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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewater Healthcare Center	14751 Carey Road Carmel, IN 46033

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50901 Based on interview and record review, the facility failed to exercise reasonable care for the protection of a resident's cell phone holder from loss or theft for 1 of 1 resident reviewed for personal property. (Resident 16) Findings include: During an interview, on 7/16/24 at 3:36 p.m., Resident 16 indicated a phone holder which he had purchased and modified to fit onto his motorized wheelchair had been missing for a while. He indicated he had asked Head of Housekeeping 4 to check in the laundry for the missing phone holder and was told the phone holder was not found in the laundry. The clinical record for Resident 16 was reviewed on 7/17/24 at 4:06 p.m. The diagnoses included, but were not limited to, generalized pain, major depressive disorder, dwarfism, and anxiety disorder. A social service note, dated 5/20/24, indicated the resident spoke with Talk Therapist 7 about modifying a phone holder for his wheelchair. A social service note, dated 6/28/24, from Talk Therapist 7, indicated Resident 16 was feeling disgruntled that the phone holder he purchased and modified was missing. He reported he had discussed it with Head of Housekeeping 4, who advised she would look for the missing phone holder. The facility was unable to able to provide a grievance form (a form which provides written documentation of a concern over something believed to be wrong or unfair) for the missing phone holder. During an interview, on 7/18/24 at 10:54 a.m., the resident indicated he would like someone to look for the missing phone holder inside of a box on top of a cabinet in his room. He was unable to check inside the box because the box was out of reach for him. He had not yet asked anyone to look inside the box. During an interview, on 7/18/24 at 11:09 a.m., Central Supply 2 indicated the missing phone holder was not found inside the box. During an interview, on 7/18/24 at 11:34 a.m., LPN 3 indicated she was not aware of the missing phone holder. She filled out a grievance form for the missing phone holder. (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/19/24 at 2:00 p.m., Head of Housekeeping 4 indicated if a resident had an item go missing, protocol would be followed. Head of Housekeeping 4 recalled the discussion with Resident 16 about his missing phone holder and indicated she looked for the missing item in the laundry. The missing phone holder was not located in the laundry. She indicated she was still looking for the item. During an interview, on 7/22/24 at 8:56 a.m., the Executive Director (ED) indicated he spoke with Housekeeping Supervisor 4 about the missing phone holder. Housekeeping 4 did not file a grievance at the time the phone holder was reported missing. A policy, titled Abuse & Neglect & Misappropriation of Property, undated and received by the ED on 7/22/24 at 5:34 p.m., indicated .Instructions for Reporting .If a resident states that his or her belongings are missing, the facility must determine whether the item ever existed in the facility and/or do a quick search. i. As soon as it is determined that the item did exist within the facility but was not found during the initial search, the facility must make a report of misappropriation of resident property . 3.1-9(b) 3.1-9(c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48525 Based on interview and record review, the facility failed to have a comprehensive care plan for a resident with congestive heart failure (CHF) for 1 of 4 residents reviewed for care planning. (Resident 3) Finding includes: The clinical record for Resident 3 was reviewed on 7/18/24 at 11:28 a.m. The diagnoses included, but were not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and hypertension. An encounter note, dated 6/26/24, indicated the resident presented to the facility with a past medical history including hypertension, gastroesophageal reflux disease (GERD), irritable bowel disease (IBS), type 2 diabetes, chronic hyponatremia (low sodium levels), chronic anemia, and CHF. A physician's order, with a start date of 6/27/24, indicated to weigh the resident daily. A nutrition care plan, initiated on 7/2/24, indicated Resident 3 had a potential for altered nutrition related to mechanically altered diet, diet restrictions, and disease process. The goals included, but were not limited to, maintain weight without significant change. Interventions included, but were not limited to, obtaining weekly weights if unplanned weight loss was identified. The care plan did not include the resident's diagnosis of CHF or any interventions for CHF. During an interview, on 7/19/24 at 11:33 a.m., the Clinical Support Nurse indicated there was no care plan for CHF. A current policy, titled Plan of Care Overview, undated and received from the Director of Nursing on 7/18/24 at 4:15 p.m., indicated .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and support the resident's goals choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting 3.1-35(a) 3.1-35(b)(1)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 36454 Based on observation, interview and record review, the facility failed to ensure there was a system in place for communication with a resident who did not speak English as the primary language for 1 of 1 resident reviewed for communication. (Resident 91) Finding includes: During an observation, on 7/17/24 at 11:35 a.m., Resident 91 was lying in bed with her eyes open. Other residents were playing bingo in the common area. The record for Resident 91 was reviewed on 7/17/24 at 4:39 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, generalized muscle weakness, need for assistance with personal care, and a cognitive communication deficit. A care plan, dated 6/2/24, indicated the resident had a potential for isolation due to being new to the facility and the desire to sleep most of