled when light pressure was applied. On 4/19/23 at 8:20 a.m., the Executive Director (ED), provided a list of additional resident who used side rails. At that time he indicated, typically the facility did not allow the use if side rails as they could be considered restraints, but there were some residents, particularly those with mobility limitations, that required rails for mobility assistance. A policy for the use of bedrails was requested at that time. On 4/19/23 from 8:20 a.m., until 9:00 a.m., the additional side rails were reviewed with the following concerns: Resident 42's bed was observed to have one half rail installed to the open side of his bed. It was wobbly with gentle pressure and created a gap between the mattress and the rail. Resident 13 was observed as she sat on the edge of the bed. Her bed was observed to have two half rails installed. When inspected, the rails were loose and rattled as Resident 13 shifted her weight		**practice;** Maintenance Director will conduct an inspection of residents apartments equipped with a hospital bed rails to audit for proper functionality and safety. **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 this deficiency. Upon admission, readmission or change in condition, all applicable residents will receive an assessment to determine if bed rails are necessary. Resident Care Director and/or non-Nursing personnel will be educated on the risk factors with bed rails in accordance with the policy and associated Bed rails use and guidelines. The Maintenance Department will conduct monthly inspection of bedrails, as part of a regular maintenance program on a monthly basis. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The apartment checklist has been updated to reflect checking Nurse call light system devices to ensure all specifications are met. The	

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	in the bed. When gentle pressure was applied the rails wobbled. She indicated she used them to help her get in and out of bed, but sometimes she needed to grab her wheelchair handle too because the rails were loose. Resident 30 was observed as he laid in bed. He woke easily to the call of his name. His bed was observed to have two half rails installed, even though his bed was pushed against the wall. The rail on the open side of the bed was loose and leaned away from the mattress which caused a gap between the rail and the mattress. It wobbled loosely with gentle pressure. On 4/20/23 at 11:00 a.m., the Director of Assisted Living provided copies of Resident 14, 42, 13 and 30's current physician orders and most recent functional assessments. Resident 14's record lacked documentation of a physician's order for bilateral half side rails to be used as enablers. Resident 14's most recent functional assessment, dated, 3/2/23 lacked documentation of the need for and/or monitoring of bilateral side rails. Resident 42's record lacked documentation of a physician's order for a half side rail to be used as an enabler. Resident 42's most recent functional assessment, dated, 10/14/22 lacked documentation of the need for and/or monitoring of his half side rail. Resident 13's record lacked documentation of a physician's order for bilateral half side rails to be used as enablers.		facility will update TELS to include a monthly preventive maintenance task of all bed rails to ensure safety. An in-service will be completed by the Resident Care Director on the Emergency Preparedness policy to all Nursing personnel. Nursing personnel will be educated on the importance of adhering to the Emergency Preparedness protocols for both day to day operations internally and during applicable external events and activities to ensure resident safety. **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 Maintenance Director will conduct monthly preventive maintenance audits of bed rails and implement appropriate action to resolve to ensure residents safety. The Quality Management Performance Improvement tool entitled Quality Management Performance Improvement tool entitled “Customer Impressions - Safety” to ensure compliance. The Maintenance Director will audit 100% of apartments with bed rails, review monthly with the Executive Director and maintain accurate records to ensure resident safety.	

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	Resident 13's most recent functional assessment, dated, 2/6/23 lacked documentation of the need for and/or monitoring of bilateral side rails. Resident 30's record lacked documentation of a physician's order for bilateral half side rails to be used as enablers. Resident 30's most recent functional assessment, dated, 2/15/22 lacked documentation of the need for and/or monitoring of bilateral side rails. During an interview on 4/20/23 at 9:35 a.m., the ED and Director of Assisted Living, other than maintenance requests for repairs, there was not system or policy or procedure to address the maintenance and monitoring for the use of resident side rails. On 4/20/23 at 9:35 a.m., the ED provided a copy of a current facility policy titled, "Assistive Devices," reviewed 8/2022. The policy indicated, " ...the community promotes resident safety by allowing and encouraging the use of resident assistive devices and mobility aids ... when a resident receives a new order for a mobility aid, the physician is contacted to request a physical therapy consult for resident teaching ... safe use of mobility aids and assistive devices is included in staff orientation ...."			
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance (i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall: (1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms			

