STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365313	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeport Health Care Center	2125 Royce Street Portsmouth, OH 45662

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on record review, resident and staff interview the facility failed to complete an accurate comprehensive assessment for Resident #28, #47 and #74. This affected three residents (Resident #28, #47 and #74) of thirteen reviewed for comprehensive assessments. The facility census was 86 in house. Findings include: 1. Review of the medical record for Resident #28 revealed an admitted [DATE] with diagnoses including hypertension, diabetes mellitus type two, hyperlipidemia, muscle weakness and difficulty walking. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #28 had clear speech and was rarely understood therefore the Brief Interview Mental Status (BIMS) was not completed. Resident #28 was coded as modified independence with decision making. Resident #28 required staff assistance to complete activities of daily living. An interview on 01/14/25 at 4:02 P.M. with Resident #28 confirmed the resident was alert and oriented with clear speech. An interview on 01/15/25 at 3:50 P.M. with the Director of Nursing (DON) confirmed Resident #28 had clear speech and would be able to complete the BIMS interview. The DON confirmed the MDS dated [DATE] revealed Resident #28 had unclear speech and was unable to be assessed for BIMS. The DON stated Resident #28 refused to participate in the interview. Review of the Resident Assessment Instrument Manual revealed if the resident was at least sometimes understood the interview should be attempted. If a resident refused to answer a particular item, accept the refusal and move on to the next question. The interviewer may stop the interview and code the answer 0 if there had been no verbal or written response to any of the question up to section C0300C-the day of the week and the resident chooses to not answer (refusal). 2. Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses including cerebral infarction, hemiplegia/hemiparesis affecting the right side, dysphagia, and diabetes mellitus type two. Review of the admission MDS dated [DATE] revealed Resident #47 range of motion was not assessed. Resident #47 required assistance from the staff to complete activities of daily living. (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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NAME OF PROVIDER OR SUPPLIER Bridgeport Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2125 Royce Street Portsmouth, OH 45662	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS dated [DATE] revealed Resident #47 was independent with decision making with no behaviors. Resident #47 had no impaired range of motion to his bilateral upper extremities or bilateral lower extremities. Resident #47 was coded as not using any device for mobility. An observation on 01/14/25 at 1:45 P.M. of Resident #47 revealed the resident's right hand was closed in a fist. The resident was unable to open his hand upon request. An interview on 01/15/25 at 3:50 P.M. with the Director of Nursing (DON) revealed the DON was not aware Resident #47 had a contracture to his right hand. The DON also confirmed the MDS dated [DATE] and 10/31/24 were not coded correctly. An observation of Resident #47 along with Occupational Therapist (OT) #143 on 01/16/25 at 10:30 A.M. confirmed Resident #47 had a contracture to his right hand. 3. Review of the medical record for Resident #74 revealed an admitted [DATE] with diagnoses including epilepsy, cerebral infarction, traumatic subdural hemorrhage and bipolar disorder. Review of annual MDS dated [DATE] revealed Resident #74 had clear speech but was coded as rarely understood. Resident #74 required staff assistance to complete activities of daily living. Interview on 01/14/25 at 4:07 P.M. with Resident #74 revealed the resident had clear speech and was oriented to person and place. An interview on 01/15/25 at 3:50 P.M. with the Director of Nursing (DON) confirmed Resident #74 had clear speech and would be able to complete the BIMS interview. The DON confirmed the MDS dated [DATE] revealed Resident #74 had unclear speech and was unable to be assessed for BIMS. The DON stated Resident #74 refused to participate in the interview. Review of the Resident Assessment Instrument Manual revealed if the resident was at least sometimes understood the interview should be attempted. If a resident refused to answer a particular item, accept the refusal and move on to the next question. The interviewer may stop the interview and code the answer 0 if there had been no verbal or written response to any of the question up to section C0300C-the day of the week and the resident chooses to not answer (refusal).