the time. The resident would benefit from social interaction and cognitive stimulation. The interventions included, but were not limited to, providing an activity calendar to view and select activities of interest, provide friendly visits to encourage attendance, and to provide verbal and tactile cues as needed. The care plan did not include interventions for the resident's primary language of Korean. A care plan, dated 6/13/24 and last revised on 7/10/24, indicated the resident was at risk for impaired psychosocial well-being related to personal health practices, cultural needs and preferences and/or linguistic needs/preferences. The interventions included, but were not limited to, approach the provision of care and services for those residents with cultural differences with dignity and respect, promote effective communication between staff and resident, and honor specific preferences. The care plan did not include what the cultural preferences or linguistic needs were for the resident. A care plan, dated 6/13/24 and last revised on 7/17/24, indicated the resident had a communication problem related to speaking primarily Korean. The interventions included, but were not limited to, allow the resident time to answer questions and to verbalize feelings, communicate with the resident and/or representative regarding the resident's capabilities and needs, provide the following tools to aide in communication in the resident's primary language including an interpreter, communication board, and utilize the language line for the interpreter needs. During an interview, on 7/17/24 at 4:39 p.m., LPN 3 indicated the resident would motion with her hands for gestures and the staff could figure out what she wanted by the hand gestures. The resident would speak a few words of English at a time. Everything in the resident's room was written in English and LPN 3 was not sure if the resident could read English. The resident did not have a dementia diagnosis and she did not know what the resident's diagnosis of cognitive communication deficit was related to. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 7/18/24 at 10:59 a.m., with CNA 2, the resident was lying in bed in her room. There was a Styrofoam cup, not dated, with some type of supplement drink in the cup. CNA 2 opened the lid to the cup and indicated the supplement appeared like it had been there for a while and she would get a new cup. The resident was pointing and appeared upset that the cup was being removed from the room. The resident smiled when a new Styrofoam cup was brought into her room. The wipe off board in the room had items written in English. During an observation, on 7/18/24 at 11:20 a.m., with the Social Services Designee (SSD), the resident was asked if she could read English. The SSD handed the resident the activity calendar posted on the wipe off board and asked if she could read it. The resident answered, my son and then stated, my eyes. The resident was not able to read the activity calendar. During an interview, on 7/18/24 at 11:52 a.m., the Administrator indicated he thought the resident's diagnosis of the cognitive communication deficit was due to the resident's language barrier. The resident did not have a diagnosis of dementia. Usually there would be some type of communication board with the resident's primary language available. The resident's primary language was Korean. During an interview, on 7/18/24 at 3:42 p.m., the Rehab Director indicated the speech therapist completed the resident's Brief Interview for Mental Status (BIMS) with the resident in English. The resident was able to follow commands in English. The resident's BIMS, dated 6/20/24, had a score of 2 which indicated the resident had a severe cognitive impairment. During an interview, on 7/18/24 at 3:47 p.m., the Clinical Support Nurse indicated they did not have the resident's BIMS score from the previous facility. The facility did not know if the resident's BIMS had declined, if the low BIMS score was due to the language barrier or possibly due to the resident having a urinary tract infection on admission. The notes from the previous facility indicated the resident's family translated for her and she had some mild confusion. During an interview, on 7/18/24 at 3:56 p.m., the Clinical Support Nurse indicated the facility did not have a policy on communication with resident's who had primary languages other than English. A current policy, titled Resident Rights, not dated and received from the Administrator upon entrance indicated .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents .The purpose of this policy is to guide the employees in the general principles of dignity and respect of caring for residents .Residents will be treated with dignity and respect including but not limited to .To have a method to communicate needs to staff . Residents have a Right to .Be treated with respect .Participate in activities .Be free from discrimination . Receive proper medical care including but not limited to .To participate in decisions that affects the resident's care 3.1-38(a)(2)(E)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48525 Based on interview and record review, the facility failed to ensure the physician was notified when a resident had a weight change in a timely manner for 1 of 4 residents reviewed for nutrition. (Resident 3) Finding includes: The clinical record for Resident 3 was reviewed on 7/18/24 at 11:28 a.m. The diagnoses included, but were not limited to, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and hypertension. A physician's order, with a start date of 6/27/24, indicated to weigh the resident daily. A daily weight paper log indicated the following weights: On 6/25/24, the resident's weight was 149 pounds. On 6/26/24, the resident's weight was 143.6 pounds. On 6/27/24, the resident's weight was 142.4 pounds. On 6/28/24, the resident's weight was 142.9 pounds. On 6/29/24, the resident's weight was143 pounds. On 6/30/24, the resident's weight was 143.7 pounds. A vitals tab in the electronic health record (EHR) indicated the following weights: On 7/1/24, the resident's weight was 141.9 pounds. On 7/2/24, the resident's weight was 141 pounds. The resident's weight went from 149 pounds to 141 pounds in 7 days (a greater than 5% weight loss). During an interview, on 7/19/24 at 3:37 p.m., the Clinical Support Nurse indicated there were no notes in the medical record about the weight loss until later. An encounter note, dated 7/19/24, indicated the physician saw the resident today about a significant weight change and CHF. There were no notes in the electronic health record until 17 days later after the weight change occurred. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Resident Height and Weight, undated and received from the Clinical Support Nurse on 7/19/24 at 11:15 a.m., indicated .Weight loss concerns are reported to the practitioner and discussed at the weekly clinical meetings 3.1-46(a)(1)

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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. 36454 Based on observation, interview and record review, the facility failed to identify and treat a resident's behavior symptom of hoarding for 1 of 1 resident reviewed for behavioral health. (Resident 70) Finding includes: During an observation, on 7/16/24 at 12:57 p.m., Resident 70 was sitting on the bed in her room. There was a clear plastic container of strawberries and some other round fruit on the resident's bed. The fruit had a large amount of varying colors from light to dark fuzzy mold growing on the fruit. There were piles of items stacked all over the room and on top of plastic tubs. The resident was very irritable. The clinical record for Resident 70 was reviewed on 7/18/24 at 10:23 a.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, acute pulmonary edema, and atrial fibrillation. A care plan, dated 1/10/23, indicated the resident had mood problems related to a disease process and the loss of independence. The interventions included, but were not limited to, administer medications as ordered, behavioral health consults as needed, communicate with the resident/resident representative regarding mood state, encourage the resident to express feelings, and encourage the resident to participate in activities of choice. A care plan, dated 1/31/23 and last revised on 1/21/24, indicated the resident was at risk for impaired psychosocial well-being related to a history of trauma and/or trauma related symptoms. The resident had past trauma from childhood regarding showers and preferred baths and washing up at the sink. The interventions included, but were not limited to, approaching the provision of care and services with dignity and respect and encouraging the resident to make informed decisions regarding care. The care plans did not include the resident's hoarding of food or collecting items in her room. A Nurse Practitioner (NP) psychiatric note, dated 4/4/24, indicated the resident was angry and argumentative. The resident refused to answer most questions and was not agreeable to any medication changes. The note did not include the resident had a tendency to hoard items including food. A physician's order, dated 6/20/24, indicated to monitor every shift for the behaviors of crying spells, self-isolation, change in appetite, restlessness, and aggression. The behaviors did not include the hoarding of items including potentially hazardous food. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/17/24 at 11:50 a.m., LPN 3 indicated the clear container which had the molded fruit was on the stack of magazines in the resident's room and no longer contained fruit. LPN 3 indicated the resident had trauma as a child and was paranoid. The resident did not eat the spoiled fruit. The staff would wait until the resident was out of her room for a shower and then they would clean the room and get rid of trash. During an interview, on 7/18/24 at 11:11 a.m., the Social Services Designee (SSD) indicated the resident had quite a few quirks. The resident had quite a few things in her room and had a tendency to hoard things. She did not have much while growing up and was very protective of her food and would collect things. The staff would have to bring the resident's attention to the spoiled food, and she had wanted the staff to trim the mold off the strawberries. It was difficult to get things away from her and to get her to understand the health risks. The SSD indicated she did not see anything in the resident's care plan about her hoarding food. During an observation and interview, on 7/18/24 at 11:27 a.m., QMA 5 walked out of Resident 70's room with two clear trash bags full of Styrofoam containers and cups along with other trash. QMA 5 indicated the resident liked to hoard things and would fuss when the staff tried to remove items from the room. QMA 5 told the resident she would get her some fresh milk. During an interview, on 7/18/24 at 11:46 a.m., the Administrator indicated the resident had some anxiety and liked to keep a lot of personal belongings in her room. The resident had a history of wanting to hang onto to things. During an interview, on 7/18/24 at 4:24 p.m., the Clinical Support Nurse indicated she was not aware the resident hoarded food and other items in her room until the surveyor started asking questions. A current policy, titled Behavior Management General, not dated and received from the Director of Nursing on 7/18/24 at 1:50 p.m., indicated .It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others .Residents will be provided with a resident centered behavior management plan to safely manage the resident and others .Assess for problematic/dangerous behaviors .Safety of the resident and others is a high priority .Document the assessment of behavior in electronic health records .Contact the physician for new onset of unusual behaviors .Assess needs and treat appropriately .Complete a Care Plan .Include resident specific interventions .Discuss plan with resident and family 3.1-37(a) 3.1-43(a)(1)