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	below ground level for resident occupancy if the floors are not more than three (3) feet below ground level. (2) Provide each resident the following items upon request at the time of admission: (A) A bed: (i) of appropriate size and height for the resident; (ii) with a clean and comfortable mattress; and (iii) with comfortable bedding appropriate to the temperature of the facility. (B) A bedside cabinet or table with a hard surface and washable top. (C) A cushioned comfortable chair. (D) A bedside lamp. (E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device. (3) Provide cubicle curtains or screens if requested by a resident in a shared room. (4) Provide a method by which each resident may summon a staff person at any time. (5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area. (6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare. (7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. Based on observation, interview, and record	R 0185	The creation and submission of	06/30/2023

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	review, the facility failed to ensure a system was in place to monitor for appropriate placement, accessibility and functioning of the emergency call light system for 2 of 5 residents reviewed for emergency call assistance (Residents 56 and 14) Findings include: On 4/18/233 at 1:00 p.m., Resident 14 was observed as she laid flat in her bed. Her eyes were closed, and she appeared to be asleep. An emergency call light pull chord was observed installed on the wall. It was behind the head of her bed, in between a narrow gap of the bed and dresser, and appeared to not be easily accessible if she were to fall on the floor. The emergency pull chord in her bathroom was observed to be less that 3 inches long, so that it would not be accessible if she were on the floor. On 4/19/23 at 8:32 a.m., Resident 56 was in her room and sat in a recliner chair. Her emergency call pendant rested on the seat of her rollator walker. Resident 56 indicated the call light was broken. The cord of the necklace was observed to broken and would no longer fasten. Resident 56 indicated she was never without her call light and when she told staff they didn't believe her that it was not working. "They just keep telling me I'm not pressing hard enough." Additionally, an emergency pull cord for the room was observed on the wall behind her recliner in between a gap of her chair and dresser. It was not easily accessible. The call cord in her bathroom was less than 3 inches long. On 4/19/23 at 10:00 a.m., Certified Nursing Aide (CNA) 25 indicated Resident 56's call pendant necklace had broken the day before. The pendant still worked, but the necklace had broken.		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 affected by the deficient practice;** A complete inspection of the Nurse call light device has been completed by the Maintenance Director and appropriate adjustments resolved in all resident apartments and discrepancies for Residents 56 & 14 corrected. **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 this deficiency. The Maintenance Director will conduct an audit of 100% of resident apartment Nurse call light systems ensure compliance and in accordance with applicable state laws and rules to meet the needs of the residents and services provided. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	

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	Resident 56 thought the pendant was not working but it was. She had let the nurse know yesterday but it appeared the light had not been fixed/replaced as of that morning. At this time, Resident 56's room was observed with CNA 25. When asked about the placement of the other call cords in her room and bathroom, CNA 25 indicated they looked like they would be hard for her to reach if she were to fall. During an interview on 4/19/23 at 3:15 p.m., the Executive Director (ED) indicated, all resident had a call pendant as either a necklace or wrist bracelet. The call cords in the resident's rooms should be attached to the wall but in an accessible area so that if a resident fell they would be able to reach the cord form the floor. The Maintenance Director should be conducting monthly preventative inspections to check for missing or broken lights. During an interview on 4/19/23 at 3:35 p.m., the ED indicated, Resident 56's call pendant was repaired. A new necklace cord had been provided, and additionally the pendant wad cleaned. Apparently there had been food spilled on it and built up which covered the light indicator which is why Resident 56 thought it was not working. On 4/29/23 at 3:35 p.m., the ED provided a copy of current facility policy titled, "Emergency Call Lights," dated 12/2013. The policy indicated, "Call lights are used by residents to request assistance with care. Call light response is completed by associates to determine and provide assistance needs." The policy did not specify or detail where call lights or pendants were placed, how often or if they were routinely checked, and/or the		**practice does not recur;** The Maintenance Director or designee will sign the apartment readiness checklist to include confirmation of the Nurse call light system prior to all new admissions. The Maintenance Director will update the preventive maintenance task in TELS to include checking the nurse call light system equipment (cords) as part of the inspection on a monthly basis. **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 Maintenance Director will audit resident apartments monthly for 6 months. Findings will be documented using the Quality Management Performance Improvement tool entitled “Safety Plant and Operations” to ensure compliance. If 100% threshold is not achieved, an action plan will be developed to resolve.	

