STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewater Center for Rehab & Nursing L L C	159 163 Front Street Binghamton, NY 13902

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 48446 Based on observations, record review, and interviews during the recertification and abbreviated (NY00355972, NY00357410, NY00358321, and NY00367882) surveys conducted 2/19/2025-2/25/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment for 3 of 8 resident units (Units 2 A, 3 A, and 4 A) reviewed. Specifically, Unit 2 A had a strong smell of urine, unclean bedrooms floors, a bathroom with brown splatter on the toilet, and an over bed table with food debris; Unit 3 A's dining room floor was unclean and sticky, there was debris on the base of the food carts, and brown material on a raised toilet seat in a resident room; and Unit 4 A had a continuously running sink in a resident room, unclean floors in multiple resident rooms, and food splatter on the floors and walls. Findings include: The facility policy, Resident Room Cleaning, revised 3/2020, documented resident rooms were cleaned daily to ensure optimal levels of cleanliness and sanitation, prohibit the spread of infection and bacteria, and maintain the outward appearance of the facility. Wastebaskets were cleaned and sanitized daily, surfaces were cleaned and dusted including over the bed tables, floormats, doors, walls, and floors were cleaned with a dust mop and damp mop. The facility's Strip and Wax binder documented the following room floors were stripped and waxed: - in August 2024 Rooms 341, 343, 347, 360, 361, 365, 366 and 367. - September 2024 Rooms 300, 301, 303, 304, 306, 307, 308, 309, 310, 311, 312, 314, 332, 340, 341, 350, 356, 357, 358, 353, and 441. - in October 2024 Rooms 262, 263, 320, 321, 322, 323, 324, 325, 327, 326, 329, 331, 347, 501, 503, 505, 506, 507, 510, 511, 512, 515, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, and 532. - in November 2024 Rooms 244, 242, 243, 245, 251, 252, 255, 256, 257, 258, 259, 261, 264, 265, 266, 267, 422, and 429. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- in December 2024 Rooms 504, 514, 526, and 533. - in January 2025 rooms [ROOM NUMBER]. There was no documented evidence that floor areas other than resident rooms were stripped or waxed on the 2nd, 3rd, 4th, or 5th floor. The following observations were made on Unit 2 A: - on 2/19/2025 at 1:19 PM room [ROOM NUMBER] had old, dried food splatter and debris on the floor, concentrated to the left side of bed where the floor mat was and at the foot of bed. The bed side table base had dried splatter. The bathroom floor had debris on the floor, the toilet had brown splatter, and on the left handle of toilet frame there was dried brown debris. - on 2/19/2025 at 1:34 PM, room [ROOM NUMBER] had scattered food debris all over the floor. - on 2/19/2025 at 2:46 PM, room [ROOM NUMBER] had food debris on the side of the bed towards the door, the bathroom had dried debris on floors and walls, 1 cotton swab was on the floor, and the toilet had brown splatter on it. - on 2/19/2025 at 2:50 PM, room [ROOM NUMBER] had dried debris on the floor mat and liquid on the floor to the right side of the bed. The over the bed table was covered with dry splatter. - on 2/20/2025 at 10:10 AM, there was a strong smell of urine that permeated the entire unit. - on 2/20/2025 at 2:26 PM, room [ROOM NUMBER] had debris on the floor, the over the bed table had a large amount dried splatter on the top and the frame, and there was dust and debris in the corners of the room. - on 2/24/2025 at 12:43 PM, room [ROOM NUMBER] had 4 straws and 2 cartons of an oral nutrition supplement under the bed, and a large amount of debris covering the floor. - on 2/25/2025 at 8:51 AM, room [ROOM NUMBER] had 4 straws, 2 cartons of an oral nutrition supplement under the bed, and other debris on the floor. room [ROOM NUMBER] had a large amount food debris on the floors in both the bedroom and bathroom. room [ROOM NUMBER] A had food debris and splatter on the floor, on the floor mat, and the over the bed table. - on 2/25/2025 at 9:01 AM, room [ROOM NUMBER]'s over the bed table was covered with splatter and the floors in the room and bathroom were unclean. -Oo 2/25/2025 at 8:56 AM, room [ROOM NUMBER] A's floor had debris, and the bathroom had brown splatter on the floor and walls. The following observations were made on Unit 3A: - on 2/19/2025 at 11:59 AM, 3 food carts holding meals trays located outside room [ROOM NUMBER] had dried debris on the base of the carts. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 2/19/2025 at 1:09 PM, the floor in the dining room was sticky and unclean. - on 2/24/2025 at 12:20 PM, the floor in the dining room was sticky and covered with several differed sized dry spots some as large as a grapefruit. During an interview and observation on 2/24/2025 at 12:31 PM, the resident in room [ROOM NUMBER]'s family member stated they were in at least weekly to visit, and the facility was unclean each time. On multiple visits there was stool on the toilet and the bathroom floor. Last week the bathroom was so dirty they told the nurse. When they opened the bathroom door, they it appeared it had not been cleaned from the previous week. There was dried brown debris covering the entire back of the raised toilet seat and the floor around the toilet had black dried debris on it. The resident in room [ROOM NUMBER] said their room was never cleaned and they thought the room was not homelike. The daily cleaning logs for Unit 3A documented feces was noted in room [ROOM NUMBER] on 2/14/2025 and one other undetermined date in 2/2025. During an observation on 2/25/2025 at 11:29 AM, the first floor entry to the A side building had a foul smell. Corporate Registered Dietitian Consultant #8 stated they believed the odor was coming from the rubbish chute in the area. The following observations were made on Unit 4 A: - on 2/19/2025 at 12:15 PM, the sink in room [ROOM NUMBER] B was continuously running. - on 2/19/2025 at 1:24 PM, there was food and crumbs on the floor in room [ROOM NUMBER] with red splatter under the television. - on 2/18/2025 at 1:59 PM, room [ROOM NUMBER] had spilled dried red liquid covering two floor tiles and brown stains under the over the bed table between the bed and the wall. - on 2/19/2025 at 2:33 PM, room [ROOM NUMBER]'s floor had multiple areas covered with food and dried debris. During an interview on 2/24/2025 at 11:56 AM, [NAME] #19 stated they were responsible for cleaning hallways, stairwells, elevators, pantries, and dining areas every day. They swept and mopped the floors, sprayed doorknobs, and sanitized handrails every day. If floors were sticky, dirty, stained, or covered with debris it was not homelike. During an interview on 2/25/2025 at 8:34 AM, Certified Nurse Aide #15 stated housekeepers were responsible for cleaning resident rooms except bodily fluids, nursing staff was responsible for cleaning bodily fluids. Housekeeping was then notified and completed a deep cleaning. It was an infection control issue if bodily fluids were left on a toilet in shared bathrooms. Sticky floors, floors covered with food and debris, and over the bed tables covered in debris was not homelike. (continued on next page)

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	335228	A. Building B. Wing	02/25/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/2025 at 8:52 AM, Registered Nurse Unit Manager #16 stated nursing was responsible for cleaning bodily fluids, then housekeeping was notified and completed a deep cleaning. Housekeeping cleaned resident rooms and bathrooms. They did not expect to see sticky floors, floors covered with debris, and tables covered with debris. It was not homelike for residents to have dirty or sticky floors, brown debris on toilet seats, or debris on surfaces or walls. During an interview on 2/25/2025 at 9:20 AM, Housekeeper #18 stated their job duties included cleaning resident rooms every day. Room cleaning included changing and emptying trash, sweeping the floors, cleaning the bathroom, dusting all surfaces, sweeping, mopping, and sanitizing the rooms. They were not allowed to touch bodily fluids until they were cleaned by nursing. After nursing cleaned the fluids, they completed a deep cleaning. They stated if rooms had food and debris on the floors and other surfaces, brown debris on toilet seats, sticky floors, and dust it was not homelike. During an interview on 2/25/2025 at 11:37 AM, Assistant Director of Housekeeping #20 stated they were responsible for making sure units and resident bedrooms and bathrooms were clean. Porters were responsible for floor care in offices, dining rooms, hallways, and completed the floor stripping and buffing of their designated areas every three months. Resident rooms were completed as requested and documented in the waxing and buffing logs in a binder. Housekeepers were responsible for cleaning resident rooms and bathrooms. Housekeepers disinfected bathrooms, cleaned bed frames, windows, changed trash, swept and mop the floors, and dusted all surfaces including walls and over the bed tables. Daily room cleaning was documented in a log. They stated nursing was responsible for cleaning bodily fluids and after the initial cleaning notified housekeeping. It was not homelike to have walls with splatter or brown debris on toilet seats, and unclean floors. 10 NYCRR 415.29(j)(1) 50561

