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	06/16/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure the comprehensive care plan was reviewed, revised, and developed by the interdisciplinary team for 2 of 3 residents reviewed for comprehensive care plans. (Resident 27 and 19) Findings include: 1. The clinical record for Resident 27 was reviewed on 6/11/25 at 9:26 a.m. The diagnoses included, but were not limited to, anxiety disorder and moderate recurrent depressive disorder. The major depressive disorder diagnosis was modified on 4/4/25. A therapist progress note, dated 4/8/25, indicated the resident had a problem of moderate recurrent major depressive episodes with a diagnosis of moderate recurrent major depressive disorder. A physician's order, dated 4/22/25, indicated to give duloxetine (an antidepressant medication) 20 mg (milligrams) at bedtime. An annual MDS (Minimum Data Set) assessment, dated 5/2/25, indicated the resident had a diagnosis of depression and was taking an antidepressant medication. A current care plan, dated as reviewed and revised on 5/27/25, did not indicate the resident was taking an antidepressant or had a diagnosis of depression. It did not include any interventions to monitor for effectiveness or side effects of the addition of an antidepressant medication or for caring for the resident experiencing current depression. During an interview, on 6/16/25 at 11:29 a.m., the Clinical Support Nurse indicated the diagnosis and antidepressant medication should have been added to the care plan. 2. During an interview, on 6/9/25 at 10:38 a.m., Resident 19 indicated she had a history of sexual abuse, and she attended virtual therapist appointments every Friday for Post Traumatic Stress Disorder (PTSD). She had attended the visits for several years prior to being admitted into the facility. The clinical record for Resident 19 was reviewed on 6/12/25 at 9:43 a.m. The diagnoses included, but were not limited to, bipolar II disorder, PTSD, and depression. A physician's order for the psychiatric services was not located in the electronic health record. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 5/20/25, indicated Resident 19 was taking Lamictal (a mood stabilizer) 25 milligrams twice a day for bipolar disorder. A MDS assessment, dated 5/29/25, indicated Resident 19 was admitted into the facility with diagnoses of bipolar disorder and PTSD. The comprehensive care plans, dated 6/12/25, did not include PTSD or bipolar disorder. A trauma informed care assessment had not been completed upon admission into the facility. During an interview, on 6/13/25 at 3:06 p.m., the Director of Nursing (DON) indicated PTSD, and bipolar disorder was not included in Resident 19's comprehensive care plan and should have been. Resident 19 should have had a trauma/PTSD assessment initiated. During an interview, on 6/16/25 at 10:19 a.m., the Social Service Director indicated a resident with a diagnosis of PTSD should have had a PTSD assessment initiated. During an interview, on 6/16/25 at 11:14 a.m., the Clinical Support Nurse indicated the facility did not have a policy regarding comprehensive care plans. A current facility policy, titled Plan of Care Overview, received from the Executive Director (ED) on 6/16/25 at 10:59 a.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 .Review care plans quarterly and/or with significant changes in care A current facility policy, titled Trauma Informed Care, received from the ED on 6/16/25 at 10:59 a.m., indicated .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, emotional needs and concerns of the residents. The purpose of this policy is to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice .Each resident will be screened for a history of trauma upon admission. If the screening indicates that the patient has a history of trauma and/or trauma-related symptoms, the baseline care plan will identify the trauma and the baseline interventions implemented upon admission . Additional screening/evaluation is completed by the facility social worker or designee when completing the social history assessment and prior to developing the comprehensive care plan .A physician order will be obtained for the patient to be evaluated by a mental health professional .The services provided or arranged by the center, as outlined by the comprehensive care plan, must be provided by qualified person in accordance with each residents written plan of care and .be culturally-competent and trauma-informed 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(1) 