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	preventative maintenance schedule.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. The facility failed to monitor a resident's weights as ordered by a physician resulting in weight loss for 1 of 2 residents reviewed for weight loss (Resident 70). Findings include: During an observation on 4/19/23 at 11:32 a.m., Resident 70 was observed sitting in a chair in his bedroom. He was alert and oriented. He indicated he had lost weight due to having COVID-19 and a PE (pulmonary embolism). He indicated he went to the dining room for meals. Resident 70's family member was present. She indicated she asked the facility to monitor his weights due to weight loss she observed. On 4/19/23 at 2:32 p.m., a record review was completed. Resident 70 had the following diagnoses, but not limited to essential hypertension, GERD (gastro-esophageal reflux disease), diabetes type 2, muscle weakness, PE, abnormal weight loss and seasonal allergies. A progress note, dated 3/14/23 at 6:10 p.m., indicated a new order was received for weekly weights. Resident 70 had an order to be weighed weekly.	R 0214	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 affected by the deficient practice;** The Physician order to monitor weights for Resident 70 has been resolved as prescribed. **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 this deficiency. The Resident Care Director or designee will audit all Physician orders daily to ensure proper implementation as prescribed. In the event of a weight discrepancy above or below the threshold, the	06/30/2023

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	Resident 70's weight on 11/16/22 was 127.6 pounds. His weight on 4/4/23 was 119.0 pounds. Resident 70's MAR (medication administration record) was reviewed for March 2023 and April 2023. The record lacked recording of his weekly weights. On 4/19/23 at 11:00 a.m., the DON (Director of Nursing) and AL ED (Assisted Living Executive Director) reported they were unable locate his weekly weights. The DON indicated she corrected the order to include recording his weight weekly. A policy titled, "Weights" dated 11/10/10, was provided by the ED (Executive Director) on 4/19/23 at 2:00 p.m., it indicated, "Record all weight the resident's vital signs flow sheet."		Resident Care Director or designee will be notified, as well as the Physician and Registered Dietician to determine a resolution. Weight fluctuations will be documented within the tracking system monthly. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Resident Care Director or designee will complete a Physician's audit to ensure compliance. In the event of a discrepancy, both the Physician will be notified and the Registered Dietician to determine a resolution. **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;** In addition to the Physicians order audit completed by the Resident Care Director, the QA committee will pull a sample of records (no less than 5 charts) of residents admitted during the previous quarter and audit those records to ensure compliance with Physician orders. The Resident Care Director will be responsible for checking the records weekly for 3 months, then monthly 3 months. Findings	

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			will be documented using the Quality Management Performance Improvement tool entitled "Resident Care" to ensure compliance. If the desired threshold is not achieved, an action plan will be developed.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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: (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.			