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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. 48675 Based on observations, record review, and interviews during the recertification and abbreviated (NY00358321 and NY00368342) surveys conducted 2/19/2025-2/25/2025, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 11 residents (Residents #46 and #99) reviewed. Specifically, Residents #46 and #99 were not assisted with showering as planned. Findings include: The facility policy Activities of Daily Living revised 10/2022 documented the facility would assist and encourage all residents to their highest practicable level of independence and to provide the necessary support in all activities of daily living functioning. Activities of daily living included bathing- inclusive of showers, tub bath, and bed bath. Activities of daily living would be completed on a daily basis for the resident with the assistance of the facility resident care staff as needed. The facility policy, Bathing or Showering a Resident, revised 11/2022 documented the facility would provide a safe environment for bathing and showering of residents to promote cleanliness and comfort to the resident. 1) Resident #46 had diagnoses including chronic obstructive pulmonary disease (lung disease) and muscle weakness. The 10/10/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, felt it was somewhat important to choose between a bed bath, tube bath or a shower, and required substantial/maximal assistance with showering. The Comprehensive Care Plan dated 2/202/2025 documented the resident required assistance with activities of daily living. Interventions included substantial/maximal assistance for showering and bathing. The resident care instructions documented the resident required substantial/maximal assistance for showering/bathing, was dependent on 2 for shower transfers, preferred showers, and was scheduled for a shower on Thursdays during the evening shift. The undated 4B shower schedule documented the resident's shower day was Thursday during the day shift. During an observation and interview on 2/19/2025 at 12:58 PM, Resident #46 was sitting in their wheelchair wearing a hospital gown. Their hair was not combed and appeared wet and greasy on top. They stated they had not received a shower in weeks, and they wanted to take one at least once a week. During an observation and interview on 2/20/2025 at 2:08 PM, Resident #46 was sitting in their wheelchair, their hair was not combed and appeared wet and greasy on top. They stated they did not receive their shower even though it was their shower day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The certified nurse aide documentation record documented the resident did not receive a shower by Certified Nurse Aide #45 during the day shift on 2/6/2025, 2/13/2025, and 2/20/2025. During an interview on 2/25/2024 at 12:36 PM, Certified Nurse Aide #45 stated they looked at the unit's shower sheet to know when resident showers were scheduled. The shower sheet was updated more than the resident care instructions. When there were not a lot of staff on the unit or staff was not willing to help, bed baths were given instead of showers. They frequently took care of Resident #46, and the resident did not refuse their showers. They stated it was important for Resident #46 to be offered and receive their showers to make them feel better, for good personal hygiene, and it was their right. During an interview on 2/25/2025 at 11:55 AM, Licensed Practical Nurse #48 stated resident showers were listed on the unit shower list. The certified nurse aides documented all care provided, and any refusals of care. If a resident refused a shower, they should document the refusal, notify the nurse, and they were not notified of Resident #46 refusing their showers. They stated it was important for Resident #46 to be offered and given a shower for general cleanliness and it was their right. During an interview on 2/25/2025 at 12:54 PM, Registered Nurse Unit Manager #44 stated the certified nurse aides looked at the shower sheet to know when residents were scheduled for their shower, and it was also written on the daily assignment sheet. They were not aware that Resident #46 had not received their shower for 3 weeks. It was important for Resident #46 to receive their shower weekly as scheduled because it was dignified and a resident right. During an interview on 2/25/2025 at 1:49 PM, the Director of Nursing stated residents should receive their showers when they were scheduled. The certified nurse aides should let the licensed practical nurse or unit manager know if a shower could not be given for any reason. They stated Resident #46 should not have gone 3 weeks without a shower and it was important for them to get their scheduled shower to make them feel better and have good hygiene. 