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	05/13/2026

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure insulin was administered according to the physician's order or new orders were documented, daily weights were obtained according to the physician's order, and cardiac medications were held according to the physician's ordered parameters for 4 of 4 residents reviewed for quality of care. (Resident 21, 6, 13 and 117)Findings include: 1. During an interview, on 5/7/26 at 10:15 a.m., Resident 21 indicated her blood sugars readings were up and down. The clinical record for Resident 21 was reviewed on 5/11/26 at 10:58 a.m. The diagnoses included, but were not limited to, type 2 diabetes, peripheral vascular disease, and failure to thrive. A physician's order, dated 3/25/26, indicated to administer Humalog (a rapid acting insulin) according to the sliding scale and to contact the physician if the blood sugar results were over 400. The sliding scale coverage was written as follows: If the blood glucose reading was 151-200, administer 2 units If the blood glucose reading was 201-250, administer 4 units If the blood glucose reading was 251-300, administer 6 units If the blood glucose reading was 301-350, administer 8 units If the blood glucose reading was 351-400, administer 10 units A blood sugar reading, on 4/27/26 at 4:00 p.m., was documented as 470. The Medication Administration Record indicated 5 units of Humalog were administered. There were no notes on the Medication Administration Record, assessment tab, or in the progress notes to indicate the nurse had contacted the physician or received new orders for the insulin administration. During an interview, on 5/11/26 at 2:30 p.m., the Director of Nursing indicated the physician was notified and gave an order to administer an additional five (5) units of insulin. The nurse should have documented, in the progress note, she had contacted the physician and received an order to give five (5) additional units of insulin. 2. The clinical record for Resident 6 was reviewed on 5/13/26 at 8:56 a.m. The diagnoses included, but were not limited to, heart failure, hypertension, and chronic kidney disease (a condition in which (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the kidneys gradually lose function). A care plan, dated 8/2/22 and last revised on 12/11/23, indicated the resident had hypertension disease and to obtain and monitor labs/diagnostic studies as ordered and to report abnormal findings to the medical provider and resident's representative. A physician's order, dated 2/2/26, indicated to obtain a weight every day on the dayshift. The Medication Administration Record (MAR), Treatment Administration Record (TAR), vital sign documentation, physician notes, assessments, and nutrition at risk (NAR) notes were reviewed and indicated: On 2/7, 2/8, 2/9, 2/12, 2/13, 2/14, 2/19, 2/21, 2/22, and 2/28, the weights were marked NA. There was no corresponding weights, physician notification, or documentation explaining the missing weights. On 3/1, 3/7, 3/8, 3/13, 3/14, 3/16, 3/18, 3/19, and 3/26, there was no documentation found to indicate the weights were obtained and no physician notification related to the missed weights. On 4/27 and 4/29, the entries were blank. On 4/28, the entry was marked with an X and no explanation was noted. During an interview, on 5/13/26 at 9:26 a.m., the Director of Nursing (DON) indicated she did not know why the staff were charting NA and X for the weights in the MAR/TAR. Staff were supposed to obtain and chart the weights daily. 3. The clinical record for Resident 13 was reviewed on 5/11/26 at 11:00 a.m. The diagnoses included, but were not limited to, hypertension, anxiety disorder, and severe protein-calorie malnutrition. a. A physician's order, dated 1/8/26, indicated to obtain daily weights. The Medication Administration Record (MAR), Treatment Administration Record (TAR), vital sign documentation, physician notes, assessments, and nutrition at risk (NAR) notes were reviewed and indicated: On 4/2, 4/9, 4/10, 4/12, 4/21, 4/22, 4/24 and 4/30, the weights were marked NA. There was no corresponding weights, physician notification, or documentation explaining the missing weights. On 4/13, in the vital tab, the weight documented was crossed out and documented as a re-weight. The re-weight was not obtained until 4/14. On 5/2, 5/6 and 5/9, the weights were marked NA. There was no corresponding weights, physician notification, or documentation explaining the missing weights. During an interview, on 5/12/26 at 10:53 a.m., LPN 5 indicated the weights were marked NA to keep the MAR open for more opportunities to attempt to obtain the weight. During an interview, on 5/12/26 at 11:13 a.m., LPN 6 indicated when documenting on the MAR, NA meant not applicable and an X meant the task was not completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A care plan, dated 10/6/20, indicated Resident 13 had the potential for unstable blood pressures due to hypertension and to administer an anti-hypertensive medication as ordered. A physician's order, dated 1/17/26, indicated to administer amlodipine (a medication used to treat high blood pressure) with instructions to hold the medication if the systolic blood pressure was less than 110. A physician's order, dated 1/7/26, indicated to administer hydralazine (a medication used to treat high blood pressure), three (3) times a day with instructions to hold the medication if the systolic blood pressure was less than 110. A physician's order, dated 1/7/26, indicated to administer losartan potassium (a medication used to treat high blood pressure) with instructions to hold the medication if the systolic blood pressure was less than 110. The MAR, dated 4/1/26 to 4/30/26, indicated the following were administered on the following dates when Resident 13's systolic blood pressure was below the