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	A. Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident 14) with a history of fall, received neurological assessment after a fall with a head injury, and failed to ensure interventions were in place to prevent additional falls for 1 of 7 residents reviewed for quality of care. B. Based on observation, interview, and record review, the facility failed to ensure administration of resident medications for a resident determined to be unsafe to administer their own medications for 1 of 2 residents reviewed for self administration of medications (Resident 70). Findings include: A. On 4/18/23 at 12:27 p.m., Resident 14 was observed in the main dining room. She had a large scab across the bridge of her nose and a large scab on her forehead. On 4/18/23 at 1:10 p.m., Resident 14's record was reviewed. She had diagnoses which included, but were not limited to, vascular dementia and syncope and collapse. A nursing progress note, dated 3/16/23 at 11:20 a.m., indicated, Resident 14 was found on the floor in front of her wheelchair and beside the overbed table. Due to her dementia, Resident 14 was not able to say what happened, and a small abrasion was noted on her forehead. The area was cleaned, and antibiotic ointment and a band-aid was applied. Although her vital signs were within normal limits, there was no indication that a neurological assessment had been completed. A post fall assessment, dated 3/16/23 at 12:31 p.m., indicated, a new intervention put into place	R 0217	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 affected by the deficient practice;** A complete Fall assessment has been completed for Resident 14 and a Physician's order obtained for Resident 70 to self-administer medication. **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. To identify other residents having the potential to be impacted by the same deficiencies, a Physicians Order audit will be completed for 100% of residents who qualify. Resident Care Director or designee will be in-serviced on the importance of obtaining the fall assessment upon notification monitoring process to be included in the service plan. **What measures will be put into place or what systemic changes the facility will make**	06/30/2023

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	was to lay the resident down after meals to allow for adequate rest periods. A nursing progress note, dated 3/17/23 at 1:46 p.m., indicated, " ...This nurse decided it was best to try to lay resident down after meals, if possible, to try to prevent her from tumbling over forward from falling asleep ...." Although her vital signs were checked and within normal limits, there was no indicated that a neurological assessment had been completed. A nursing progress note, dated 4/9/23 at 11:05 a.m., indicated, Resident 14 was found on the floor in front of her wheelchair. She was unable to say what happened due to her dementia, "but it looks like resident fell out of wheelchair and hit top of forehead on TV stand in room causing laceration, and also gave herself a small abrasion to bridge of nose ...." A post fall assessment, dated 4/9/23 at 11:15 a.m., indicated the previous intervention, to lay resident down after meals, was not in place at the time of the fall, and no new intervention was selected. Resident 14's service plan was reviewed. The Service plan colored out red in the electronic record, and in bold letters indicated, "OVERDUE." She had a service plan for "Managed Risk," which had not been updated or revised to include the new intervention to lay resident down after meals. On 4/19/23 at 8:43 a.m., Resident 14 was observed. She was sitting up in her wheelchair with the overbed table in front of her, positioned in front of the TV. Her head dropped forward, her eyes were closed, and she appeared to be asleep.		**to ensure that the deficient practice does not recur;** The Resident Care Director or designee will ensure the fall assessment documentation is included within the resident care plan upon readmission. Chart audits will be completed by the Resident Care Director or designee on a monthly basis to ensure all resident documentation is compliant and signatures obtained. Residents and families will also be educated on safety and resident rights. **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 Resident Care Director will maintain a listing of residents with self-medication orders form for applicable residents. The Resident Care Director will be responsible for auditing the records weekly for 3 months, then monthly for 3 months. A resident Self-Administration Assessment will be completed by the Resident Care Director or designee quarterly. Findings will be documented using the QA tool entitled “Resident Care – Medication Process” to ensure compliance. If 100% threshold is not achieved, an action plan will be developed.	

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	During an interview on 4/19/23 at 3:15 p.m., with the Executive Director, (ED) and Director of Nursing (DON) present, the ED indicated if a resident had a fall, the Interdisciplinary Team (IDT) would take a trip to the resident's apartment to observe for tripping hazards or other safety concerns and modifications could be made as needed. The IDT would determine what interventions would be best and put them in place. In Resident 14's case, it had been determined she was falling asleep in her wheelchair and fell forward from the chair, so she should be laid down after meals or when she was noted to be asleep in her wheelchair. On 4/20/23 at 9:21 a.m., the DON indicated there was no policy for post fall evaluations or fall management, but provided a copy of current facility policy titled, "Evaluations," dated 7/2021. The policy indicated, " ...The assessment process ... complete full evaluation within 7 days after move-in, review at 30 days, and then update every 6 months or change of condition ...." B. During an observation on 4/19/23 at 11:32 a.m., Resident 70 was observed sitting in a chair in his bedroom. He was alert and oriented. He indicated he took his morning medications. Resident 70's family member indicated his medications were in an unlocked drawer. Inside the drawer were medication bottles and 3 pill boxes. One pill box contained his morning medications. The second one contained his Neurontin. He only took the Neurontin as needed for leg pain. The third box contained his evening dose of Eliquis. His family member indicated she set his medications up for the week. She indicated staff would not remind him to take his evening Eliquis. She indicated if staff would have called her; she would have come over to give him the medication.			