2) Resident #99 had diagnoses including cerebral palsy (disorder of movement, muscle tone, or posture) and muscular dystrophy (causes progressive weakness and loss of muscle mass). The 1/16/2025 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, had upper and lower extremity impairments on both sides, and required substantial/maximal assistance with showering. The Comprehensive Care Plan dated 1/15/2024 documented the resident required assistance with activities of daily living. Interventions included extensive assistance with bathing, and personal hygiene. The resident's care instructions documented the resident preferred a shower. Shower was on Monday with no shift specification. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/19/2025 at 1:56 PM, Resident #99 was sitting up in bed and had greasy hair. They stated they did not get their weekly shower like they were supposed to and there was not always a mechanical lift pad available so they could take a shower. They preferred a shower twice a week but when a shower was missed, they had to go two weeks between them. They were scheduled for a shower on 2/17/2024 but did not get it. The certified nurse aide asked them if they wanted a shower, they said yes, and then the certified nurse aide never returned to take them to the shower. The 2/17/2025 care log by Certified Nurse Aide #50 documented the resident did not get a shower. During a telephone interview on 2/25/2025 at 10:02 AM, Certified Nurse Aide #50 stated showers were highlighted in the assignment binder they looked at when they started their shift. On 2/17/2025 Resident #99 told them they wanted a shower around 8:00 PM. They did not get to it because they gave another resident their shower at that time. They had asked the other certified nurse aides working to give Resident #99 a shower, but that certified nurse aide did not get to it either. The resident liked to take showers. During a telephone interview on 2/25/2025 at 11:18 AM, Registered Nurse #30 stated the certified nurse aides were supposed to report to them if they did not give their scheduled showers. They were not told Resident #99 did not get their shower on 2/17/2025. They did not see the shower documentation in the electronic medical record, so they just had to rely on the certified nurse aides to tell them if they received them or not. During an interview on 2/25/2025 at 12:01 PM, Registered Nurse Unit Manager #13 stated Resident #99 was scheduled for showers on Mondays on the second shift. The resident liked showers, and it was important for good hygiene. They only got a shower once a week. If the resident did not get their shower, the certified nurse aide should have relayed that to the nurse and then it would be relayed to the oncoming shift. 10NYCRR 415.12(a)(3) 49448

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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. 48446 49448 Based on observations, record review, and interviews during the recertification and abbreviated (NY00370596, NY00368342, and NY00355972) surveys conducted 2/19/2025-2/25/2025, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 of 2 residents (Resident #99 and #236) reviewed. Specifically, for Resident #236 Licensed Practical Nurses #14 and #17 administered medications outside of acceptable time parameters, a tube feeding was not given and documented as administered, medications were signed as given prior to administration, signed as given on time when they were given late, and treatments were signed completed when they were not; Resident #99 had an order for a medicated shampoo weekly with showers, the medicated shampoo was left at the resident's bedside, and certified nurse aides administered the medicated shampoo instead of licensed staff. Additionally, the provider was not notified of late and missing medications and treatments. Findings include: The facility policy, Medication Administration, revised 11/2022, documented all medications were administered by a licensed professional nurse or a registered professional nurse and were documented in the electronic medical record. Medications were not left at the bedside. Medications were administered no more than one hour before and one hour after the ordered time. If medications were administered outside the one-hour time frame, the registered nurse/ Nurse Manager/ supervisor were notified. The Registered Nurse Supervisor evaluated the late medications and determined the course of action for the residents and medical staff notification. The nurse practitioner or physician were notified for any refusal of medications or missed dose of medications. The registered nurse completed an assessment as needed for a missed dose of medications. The facility policy, Charting Guidelines, revised 10/2024, documented an accurate record of care and treatment was provided. The resident's medical record was a legal document, and everything must be correct and legible. Medications were documented after they had been administered and treatments were documented upon completion. 