STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155696	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepointe Health Campus	1900 College Ave Vincennes, IN 47591

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide assistance with oral/denture care for 2 of 3 residents reviewed for activities of daily living (ADLs). Residents did not receive assistance with ADL's (oral/denture care) according to the plan of care and resident needs. (Resident B, Resident C)Findings include:1. A record review on 12/15/25 at 11:00 A.M., Resident B's diagnoses included, but were not limited to, Parkinson's disease, dementia with behavioral disturbance, anxiety, muscle weakness, and need for assistance with personal care. Resident B's most recent quarterly MDS (Minimal Data Set) assessment, dated 8/29/2,5 indicated the resident had moderate cognitive impairment, required set up or clean-up assistance with oral hygiene, and required partial to moderate assistance with transfers. Resident B's care plan included, but was not limited to, pay attention to basic needs and provide ADL care as required. The resident has upper partial dentures (started 4/9/25). Resident B's nurse's progress notes included, but were not limited to: 11/9/2025 at 5:59 P.M., Resident's spouse noticed upon arrival that his partial temporary plate was not there. Staff and the resident's spouse searched the resident's room and did not find them. Spouse suspected the resident had swallowed a partial denture and requested that he go to the hospital. A change in physical condition event started 11/9/25 at 5:26 P.M. indicated Resident B was thought to have swallowed his partial denture at some point between the administration of intramuscular medication Haldol on 11/8/25 at approximately 6:00 P.M. and 11/9/25 at approximately 6:00 P.M. when the dentures were discovered to be missing. During an interview on 12/15/25 at 2:55 P.M., CNA 5 indicated Resident B required assistance with denture care.Resident B's record contained no documentation that denture care was provided during November 2025. 2. During an observation and interview on 12/15/25 2:40 P.M., Resident C was lying in bed. Resident C indicated she wore dentures, could remove them herself, and staff would soak them overnight. Resident C indicated her dentures were not removed and soaked every night; at times, they would be forgotten, and she wouldn't realize until she woke. A record review on 12/15/25 at 3:00 P.M., Resident C's diagnoses included, but were not limited to, dementia, dysphagia (difficulty swallowing), and anxiety. Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 12/12/25, indicated the resident had no cognitive impairment, required assistance with oral hygiene, and had a broken or loosely fitting full or partial denture. Resident C's care plan included, but was not limited to, the resident having potential for mouth pain due to edentulous and has upper/ lower denture (last reviewed 9/25/25), offer and provide mouth care as needed (started 6/23/21). Resident C's record contained no documentation that oral/denture care was provided during a 30-day review period.During an interview on 12/15/25 at 2:15 P.M., LPN 3 indicated the CNAs should remove dentures nightly, place them in a denture cup, clean them, and assist the resident to re-insert them in the morning. CNAs should document oral care in the CNA charting. On 12/15/25 at 3:30 P.M., RN 7 provided a Standard Operating Procedure titled Oral Care, dated 12/16/24. The procedure included, Overview . To provide each resident with good oral hygiene . Providing care to dentures: .4. Rinse dentures in cool running water before brushing them . 6. Brush dentures on all surfaces . 9. Place dentures in a clean denture cup . Procedure to be performed with am and pm care .This citation is related to intake 2679150. 3.1-38(b)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure comprehensive care was provided for 1 of 3 residents reviewed for behavioral healthcare and monitoring. A resident's plan of care was not updated following an escalation of behaviors, was not monitored for antipsychotic drug use, and did not receive routine care following the administration of an antipsychotic medication. (Resident B)Finding includes:A record review on 12/15/25 at 11:00 A.M., indicated Resident B's diagnoses included, but were not limited to Parkinson's disease, dementia with behavioral disturbance, anxiety, muscle weakness, and need for assistance with personal care. Resident B's most recent quarterly MDS (Minimal Data Set) assessment, dated 8/29/25 indicated the resident had moderate