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	On 4/19/23 at 2:32 p.m., A comprehensive chart review was completed. Resident 70 had the diagnoses, but not limited to essential hypertension, GERD (gastro-esophageal reflux disease, diabetes type 2, muscle weakness, PE, abnormal weight loss and seasonal allergies. A medication self-administration assessment was completed on 4/18/23. It indicated he was unsafe to take his own medications. A review of his medication orders indicated he was to have supervised self-administration of medications for the following medications. a.) amlodipine besylate oral tablet 2.5mg in the morning for hypertension. b.) amlodipine besylate oral tablet 5mg in the morning for hypertension (take with 2.5mg tablet to equal 7.5mg dosage) c.) atorvastatin calcium oral tablet 20mg in the morning for hyperlipidemia. d.) Eliquis starter pack oral therapy pack 5mg 1 tablet two times daily for pulmonary embolism (PE). f.) fluticasone propionate nasal suspension 50mcg to both nostrils in the morning for seasonal allergic rhinitis. g.) gabapentin oral capsule 100mg two times daily for neuropathy. h.) losartan potassium 100mg every morning for hypertension. i.) metoprolol succinate extended-release oral tablet 100mg in the morning for hypertension. j.) Synthroid oral tablet 75mcg in the morning for hypothyroidism. k.) Tylenol extra-strength oral tablet 500mg, two tablets every 4 hours as needed for pain. l.) Tylenol extra-strength oral tablet 500mg two tablets every 4 hours as need for pain. Do not administer with hydrocodone.			

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	During an interview with the ED (Executive Director) on 4/18/23 at 2:39 p.m., he indicated residents would either take their own medications after a self-medication evaluation or the staff would give the medications. He indicated there was no supervised self-administration of medications offered at the facility. During an interview with the DON (Director of Nursing) on 4/20/23 at 1:32 p.m., she indicated Resident 70's medications were removed from his apartment. She indicated staff would be administering his medications moving forward. A policy was requested on 4/18/23 at 3:00 p.m. and was not provided at the time of the exit.			
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview, the facility failed to monitor residents for potential adverse effects of blood thinner medication (Eliquis also known as apixaban) for 2 of 2 residents reviewed for medication monitoring (Residents 5 and 70). Findings include: 1. On 4/19/23 at 9:23 a.m., Resident 5's record was reviewed. She had the following diagnoses, but not limited to unspecified fracture of the left pubis, CHF (Congestive Heart Failure), vitamin C deficiency, repeated falls, muscle weakness, atrial	R 0242	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 affected by the deficient practice;** Skin assessments were completed for Resident 5 & Resident 70 and monitored for	06/30/2023