1) Resident #236 had diagnoses including Guillain-Barre syndrome (a condition that affects the nerves), dysphagia (difficulty swallowing), and need for assistance with personal care. The 2/6/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment, had medically complex conditions, and received nutrition via tube feedings. The 7/17/2023 Comprehensive Care Plan, revised 11/14/2024, documented the resident received tube feedings, received nothing by mouth, and received all nutrition and medications via gastric tube. Nurse Practitioner #28 orders documented: - on 9/29/2023, may crush medications and administer together if not contraindicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 2/13/2024 sertraline hydrochloride (an anti-depressant) 50 milligram tablet once daily via gastric tube. - on 7/24/2024, Jevity 1.5 calorie (tube feeding) oral liquid, full strength, bolus via pump 240 milliliters over an hour daily at 6:00 AM, 10:00 AM, 2:00 PM, and 6:00 PM; flush tube with 120 milliliters of water before and after each feeding; flush 60 milliliters of water before and after medication pass at 6:00 AM, 8:00 AM, 11:00 AM, 2:00 PM, 8:00 PM and 10:00 PM; flush 60 milliliters between medications; check residual every shift and if equal to or greater than 100 milliliters, hold feeding for one hour and recheck and notify physician if residual remains; check for proper tube placement prior to each feeding, flush, or medication; elevate head of bed 30 degrees during feeding and one hour after feeding; tube site care daily in the morning; check bowel sounds all quadrants daily; and provide mouth care daily. - on 8/21/2024, senna (stool softener) oral 8.6 milligram tablet two tablets twice daily at 8:00 AM and 8:00 PM via gastric tube. - on 12/5/2024, gabapentin (treats nerve pain) 600 milligrams one tablet three times a day via gastric tube. - on 1/14/2025, omeprazole (treats heartburn) delayed release 20 milligrams tablet via gastric tube daily at 8:00 AM; midodrine hydrochloride (treats low blood pressure) 2.5 milligram tablet via gastric tube one tablet twice daily, hold if systolic blood pressure greater than 120; and lactobacillus (a probiotic) extra strength oral capsule via gastric tube twice daily. - on 2/14/2025, nothing by mouth, tube feeding. The following observations of Resident #236 were made: - on 2/19/2025 at 12:46 PM and at 5:23 PM, lying in bed with the head of bed elevated 45 degrees. There was a full Jevity 1.2 calorie 1000 milliliter bottle hanging from the tube feeding pole, the tubing was in the pump, there was no cap on the end of the tubing, and the tubing was not connected to the resident. There were ten 240 milliliter Jevity 1.5 calorie boxes on the bedside table. - on 2/20/2025 at 2:48 PM, lying in bed with the head of the bed elevated 45 degrees. There was nothing hanging from the tube feeding pole and there were nine 240 milliliter Jevity 1.5 calorie boxes on the bedside table. - on 2/21/2025 at 9:50 AM, lying in bed with the head of the bed elevated 45 degrees. There was nothing hanging from the tube feed pole and there were eight 240 milliliter Jevity 1.5 calorie boxes on the bedside table. The following was observed during a continuous observation on 2/21/2025 from 10:06 AM through 1:57 PM: - from 10:06 AM through 11:30 AM, Licensed Practical Nurse #17 did not enter the resident's room. The 10:00 AM tube feeding, and water flushes were not signed off in the electronic medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 11:31 AM, the 10:00 AM tube feeding, and water flushes were signed off in the electronic chart by Licensed Practical Nurse #17. The nurse did not enter the resident's room. - at 11:34 AM, the 12:30 PM check tube placement and check bowel signs was signed off in the electronic chart by Licensed Practical Nurse #17. The nurse did not enter the resident's room. - at 12:38 PM, Licensed Practical Nurse #17 left the unit and returned at 1:00 PM. - at 1:07 PM, Licensed Practical Nurse #17 signed off the 2:00 PM tube feeding and water flushes. The nurse did not enter the resident's room. - at 1:12 PM, Licensed Practical Nurse #17 took medications into another resident's room. - at 1:14 PM, Licensed Practical Nurse #17 entered the resident's room with a bag of tube feeding that was initialed and dated 2/21/2025. They hung the bag on the pole and connected it to the resident. The pump on the pole was not utilized as ordered. There were seven Jevity 1.5 calorie boxes on the bedside table. - at 1:57 PM, the tube feed bag was empty and still connected to the resident. The following was observed during a continuous observation on 2/24/2025 from 8:44 AM through 1:43 PM: - at 8:44 AM, Licensed Practical Nurse #14 had not signed off any medications, tube