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on observation, record review and interview the facility failed to develop and implement a comprehensive and individualized range of motion program to timely identify and implement therapy recommendations to treat and prevent potential worsening of a right-hand contracture for Resident #47, a resident admitted to the facility with diagnosis of cerebral infarction, hemiplegia/hemiparesis affecting the right side. This affected one resident (#47) of one resident reviewed for range of motion. The facility census was 86. Findings include: Review of the medical record for Resident #47 revealed an initial admitted [DATE] with diagnoses including cerebral infarction, hemiplegia/hemiparesis affecting the right side, dysphagia, chronic obstructive pulmonary disease and diabetes mellitus type two. Review of the admission nursing assessment dated [DATE] revealed Resident #47 did not have any contractures to the bilateral upper extremities. Review of an Occupational Therapy (OT) evaluation dated 06/27/24 revealed it did not assess Resident #47's range of motion to right upper extremity. The evaluation noted Resident #47 had hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Review of Resident #47's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had unclear speech and was rarely understood with no memory problem. Review of the mood and behaviors section of the assessment revealed Resident #47 had little interest or pleasure in doing things, feeling tired, trouble with sleep, trouble with concentrating but did not have any behaviors. Resident #47 was totally dependent on staff for activities of daily living per section G. The assessment did not address range of motion. Review of an OT treatment note dated 08/05/24 revealed OT was providing joint mobilization and assisted active range of motion to right upper extremity. The recertification also noted to add a splint to the right hand as it was becoming contracted. Review of the physician's orders for August and September 2024 revealed no orders for a hand splint device or range of motion to the resident's upper extremities. Review of an OT treatment note dated 10/01/24 revealed Resident #47 received orthotic training on use of palm guard for three hours to right hand with no signs and symptoms of decreased skin integrity. Review of an OT treatment note dated 10/03/24 revealed Resident #47 was noted with increased tone throughout his right upper extremity. Resident #47 had decreased tolerance with ranging of right hand. Resident #47 was at risk for skin breakdown in palm of right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an OT treatment note dated 10/21/24 revealed Resident #47 was seen for completing staff education as appropriate related to the palm guard. OT placed folded soft device in hand. Per facility policy, nursing to write the order and complete the plan of care for palm guard (to right hand). Resident discharged from OT services this date. Review of Resident #47's quarterly MDS assessment dated [DATE] revealed the resident was rarely understood, was independent in decision making, had no behaviors, had no impaired range of motion to bilateral upper and lower extremities, and was dependent on staff for activities of daily living. Review of Resident #47's medical record in October 2024, including occupational therapy notes, revealed no evidence the facility assessed the severity of Resident #47's right upper extremity impairment at this time. Review of the physician's orders from October through December 2024 revealed no orders for a hand splint device and range of motion to upper extremities to Resident #47 right hand were written. Review of the physician's orders for January 2025 revealed no orders for a hand splint device, range of motion to upper extremities, or specific skin treatment to Resident #47 right hand. Review of Resident #47's plan of care revealed no care plan addressing the resident's contracture to his right hand. An observation on 01/14/25 at 1:45 P.M. of Resident #47 revealed the resident's right hand was closed in a fist. The resident was unable to open his hand upon request. An observation on 01/15/25 at 9:05 A.M. of Resident #47 revealed the resident's right hand remained closed in a fist. An interview with Resident #47 at the time of the observation revealed the resident responded no when asked if he had a device to put on his right hand, and that no one stretched his hand. An interview on 01/15/25 at 9:29 A.M. with Licensed Practical Nurse (LPN) # 203 confirmed Resident #47 did not have any orders for a splint, carrot or any device for his right hand (to address the identified contracture). In addition, LPN #203 stated the facility did not currently have a restorative program. An interview on 01/15/25 at 1:45 P.M. with Certified Nursing Assistant (CNA) # 124 revealed the CNA provided care for Resident #47. CNA #47 stated she did not provide range of motion or a device to the right hand of Resident #47 as part of the resident's routine care. An interview on 01/15/25 at 3:50 P.M. with the Director of Nursing (DON) revealed the DON was not aware Resident #47 had a contracture to his right hand. The DON confirmed there were no orders to care for the contracture or skin of Resident #47's right hand. The DON stated she would call the physician for orders for skin care and a therapy evaluation at this time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #47 