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	fibrillation, major depression, GERD (gastro-esophageal reflux disease), hypertension, osteoarthritis, vitamin D deficiency, and vitamin b12 deficiency. Resident 5 had orders to take apixaban 5 milligrams (mg) two times daily for atrial fibrillation. Resident 5 was able to take her medication unsupervised. She was not being observed for abnormal effects of the medication (bleeding and bruising of the skin). 2. On 4/19/23 at 2:32 p.m., a record review was completed. Resident 70 had the following diagnoses, but not limited to essential hypertension, GERD (gastro-esophageal reflux disease, diabetes type 2, muscle weakness, PE, abnormal weight loss, and seasonal allergies. Resident 70 had orders to take Eliquis starter pack oral tablet therapy pack 5 mg (apixaban) 2 tablets by mouth every12 hours related to pulmonary embolism. Resident 70's order included to take this medication with supervised self-administration. He was not being observed for abnormal effects of the medication (bleeding and bruising of the skin). During an interview with the DON (Director of Nursing) on 4/19/23 at 11:32 a.m., she indicated she was not aware the residents were not being monitored. The DON provided an updated order dated 4/19/23 at 12:18 p.m., indicating nursing measures added to monitor for adverse reactions. On 4/19/23 at 2:50 p.m., a policy was requested		adverse effects. There were no adverse effects observed. **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 this deficiency. Resident Care Director or designee will monitor residents to identify if resident displays signs and symptoms due to an adverse drug reaction. In the event of adverse drug reaction, the Resident Care Director or designee will obtain a Physicians order, medical evaluation, services and if necessary, transfer resident to appropriate medical facility. Resident Care Director or designee will notify the physician and pharmacy of adverse drug reaction, verify with physician's and pharmacist's documentation of medication as a medication allergy, notify residents family and document in the progress notes. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Resident Care Director or designee will participatein the audit of Physician orders daily to	

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	and was not provided.		ensure compliance using the PCC Dashboard. **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 Resident Care Director will maintain a listing of residents with self-medication orders form for applicable residents. A resident adverse reaction will be documented and reported to applicable State agency. An audit will be completed by the Resident Care Director or designee weekly for six (6) months. Findings will be documented using the Quality Management Performance Improvement tool entitled "Resident Care – Medication Process" to ensure compliance. If 100% threshold is not achieved, an action plan will be developed.	
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation and interview the facility failed to safely administer medications one resident at a time and ensure residents took medications administered for 1 of 1 random observation of medication administration (Resident 20). Findings include: On During meal observation on 4/18/23 at 11:33	R 0244	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 affected by the deficient**	06/30/2023

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	a.m., LPN 5 was carrying a basket with hand sanitizer sticking out of the top of it. LPN 5 was observed taking a clear plastic cup of medications out of the basket and sat the cup on the table next to Resident 20. LPN 5 walked away without observing him take his medications. During an interview and observation with LPN 5 on 4/18/23 at 11:35 a.m., the basket contained two empty clear medication cups turned over and were empty. There were 4 clear medication cups with letters on written on the outside of the cup. Inside the 4 cups were medication tablets. A pump hand sanitizer was present. There were eye drops inside plastic bags inside the basket. LPN 5 indicated there were not that many medications at noon and this was how she delivered the medication to the residents. During an interview with the DON (Director of Nursing) on 4/18/23 at 2:32 p.m., she indicated she had seen her nursing staff deliver multiple resident's medications in this manner. She indicated she was new to the facility and needed to make some changes. During an interview with the ED (Executive Director) on 4/18/23 at 2:39 p.m., he indicated LPN 5 had been addressed and the facility was working on re-education of nursing staff not to carry a basket containing multiple residents' medications. A policy titled "Med Pass Observation" dated 3/18/11 was provided by the ED on 4/19/23 at 2:39 p.m. It indicated, " ...State Regulations supersede company policy ...." A medication administration observation checklist was provided by the ED on 4/19/23 at 1:55 p.m. It indicated, " ...Administers meds using 7 rights:		**practice;** All licensed and/or qualified Nursing personnel were in-serviced regarding proper medication administration process. **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 this deficiency. To identify other residents having the potential to be affected by the same deficient practice, an in-service has been completed by the Resident Care Director on the Medication Administration policy to all Nursing personnel. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Resident Care Director or designee will review the MAR weekly to ensure the procedure is being followed by all QMA's administering PRN medications. The Nursing Director or designee will conduct random audits quarterly to ensure medication administration compliance by all licensed Nursing personnel. **How the corrective action(s)**	