physician's ordered hold parameter: a. On 4/28/26, amlodipine, losartan potassium and 2 of the 3 doses of hydralazine. b. On 4/30/26, amlodipine and losartan potassium. During an interview, on 5/12/26 at 10:53 a.m., LPN 5 indicated when vital signs were outside of the physician's ordered hold parameters, the nurse would document the vitals on the MAR and indicate the medication was held. 4. The clinical record for Resident 117 was reviewed on 5/11/26 at 8:44 a.m. The diagnoses included, but were not limited to, hypertension and systolic and diastolic congestive heart failure. A care plan, dated 6/13/25, indicated Resident 117 had altered cardiovascular status and to administer medications according to the physician's orders. A progress note, dated 3/31/26, indicated Resident 117 was sent to the emergency department, on 3/26/26, with severe hypotension (low blood pressure). The hospital records indicated the resident was taken off all hypertension medications during the hospital stay and was on midodrine (a medication used to treat low blood pressure) which helped elevate his blood pressure. A physician's order, dated 3/29/26, indicated to administer two (2) tablets of midodrine 5 milligrams every 6 hours for hypotension until 4/12/26 and with instructions to hold the medication if the systolic blood pressure was greater than 110. The MAR, dated 4/1/26 to 4/12/26, indicated the medication was administered on the following dates when Resident 117's systolic blood pressure outside the physician's ordered hold parameter: a. On 4/2/25, 1 of 4 doses. b. On 4/4/26, 1 of 4 doses. c. On 4/5/26, 2 of 4 doses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 4/6/26, 3 of 4 doses. e. On 4/8/26, 1 of 4 doses. f. On 4/9/26, 2 of 4 doses. g. On 4/11/26, 1 of 4 doses. h. On 4/12/26, 2 of 4 doses. A current facility policy, titled Resident Height and Weight, undated and received from the DON on 5/12/26 at 2:54 p.m., indicated .It is the policy of this facility that a resident's height and weight will be accurately obtained.Document weight in EHR.residents will be weighed monthly thereafter, unless physician or diagnosis indicates otherwise. A current facility policy, titled Medication Administration, undated and received from the DON on 5/12/26 at 2:54 p.m., indicated .Administer medication only as prescribed by the provider.Observe the five rights in giving each medication .the right dose .Medications that are refused or withheld or not given will be documented.Record pertinent information prior to giving medication if appropriate.Documentation of medications will follow accepted standards of nursing practice. 410 IAC (Indiana Administrative Code) 410 IAC 16.2-3.1-37(a)

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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. Based on interview and record review, the facility failed to ensure a comprehensive care plan for a cardiac pacemaker was implemented for 1 of 1 resident reviewed for comprehensive care planning. (Resident 100)Findings include:The clinical record for Resident 100 was reviewed on 5/11/26 at 2:36 p.m. The diagnoses included, but were not limited to, presence of a cardiac pacemaker, congestive heart failure, and atherosclerotic heart disease.A progress note, dated 1/16/26, indicated Resident 100 was admitted to the facility. A skin assessment was completed and no skin issues other than a pacemaker were noted.An admission evaluation, dated 1/16/26, indicated Resident 100 utilized a cardiac pacemaker device.A physician's note, dated 1/19/26, indicated Resident 100's medical history included, but were not limited to, heart failure with reduced ejection fraction and pacemaker dependence.Resident 100's care plans did not include her pacemaker.During an interview, on 5/12/26 at 11:55 a.m., the MDS Coordinator indicated the pacemaker was not included and should have been. She indicated there was not an item place for pacemakers in the MDS assessment but a diagnosis code or documentation of a pacemaker in the nursing assessment should trigger the care plan.During an interview, on 5/12/26 at 12:08 p.m., Unit Manager 5 indicated items could be added into a resident's care plan by nursing, social service, and the MDS Coordinator.A current facility policy, titled Plan of Care Overview, undated and received from the Director of Nursing (DON) on 5/12/26 at 2:54 p.m., indicated .for the purpose of this policy the Plan of Care, also Care Plan is written treatment provided for a resident that is resident-focused and provides for optimal personalized care.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.410 IAC (Indiana Administrative Code) 3.1-35(a)410 IAC (Indiana Administrative Code) 3.1-35(b)(1)410 IAC (Indiana Administrative Code) 3.1-35(d)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure physician's orders for oxygen administration were in place for 1 of 2 residents reviewed for respiratory care. (Resident 101)Findings include: During an observation, on 5/8/26 at 9:45 a.m., Resident 101 was observed to receive oxygen at 4.5 liters per minute via nasal cannula. The clinical record for Resident 101 was reviewed on 5/8/26 at 12:03 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, pulmonary hypertension, and type 2 diabetes.A physician's order for the use of oxygen was not located at the time of the record reviewDuring an interview, on 5/12/26 at 8:14 a.m., the Director of Nursing indicated physician's orders for oxygen should have been in the record prior to the initiation of the oxygen.A current facility policy, titled Supplemental Oxygen Using Nasal Cannula, undated and received from the Director of Nursing on 5/13/26 at 8:20 a.m., indicated .Supplemental oxygen may be administered to residents via various routes including through the use of a nasal cannula at the order of a physician or provider 410 IAC (Indiana Administrative Code) 410 IAC 16.2-3.1-47(a)(6)