3.1-35(d)(2)(A) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-35(d)(2)(B) 3.1-35(e)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to ensure blood pressure medications were administered according to the physician's orders for 2 of 4 residents reviewed for quality of care. (Resident 20 and 27) Findings include: 1. The clinical record for Resident 20 was reviewed on 6/11/25 at 2:35 p.m. The diagnoses included, but were not limited to, essential primary hypertension, chronic obstructive pulmonary disease, and pulmonary fibrosis. A current care plan, dated 10/6/20, indicated the resident had the potential for unstable blood pressures. A physician's order, dated 4/2/25, indicated to give Lasix (a diuretic which could lower blood pressure) 20 mg (milligrams) once day with special instructions to hold the medication for a systolic blood pressure of less than 100. A Medication Administration Record (MAR), dated April 2025, indicated Lasix was given with no systolic blood pressure recorded on 4/7/25, 4/8/25, 4/9/25, 4/11/25, 4/13/25, 4/14/25, 4/15/25, 4/16/25, 4/17/25, 4/18/25, 4/21/25, 4/22/25, 4/23/25, 4/24/25, 4/25/25, 4/26/25, 4/27/25, 4/28/25, 4/29/25, and 4/30/25. A MAR, dated May 2025, indicated Lasix was given with no systolic blood pressure recorded on the MAR or in the vitals section of the electronic medical record on 5/1/25, 5/2/25, 5/3/25, 5/4/25, 5/5/25, 5/6/25, 5/7/25, 5/8/25, 5/9/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, and 5/22/25. On 5/26/25, Lasix was given with a systolic blood pressure of 97. During an interview, on 6/13/25 at 10:48 a.m., Unit Manager 6 indicated the nurse should have taken the resident's blood pressure when giving a medication which had a hold parameter, held the medication if needed, and made a nurse's note. If the nurse obtained a blood pressure reading, it would have been recorded in the medical record. 2. The clinical record for Resident 27 was reviewed on 6/11/25 at 9:26 a.m. The diagnoses included, but were not limited to, essential primary hypertension, acute on chronic diastolic congestive heart failure, acute respiratory failure with hypoxia, paroxysmal atrial fibrillation, and acute pulmonary edema. A current care plan, dated 1/13/22, indicated the resident had hypertension with an intervention to administer medications per the physician's orders. A physician's order, dated 6/7/24, indicated to give hydralazine 50 mg every 12 hours as needed for a systolic blood pressure greater than 160. A MAR indicated Resident 27's systolic blood pressure was greater than 160 and the hydralazine medication was not administered on the following dates: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 3/24/25, with a systolic blood pressure of 166. b. On 5/18/25, with a systolic blood pressure of 165. c. On 6/2/25, with a systolic blood pressure of 171. d. On 6/5/25, with a systolic blood pressure of 163. e. On 6/9/25, with a systolic blood pressure of 165 at 9:03 a.m. and 1:22 p.m. f. On 6/11/25, with a systolic blood pressure of 172 at 11:48 a.m. and 11:57 a.m. During an interview, on 6/13/25 at 10:48 a.m., Unit Manager 6 indicated if the resident had an as needed medication for high blood pressure, the nurse would give the medication according to the order and document it. During an interview, on 6/16/25 at 11:29 a.m., the Director of Nursing indicated the as needed hydralazine should have been administered based on the physician's order. A current facility policy, titled Medication Administration, received from the Infection Preventionist on 6/13/25 at 3:45 p.m., indicated .Administer medication only as prescribed by the provider .Record pertinent information prior to giving medication if appropriate .Blood pressure recorded 3.1-37(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure staff followed the facility policy and procedure for reconciliation of controlled medications for 2 of 3 narcotic reconciliation logs reviewed for medication storage. (3000 and 4000 units) Findings include: 1. During an observation, on 6/9/25 at 10:29 a.m., with Infection Preventionist 8, the SHIFT CHANGE/CONTROLLED SUBSTANCE INVENTORY TRACKER document for the 3000-unit medication cart 1 was missing signatures to show the narcotics had been reconciled and accounted for on the following shifts: June 1, 2025, was missing a signature for the off-going nurse on the day shift. There was a missing signature for the on-coming nurse for the day shift. There was no date filled in on the form. There was a missing signature for the off-going nurse for the day shift. There was no date filled in on the form. There was a missing signature for the on-coming nurse for the day shift. There was no date filled in on the form. There was a missing signature for the off-going nurse for the day shift. There was no date filled in on the form. There was a missing signature for the on-coming nurse for the night shift. There was no date filled in on the form. There was a missing signature for the off-going nurse for the night shift. There was no date filled in on the form. During an interview, on 6/9/25 at 10:29 a.m., Infection Preventionist 8 indicated the narcotic inventory tracker was to be signed every shift. 