along with Occupational Therapist (OT) #143 on 01/16/25 at 10:30 A.M. confirmed Resident #47 had a contracture to his right hand. At the time of the observation, Resident #47 refused to permit OT #143 to stretch out his hand. OT #143 stated Resident #47 had been on therapy case load and was discharged in October 2024 (with recommendations for contracture management). OT #143 also confirmed Resident #47 did not currently have any kind of device for his right hand to keep it stretched out, prevent decline in range of motion or worsening of the contracture. OT #143 stated Resident #47 initial/admission therapy evaluation did not indicate the resident had a contracture of his right hand and it was possible that Resident #47 range of motion to right hand would become worse without treatment and care. A telephone interview on 01/23/25 at 12:10 P.M. with OT #143 revealed OT #143 did not complete the admission therapy evaluation for Resident #47. OT #143 did complete an evaluation for the contracture of Resident #47's right hand on 01/16/25. OT #143 stated the contracture did not visibly appear worse than it was when she saw it in 10/2024. OT #143 also verified there were no measurements taken of the resident's range of motion of the right hand in 10/2024 to compare to the measurements she did on 01/16/25. OT #143 stated the admission evaluation did not include range of motion and it was not required to. An interview on 01/23/25 at 3:15 P.M. with the Administrator revealed Resident #47's October 2024 MDS was incorrect, and it should have been coded the resident had impairment to his upper extremity. The facility did not have a policy on prevention of decline in range of motion per the Administrator.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34299 Based on review of the Self Reporting Incident (SRI), record review, and interview the facility failed to implement individualized interventions and revise the care plan to address the Resident #69's dementia care needs related to sexual behaviors. This affected one resident (Resident #69) of one reviewed for dementia care. The facility census was 86. Findings include: Review of the medical record of Resident #69 revealed an admitted [DATE] with diagnoses including unspecified dementia, anxiety, hypertension and hyperlipidemia. Resident #69 had a durable power of attorney (DPOA) listed in the medical record. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #69 had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of three with no behaviors. Resident #69 required supervision of staff to complete activities of daily living. Review of SRI #256217 dated 01/17/25 revealed Resident #69 was observed by staff in a sexual act with Resident #64. The facility was completing the investigation. However, the investigation revealed both residents were interviewed, assessed and monitored for psychosocial adverse effects. The staff were interviewed along with other residents with no concerns. The Social Worker had provided education to both Resident #64 and Resident #69 about safe sexual relationships. The Social Worker also spoke to both residents about a plan for future sexual encounters. Resident #64 and #69 agreed that if they wanted to have a sexual encounter they would inform the staff so that privacy would be provided. Review of Resident #69's medical record revealed no evidence the facility discussed Resident #69's plan to provide privacy for sexual contact with the resident's DPOA or physician. The plan of care had not been revised with interventions to address the sexual contact as well. Interview on 01/22/25 at 1:10 P.M. with Resident #69 DPOA revealed the facility had notified her of the sexual encounter. However, the facility had not informed her or discussed with her the plan to provide privacy for the residents to have a sexual relationship. The DPOA stated Resident #69 was not able to make safe, right or wrong decisions. Interview on 01/22/25 at 1:55 P.M. with Resident #69 revealed the resident was alert and oriented to person and place. Resident #69 denied any knowledge of the event or the discussion with Social Worker about the plan for privacy. A phone interview on 01/22/25 at 2:18 P.M. with Resident #69's nurse practitioner, who provided services to Resident #69, confirmed Resident #69 had dementia, confusion and was not cognitively able to make safe decisions on his own. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 3:09 P.M. with the Director of Nursing (DON) confirmed the facility did not inform or discuss the plan for privacy for Resident #64 and #69 with the DPOA of Resident #69. DON revealed the licensed social worker (LSW) completed a sexual consent form provided by corporate and completed it on both residents. Both residents were assessed to be able to consent to a sexual relationship. Review of the facility policy titled Dementia Care revealed 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 the residents, staff and visitors. Residents with dementia and/or dementia-related diagnoses will be treated with the same respect and dignity and afforded the same resident rights regardless of diagnoses, severity of condition or payment source . The policy continued with resident representatives will be communicated with for resident needs, updated, and notification as required by law. This deficiency represents non-compliance investigated under Complaint Number OH00161778.