cognitive impairment, did not have unwanted behaviors during a 7 day look back period, required set up or clean-up assistance with oral hygiene, and had complaints of difficulty or pain when swallowing. Resident B's care plan included but was not limited to, resident has impaired cognition with associated short term memory impairment and risk for confusion, disorientation, altered mood, impaired or reduced safety awareness due to dementia. Resident will remain safe and not injure self secondary to impaired decision making. Pay attention to basic needs and provide ADL care as required, resident has upper partial dentures (reviewed 10/8/25). Resident has impaired swallowing due to dysphagia (reviewed 10/8/25), Resident has impairment in functional status due to Parkinson's disease, dementia, dysphagia, and decreased mobility. Provide assistance as needed with self-care (reviewed 10/8/25). Resident demonstrates altered behaviors including hallucinations due to long-standing Parkinson's disease. Monitor resident mood, affect, and behaviors (reviewed 10/8/25). Resident B's physician orders through November 2025 included but were not limited to, Target behavior (Restlessness/anxiety). At the end of each shift, mark frequency and intensity of behavior three times a day (started 9/17/25), Target behavior (agitation). At the end of each shift, mark frequency and intensity of behavior three times a day (started 10/2/25). Haldol injection, 5 milligrams (mg) intramuscular one time (started and completed 11/1/25). Haloperidol lactate (Haldol) solution 5 mg / milliliter (mL) injection one time (started and completed 11/8/25).Resident B's nurses progress notes included, but were not limited to:11/1/25 at 2:50 P.M. - Resident yelling loudly and hitting at staff. Attempting to get out of chair despite three workers holding him. Unable to get oral medications down. Resident is spitting. Spouse at side and trying to console resident with no response. Physician called and orders received for injection sedation. Haldol 5 mg given. 11/1/25 at 6:50 P.M. - Resident resting quietly post Haldol administration. Resident ate in dining room with wife and was cooperative. Resident sleeping now.11/2/25 5:40 A.M. - Resident rested in Geri-chair this entire shift. Resident has been very sedated post Haldol injection given on 11/01/25. Monitored closely this shift and will continue to monitor.11/3/25 at 5:50 A.M. - Resident awake most of night shift, sleeping occasionally for short periods of time. At times is very agitated and resistive of care or directions. Physically very strong with upper extremities and will grab staff very tightly. Resident grabbed this nurse's left wrist, and it was very difficult to get him to let go. Resident keeps leaning forward or attempting to stand, frequently setting off his chair alarm. Difficult to understand resident's speech at times. Did calm briefly when another staff turned on hymn music for resident and he sang along to the hymns. Currently up in wheelchair with staff taking turns monitoring resident.11/8/25 at 6:01 P.M. - Resident very agitated and attempted to hit wife, another resident, and staff. Unable to give oral medication, resident spits medications out. Nurse practitioner notified and received a one-time dose of Haldol 5 mg intramuscular injection for agitation. Resident's wife is here and aware of condition and new order.11/9/25 at 5:38 A.M. - Resident asleep in recliner this shift. Evening medications were not given as resident was asleep after Haldol injection. No further behaviors this shift. 11/9/25 at 12:07 P.M. Resident sitting up in his recliner. Resident declined to take his medication. Nurse educated resident on benefits and dangers of not taking medication, resident still declined. Call light and water within reach, will continue to monitor. 11/9/2025 5:59 P.M. - Wife noticed upon arrival that resident's partial temporary plate (denture) was not in place. Staff and resident's wife searched the resident's room and did not find them. Wife suspected he had swallowed partial denture and requested that he go to emergency room via ambulance.Resident B's November medication administration record (MAR)/ treatment administration record (TAR) indicated the resident was observed for agitation on 11/8/25 between 8:00 P.M. and 10:00 P.M., with no agitation documented. Resident B was observed for restlessness/anxiety on 11/8/25 between 8:00 and 10:00 P.M., with no behavior present. Resident B's hospital emergency department notes dated 119/25 at 8:10 P.M., included, patient apparently became argumentative and violent last evening