2. During an observation, on 6/2/25 at 11:04 a.m., with RN 9, the SHIFT CHANGE/CONTROLLED SUBSTANCE INVENTORY TRACKER document for the 4000-unit medication cart 1 was missing signatures to show the narcotics had been reconciled and accounted for, on 6/5/25, for the off-going nurse for the evening shift. During an interview, on 6/9/25 at 11:21 a.m., RN 9 indicated staff were to sign the narcotic count sheets every shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Medication Controlled Drugs and Security, undated and received from the Director of Nursing on 6/9/25 at 1:03 p.m., indicated .Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with nurse reporting off duty .The inventory of the controlled drugs count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count 3.1-25(e)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications were stored in their original containers, were labeled with an open date, and outdated medications were discarded in 2 of 4 medication carts (3000 and 4000 units) and in 1 of 2 medication refrigerators (4000 unit) reviewed for medication storage. (4000 Unit) Findings include: 1. During an observation, on 6/9/25 at 10:29 a.m., with Infection Preventionist 8, the 3000-unit medication cart 2 was found to have the following items opened and not dated: a. one bottle of latanoprost eye drops was open and was not dated. b. one vial of Lantus insulin was open and was not dated. c. one Lantus insulin pen was open and was not dated. 2. During an observation, on 6/9/25 at 11:13 a.m., with RN 9, the 4000-unit medication cart 1 was found to have the following items opened and not dated: a. one full Lantus insulin pen was open and was not dated. b. one vial of Humalog insulin was open and was not dated. c. one half full Lantus insulin pen was open and was not dated. d. one lispro insulin pen was open and was not dated. During an interview, on 6/9/25 at 11:20 a.m., RN 9 indicated insulin needed to have an open date because it could only be kept for 30 days once it was opened. 3. During an observation, on 6/9/25 at 11:04 a.m., the 4000-unit medication storage refrigerator had a Lantus insulin opened with an expiration date of 5/24/25. During an interview, on 6/9/25 at 11:07 a.m., RN 9 indicated the medication was not to be used after 5/24/25. A current facility policy, titled Storage of Medications, undated and received from the Director of Nursing on 6/9/25 at 1:03 p.m., indicated .All medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label .Outdated .are immediately removed from inventory, disposed of according to procedures for medication disposal 3.1-25(j) 3.1-25(k)(6) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food items stored in the unit kitchen refrigerators were dated for 2 of 4 kitchenettes reviewed for food storage. (3000 and 4000 units) Findings include: 1. During an observation, on 6/9/25 at 9:56 a.m., the 3000-unit kitchenette refrigerator had a white Styrofoam container for Resident 17 and a white Styrofoam container for Resident 20. Neither container had a date to show when the items were placed for storage. During an interview, on 6/9/25 at 10:01 a.m., Infection Preventionist 8 indicated the items should have been dated. 2. During an observation, on 6/9/25 at 11:55 a.m., the 4000-unit kitchenette refrigerator had a clear container with a red lid stored in the refrigerator without a name or date. There was a bag of yogurt and a container of fruit stored in the refrigerator without a name or date. There was also a container of spread for Resident 19 without a date. During an interview, on 6/9/25 at 12:00 p.m., RN 9 indicated the items should have been dated and if the items belonged to staff members, then they should have been stored in the employee break room. A current facility policy, titled Storage of Resident Food, undated and received from the Executive Director on 6/9/25 at 12:27 p.m., indicated .Staff will date the container when food or beverages are brought