feedings, or water flushes in the electronic medical record for their shift. - at 8:51 AM, the resident was lying in bed with the head of the bed elevated 45 degrees. An empty tube feeding bag dated 2/23/2025 was connected to the resident. There was nothing flowing through the tube feeding pump. There were no 1.5 calorie Jevity boxes on the bedside table. - at 10:23 AM, Licensed Practical Nurse #14 put on a gown and gloves and entered the resident's room. At 10:25 AM, the nurse exited the room and used alcohol-based hand rub from the hallway dispenser. - at 10:27 AM, the resident was lying in bed. There was no tube feeding connected to the resident and the bag and tubing were no longer hanging from the pole. - at 12:33 PM, Licensed Practical Nurse #14 took a blood pressure cuff into the room and closed the door. At 12:34 PM, the nurse exited the room with the blood pressure cuff. There were no medications, tube feedings, flushes, or other treatments signed off in the electronic medical chart by Licensed Practical Nurse #14. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER: Bridgewater Center for Rehab & Nursing L L C		STREET ADDRESS, CITY, STATE, ZIP CODE: 159 163 Front Street Binghamton, NY 13902	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 1:15 PM, Licensed Practical Nurse #14 documented in the electronic medical record that water flushes, tube feedings, other treatments and medications were all given. This included the 10:00 AM and 2:00 PM tube feedings; the 120 milliliter water flushes for 8:00 AM and 11:00 AM; the 60 milliliter water flushes for 8:00 AM and 11:00 AM; the tube feeding residual check for 12:30 PM; the tube feeding placement check at 12:30 PM; the bowel sounds check for 12:30 PM; the tube feeding site care at 11:00 AM; the mouth care at 12:30 PM; the medications scheduled for 8:00 AM including 50 milligrams of sertraline, two 8.6 milligram tablets of senna, 20 milligrams of omeprazole, and 600 milligrams of gabapentin; the medications scheduled for 11:00 AM including lactobacillus extra strength capsule and 2.5 milligrams of midodrine; and the 2:30 PM scheduled dose of gabapentin 600 milligrams. The nurse did not enter the resident's room during the time frames documented as completed. - at 1:32 PM, during a tube feeding and medication administration observation with Licensed Practical Nurse #14, they entered the room with gloves on and was not wearing a gown. They had a plastic cup with cloudy water with flecks and a 60 milliliter syringe in their hand. The dressing to the gastric tube site on the abdomen was clean and intact, dated 2/23/2025. At 1:34 PM, the nurse put the plastic cup and the syringe down on the bedside table and left the room to get a Jevity 1.5 calorie box. At 1:36 PM, the nurse returned to the room and flushed the tube with 60 milliliters of water. The nurse did not check the placement of the tube, check residual, or check bowel sounds as previously charted. The nurse stated they were administering omeprazole, sertraline, senna, gabapentin, and a probiotic with 60 milliliters of water. At 1:38 PM, the nurse gave another 60 milliliters of water. At 1:40 PM, they put 240 milliliters of Jevity 1.5 calorie into a tube feed bag dated 2/24/2025, hung it from the pole and did not utilize the pump. The nurse did not provide tube site care or mouth care as charted. They stated that was the second feeding they gave on their shift and the resident received a feeding at 6:00 AM, 10:00 AM, 2:00 PM and 6:00 PM. They stated they were administering the 2:00 PM tube feeding and did not have a chance to give the 10:00 AM tube feeding because they came in late at 8:00 AM. They stated they had to prioritize their residents as they had another resident that was on comfort care and needed pain medications. They stated they had called a nurse practitioner about the missed feeding but did not know the name of the nurse practitioner. They stated it was important the resident received their ordered tube feedings and water flushes for nutrition and because they had a low blood pressure. Anytime they talked to a provider they documented in a note. The 2/24/2025 at 2:00 PM Licensed Practical Nurse #14 progress note documented Nurse Practitioner #28 was notified of gastric tube feed adjustments. During a telephone interview on 2/24/2025 at 4:41 PM, Nurse Practitioner #28 stated if any order was not completed, they should be notified, and the resident would be evaluated if warranted. They should be notified of missed tube feedings and Resident #236 needed the tube feedings as they were life sustaining treatments. Today was the first time they had been notified that the resident had missed a feeding. Licensed Practical Nurse #14 had called them after they started the 2:00 PM tube feeding and informed them the 10:00 