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	Resident name, medication, dose (compares label with EMAR (electronic medication administration record), route (compares label with EMAR), time (verifies time via EMAR administered within 1 hour of scheduled time, given as ordered before/after meals) ...."		**will be monitored to ensure the deficient practice will not recur *I.e.,* what quality assurance program will be put into place;** The Resident Care Director will audit Medication Administration Record weekly to ensure that all PRN medications are approved and signed off by the Nurse for compliance. Findings will be documented using the Quality Management Performance Improvement tool entitled "Resident Care – Medication Process" to ensure compliance. If 100% threshold is not achieved, an action plan will be developed. In the event Nursing personnel is identified as being noncompliant with this practice, appropriate disciplinary action will be administered, up to and including termination.	
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 medications were secure for 1 of 5 residents reviewed for secure self-administration of medication (Resident 32). Findings include: On 4/19/23 at 11:29 a.m., Resident 32 was observed in the hallway, she indicated to was	R 0295	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 affected by the deficient**	06/30/2023

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		A. BUILDING 00 B. WING	04/20/2023

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BRIDGE AT GARDEN PLAZA	8614 W 10TH ST INDIANAPOLIS, IN 46234

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	going to lunch. She returned to her apartment and her door was observed unlocked. She indicated she self-administered her own medications. She listed them by name: a. Lyrica (treats nerve pain) b. Amlodipine (treats high blood pressure) c. Fumarate (treats relapsed multiple sclerosis, a disease where nerves do not function properly) d. Bisoprolol (treats high blood pressure) e. Warfarin (blood thinner) f. Tylenol (as needed) (analgesic) g. Imodium (as needed) (anti-diarrhea) h. Albuterol (as needed) (dilates airways) i. Centrum Silver (supplement) j. Vitamin C (supplement) She indicated the Lyrica was her only narcotic and she kept it by the kitchen sink. She only locked her apartment when she was going to be away for quite a while, but if she was going to the library to do puzzles and games, she did not lock it then. Sometimes, she did not lock it when she went to lunch. Maybe, she should lock her door more than she did. She kept some of her Lyrica in the kitchen drawer with the broken lock. She told the facility the kitchen drawer was broken, but no one replaced the lock. An open medication cup was observed beside the kitchen sink, on the counter, with 3 Lyrica, 2 Centrum Silver vitamins, and an unknown dark red pill. During an interview, on 4/19/23 at 2:19 p.m., the Director of Nursing (DON) indicated Lyrica should have been double locked. During an interview, on 4/19/23 at 2:21 p.m., the		**practice;** All medication for Resident 32 has been secured. **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 this deficiency. Secured locked cabinets have been provided for all resident apartments. The Resident Care Director or designee will ensure all residents have been educated on securing medication for the safety of the community. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Resident Care Director will conduct a daily audit weekly for 4 weeks and then monthly to track compliance by the Nursing staff. The Maintenance Director will ensure all lock cabinets within resident apartments are functional. **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;** Nursing personnel will audit all the	

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	Director of Assisting Living (AL) indicated the drugs should be locked, specifically the Lyrica. Either the room was locked or in a locked drawer. A current policy, titled, "Self-Administration of Medications," was provided by the Director of AL, on 4/19/23 at 2:51 p.m. A review of the policy indicated, " ...Residents are required to store medication in a locked/secured cabinet/area ...."		safety cabinets daily to ensure all medication is properly secured. Findings will be documented using the Quality Management Performance Improvement tool entitled “Resident Care – Medication Process - Safety” to ensure compliance. If 100% threshold is not achieved, an action plan will be developed. The QA committee will discuss compliance in this area during the monthly meeting. Monitoring will be ongoing.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to ensure a resident received her physician ordered medication for 1 of 5 residents reviewed for medication administration (Resident 59). Findings include: On 4/20/23 at 9:52 a.m., Resident 59's medical record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), hypertension (high blood pressure), and generalized anxiety disorder. On 4/19/23 at 12:01 p.m., Resident 59 indicated to Qualified Medication Aide (QMA) 7 that she did	R 0297	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 affected by the deficient practice;** Resident 59 prescribed medications are available. **How the facility will identify other residents having the potential to be affected by the**	06/30/2023