into the facility 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Personal Protective Equipment (PPE) was worn in an Enhanced Barrier Precaution (EBP) room while providing care and wound care was completed according to the standard of practice for 2 of 2 residents randomly observed for infection control. (Resident 80 and 77) Findings include: 1. During an observation, on 6/11/25 at 9:42 a.m., CNA 2 completed catheter care for Resident 80. CNA 2 performed catheter care from start to finish without putting on a gown and Resident 80 was in EBP. An EBP sign was posted on Resident 80's door which indicated Personal Protective Equipment (PPE), which included gowns for close contact care, was required. The clinical record for Resident 80 was reviewed on 6/13/25 at 2:58 p.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy, retention of urine, and type 2 diabetes mellitus with diabetic chronic kidney disease. A physician's order, dated 4/30/25, indicated Enhanced Barrier Precautions was required for Resident 80 for personal hygiene and when providing personal hygiene. A care plan, dated 5/19/25, indicated Resident 80 had an indwelling Foley catheter and interventions for EBP while providing peri-care and while providing care to urinary catheter. During an interview, on 6/11/25 at 9:42 a.m., CNA 2 indicated that gowns needed to be worn if the resident was on EBP. During an interview, on 6/13/25 at 2:12 p.m., the Infection Preventionist (IP) indicated CNA 2 missed putting on a gown for catheter care. 2. During a continuous wound care observation, on 6/11/25 at 10:21 a.m., Wound Nurse 7 provided wound care to Resident 77. She took the bandage off a sacral wound and began to clean it with one (1) piece of gauze. She cleaned the wound from the inside of the wound bed to the outside. Then with the same piece of gauze, she cleaned the wound back towards the inside of the wound, then towards the outside again, and then briefly cleaned the inside of the wound bed again all with the same piece of gauze. Wound Nurse 7 broke clean to dirty technique by using the same piece of gauze and cleaning the outside of the wound bed to the inside of the wound bed multiple times. During an interview, on 6/11/25 at 10:50 a.m., Wound Nurse 7 indicated it was not typical to clean from the outside of the wound bed back to the inside of the wound bed using the same piece of gauze. She should have gotten a new piece of gauze to continue to clean the wound. During an interview, on 6/12/25 at 10:30 a.m., Clinical Support Nurse 4 indicated staff should not go back and forth from clean to dirty areas with the same piece of gauze. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 6/16/25 at 11:00 a.m., Clinical Support Nurse 4 indicated they did not have a policy for clean to dirty technique. A current facility policy, titled Catheter Care, received from the Director of Nursing (DON) on 6/12/25 at 12:08 p.m., indicated .Catheter care .check physician orders .Observe Standard Precautions .Doff and discard .if worn .other personal protective equipment A current facility policy, titled Enhanced Barrier Precautions, received from the Director of Nursing (DON) on 6/12/25 at 10:33 a.m., indicated .Enhanced Barrier Precautions [(EBP)] refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include .providing hygiene . Device care .urinary catheter .EBP are indicated for residents with any of the following .Indwelling medical devices [(even if the resident is not known to be infected)] .Indwelling medical device examples include . urinary catheters .It is not necessary for staff to don PPE prior to entering the resident room but will don PPE when providing high contact care activities as described above A current facility policy, titled Skin Care & Wound Management Overview, undated and received from Clinical Support 4 on 6/12/25 at 10:30 a.m., indicated .Skin care and wound management program includes, but is not limited to .Application of treatment protocols based on clinical best practice standards for promoting wound healing The undated National Library of Medicine techniques for aseptic dressing and procedures, retrieved on 6/18/25 at 10:48 a.m., at https://pmc.ncbi.nlm.nih.gov/articles/PMC4579997/ indicated, .Start from the dirty area and then move out to the clean area .Make sure you do not re-introduce dirt or ooze by ensuring that cleaning materials (i.e. gauze, cotton balls) are not over-used. Change them regularly (use once only if possible) and never re-introduce them to a clean area once they have been contaminated 3.1-18(b)(2) 3.1-18(j)