AM tube feeding was not administered. They ordered a one-time 10:00 PM tube feed dose for today to make up for it. They were not made aware of medications given late or treatments not completed. During an interview on 2/25/2025 at 10:43 AM, Licensed Practical Nurse #17 stated she gave Resident #236 their 10:00 AM tube feeding after they came back from break on 2/21/2024. They stated they never missed an administration, and it was important the resident received the ordered feedings because it was their only source of nutrition. The provider should be notified of any missed doses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 12:01 PM, Registered Nurse Unit Manager #13 stated medications could be given one hour before or one hour after a scheduled administration and the provider should be notified of anything given outside that window. The nurse administering the medications should notify the provider. If the provider was notified, a nursing progress noted should be documented. Without a note, they would not know if a provider was notified. During an interview on 2/25/2025 at 1:22 PM, the Director of Nursing stated the provider should be updated on any medication given outside the ordered time frame so they could decide what actions needed to be taken, if changes needed to be made, or if an order for monitoring needed to be implemented. Orders were expected to be followed. 2) Resident #99 had diagnoses including atopic dermatitis (itchy, red, dry patches of skin), seborrheic dermatitis (itchy rash with flaky scales), and need for assistance with personal care. The 1/16/2025 Minimum Data Set assessment (a health status tool) documented the resident was cognitively intact, required substantial/ maximum assistance with bathing, had applications of ointments/ medications other than to feet, and did not reject care. The Comprehensive Care Plan for activities of daily living initiated 1/16/2025 documented showers were on Mondays (shift not specified) and the resident was dependent with transfer to the tub/ shower. It did not include the use of a medicated shampoo with showers. The 4/6/2023 physician order documented Ketoconazole shampoo 2 percent, applied to their scalp weekly on Mondays at 8:00 PM with shower for seborrheic dermatitis. The 1/29/2025 Nurse Practitioner #49 progress note documented the resident was seen for routine follow up. Seborrheic dermatitis was listed as an active medical problem. The plan was to monitor for worsening dry patches of the skin and refer to dermatology as needed. The 2/2025 Treatment Administration Record documented Ketoconazole Shampoo 2 percent was not administered as ordered on 2/17/2025 and 2/24/2025. During an observation and interview on 2/19/2025 at 1:56 PM, Resident #99 was sitting up in their bed, their hair was greasy. They stated they had a problem with their scalp, and they could scrape their skin off in patches. They were supposed to receive a medicated shampoo, but they did not always get their weekly shower which was not helping their scalp issue. Their Ketoconazole 2 percent shampoo was observed on their nightstand next to the bed. They stated during showers the certified nurse aides used that shampoo. During a telephone interview on 2/25/2025 at 10:12 AM, Certified Nurse Aide #50 stated they did not get a chance to give Resident #99 their scheduled shower on 2/17/2025. The resident handed them a special shampoo to use during the shower. During a telephone interview on 2/25/2025 at 11:18 AM, Registered Nurse #30 stated Resident #99 had an order for a medicated shampoo, but they never saw it. They did not think the resident ever received the shampoo because the facility did not have it on hand. They just signed the medicated shampoo off as not available but did not notify anyone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 12:01 PM, Registered Nurse Unit Manager #13 stated Resident #99 had a medicated shampoo used during showers. The certified nurse aide should communicate with the nurse when it was time for the shower so the medicated shampoo could be administered by the nurse. During an interview on 2/25/2025 at 1:22 PM, the Director of Nursing stated if a resident received a medicated shampoo, the certified nurse aide and the nurse needed to communicate. The certified nurse aides could not administer medications, so the nurse needed to administer the medicated shampoo. If the medicated shampoo was not given, the nurse should have notified the provider. During a telephone interview on 2/25/2025 at 2:24 PM, Nurse Practitioner #49 stated they expected to be notified of every dose of every missed medication. Resident #99 had the medicated Ketoconazole shampoo for seborrheic dermatitis. Without it, it could get worse. They were not notified of any missed doses of the shampoo. 10NYCRR 415.12