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	not get her injection to stabilize her diabetes on Friday. On 4/19/23 at 12:03 p.m., QMA 7 looked at Resident 59's Medication Administration Record (MAR) and indicated she did not get a weekly injection for diabetes mellitus. On 4/19/23 at 2:59 p.m., Resident 59's MAR was reviewed. A physician's order, dated 12/10/21, indicated to provide scheduled Bydureon (anti-diabetic), inject 2 mg subcutaneously (under the skin), every Friday due to diabetes mellitus. Bydureon was charted as given on Friday 4/7/23, but not given on 4/14/23. A current policy, titled, "Resident Rights," dated 3/2017, was provided after entrance conference. A review of the policy indicated, " ...You have the right to be informed and participate in you treatment ...Participate in establishing the expected goals and outcomes of care, the type, amount, frequency and duration of care, and any other factors related to the effectiveness of the plan of care ...."		**same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this deficiency. The Resident Care Director or designee will review the transmitted reorders for status and potential issues and Pharmacy response via the PCC Dashboard. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Regional Director of Clinical Service will in-service the Resident Care Director on protocols for missed medications and ensuring prescribed medications are available and the risks and potential hazards associated when noncompliant. The Resident Care Director will inservice Nursing personnel on the protocols for missed medications. **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;** Resident Care Director will complete chart audits to ensure each prescribed medications are available 4 weeks for 3 months, then monthly for 3 months.	

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			Findings will be documented using the Quality Management Performance Improvement A tool entitled “Missed Medication” to ensure compliance. If 100% threshold is not achieved, an action plan will be developed.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure hand washing was completed correctly before a resident received an injection for 1 of 1 resident observed for receiving an injection (Resident 59). Findings include: On 4/20/23 at 9:52 a.m., Resident 59's medical record was reviewed. Her diagnoses included, but were not limited to, diabetes mellitus (blood sugar disorder), hypertension (high blood pressure), and generalized anxiety disorder. A physician's order, dated 9/13/22, indicated to provide scheduled Humalog 8 units with meals, subcutaneously (under the skin) due to diabetes mellitus. On 4/19/23 at 11:52 a.m., during a medication administration with Qualified Medical Aide (QMA) 7, she was observed to wash her hands in the resident's kitchen sink. After hand washing, she turned off the water faucet with her bare hand, and dried her hands with a paper towel. She checked the resident's blood glucose (sugar)	R 0414	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 affected by the deficient practice;** Proper handwashing procedures have been followed for Resident 59 and all residents per the handwashing guidelines. **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 this deficiency. The Resident Care Director or	06/30/2023

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	levels, then injected 8 units of scheduled Humalog (insulin) into the resident's left abdomen. On 4/19/23 at 3:23 p.m., the Director of Nursing (DON) indicated correct hand washing should have been to turn the water on, wet hands, used soap for 60 seconds up to the elbow, dry hands on paper towels, then turned off water with the paper towel. She indicated staff should have used the proper hand washing protocol prior to using an accu-check (device for measure blood glucose levels) and administering insulin. A current policy, titled, "Hand Hygiene," was provided by the Director of Assisted Living (AL), on 4/20/23 at 9:23 a.m. A review of the policy indicated, " ...Turn on water to a comfortably warm temperature. Moisten hands with soap and water and make a heavy lather. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction. Rise hands well under running water. Dry thoroughly with a disposable towel. Use a towel to turn off the facet then discard ...."		designee will conduct an in-service with all Nursing personnel on proper handwashing procedures following medication administration. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Upon hire, all Nurses and/or Nursing personnel will be educated regarding proper handwashing procedure. The Resident Care Director or designee will audit Nursing personnel monthly to ensure compliance. **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;** A skills and competency lab has been scheduled and will be conducted annually to include proper handwashing protocols. Resident Care Director will complete proper handwashing initially for 3 months, then monthly for 3 months. Findings will be documented using the Quality Management Performance Improvement tool entitled “Resident Care – Infection Control” to ensure compliance. If 100% threshold is not achieved, an action plan will be developed.	

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