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	06/26/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, review of the of the facility Self-Reported Incident (SRI) form, interviews, and review of facility policy, the facility failed to ensure an incident of resident elopement was appropriately identified and addressed according to the policy implemented by the facility. This affected one resident (#90) out of the three residents reviewed for elopement. The facility census was 88. Findings include:Closed record review for Resident #90 revealed the resident was admitted to the facility on [DATE] with diagnoses including intracranial injury with loss of consciousness, epilepsy, repeated falls, and need for assistance with personal care.Review of the facility Nursing admission Assessment, dated 05/20/26, revealed Resident #90 was assessed to not be at risk for elopement. Review of the admission Minimum Data Set (MDS) 3.0 assessment, dated 05/25/26, revealed Resident #90 was assessed to have impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 12/15. The resident was assessed to have had two or more falls with no injury since admission or the prior assessment, whichever was more recent. Review of the progress notes, dated 05/20/26 through 06/01/26, revealed no documentation of Resident #90 leaving the facility without staff knowledge or supervision. On 06/01/26, the resident was documented to be discharged to the group home.Review of the facility SRI form, dated 06/05/26 and timed 12:21 P.M., revealed on 06/04/26 Ombudsman #900 entered the building and alleged the discharge of Resident #90 on 06/01/26 may be considered an elopement. On 06/01/26 at approximately 6:45 P.M., Resident #90 left the facility with the intent to return to his group home, less than a mile from the facility. Resident #90, when interviewed by the Director of Nursing (DON), stated his intent was to return to living at the group home and once he arrived at the group home, he was readmitted under their care. Resident #90 was alert and oriented with a BIMS assessment score of 14/15, who was assessed on admission to not be at risk of elopement. Resident #90 arrived at the group home independently without incident and voiced he left the facility because he felt he was ready to return to the group home (his previous living situation). Discharge was coordinated with the group home, and all discharged medications were called in to the local pharmacy and follow-up appointments scheduled. Follow-up call to the group home by Administrator on 06/02/26 made with no concerns voiced.During an interview on 06/26/26 at 8:15 A.M., the Administrator and DON confirmed no residents had eloped from the facility in the past three months. They confirmed Resident #90 had left and went back to the group home, but the resident had a BIMS assessment score of 14 indicating he was cognitively intact and the facility did not have paperwork indicating the resident had a legal guardian. During a telephone interview on 06/26/26 at 9:35 A.M., Resident Representative (RR) #888 confirmed she had been appointed guardian for Resident #90 approximately nine years prior and had paperwork for the guardianship which had never been requested by the facility. RR #888 confirmed Resident #90 had a traumatic brain injury, became confused at times, and was not always able to make safe decisions. RR #888 confirmed on 06/01/26, at approximately 8:00 P.M., she received a telephone call from Group Home Supervisor (GHS) #655 informing her Resident #90 was sitting on the couch of the group home. RR #888 confirmed she had not been made aware Resident (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#90 was returning to the group home, so she called the facility. RR #888 confirmed the DON called her back and stated she would drive to the group home to check on the resident. RR #888 confirmed she was concerned regarding how the resident was able to leave without staff knowledge. RR #888 confirmed Resident #90 had to walk across active railroad tracks and busy streets to return to the group home located over a mile from the facility and had fallen several times in the past with injuries that had resulted in hospitalization. RR #888 confirmed she had agreed to allow Resident #90 to be admitted back to the group home on [DATE] since he wanted to stay there. During a telephone interview on 06/26/26 at 9:50 A.M., GHS #655 confirmed she lived across the street from the group home Resident #90 lived in prior to going to the facility. GHS #655 confirmed Resident #90 had fallen several times and had to be admitted to the facility for therapy services. GHS #655 confirmed sometime during the evening of 06/01/26, she received a telephone from an employee at the group home stating Resident #90 was sitting on the couch inside the home. GHS #655 confirmed she was surprised because she had no idea he was coming. GHS #655 confirmed she called RR #888 who was the residents guardian to see if she knew he was coming back to the group home, and she was also not aware. GHS #655 confirmed the DON of the facility came to the group home to check on Resident #90, and the resident wanted to remain at the facility, so it was agreed by all the resident would remain there. GHS #655 confirmed there were busy roads between the facility and the group home Resident #90 would have had to cross which were not safe for him to walk alone. GHS #655 confirmed she had a copy of the guardianship paperwork indicating RR #888 was Resident #90's court appointed guardian but had never been asked to provide a copy to the facility. During a telephone interview on 06/26/26 at 9:55 A.M., Ombudsman #900 confirmed RR #888 was the guardian of Resident #90. Ombudsman #900 confirmed Resident #90 exited the facility alone and unbeknownst to staff on 06/01/26 and walked across railroad tracks and busy streets to get to the group home located approximately one mile from the facility. Ombudsman #900 confirmed facility staff were not aware Resident #90 had left the facility until they were contacted by RR #888. Ombudsman #900 confirmed the facility was denying Resident #90 had eloped from the facility, but per their policy he did elope. During an interview on 06/26/26 at 11:24 A.M., Social Service Designee (SSD) #200 confirmed she had requested documentation of guardianship for Resident #90 from RR #888, but it was never produced. SSD #200 confirmed the request for guardianship paperwork and failure to provide it had not been documented in the resident's medical record. SSD #200 confirmed RR #888 was listed as Resident #90's guardian in the resident's electronic health record maintained by the facility. SSD #200 confirmed Resident #90 exited the facility sometime after dinner on 06/01/26 without staff knowledge and returned to the group home he had resided in prior to being admitted to the facility. SSD #200 confirmed the DON went to the group home after being notified Resident #90 was there and it was agreed the resident would be discharged from the facility to the group home at that time.During an interview on 06/26/26 at 12:04 P.M., the DON confirmed the facility was unaware Resident #90 had left the facility until RR #888 called in stating he was at the group home. The DON confirmed she went to the group home upon learning he was there and assessed him with no injuries assessed or reported by the resident. The DON confirmed she and other administrative staff returned to the facility following Resident #90 leaving and interviewed all staff present. The DON confirmed the last time staff reported observing the resident was at approximately 6:30 P.M. on 06/01/26 when picking up his dinner meal tray and confirmed she had received the telephone call from facility staff at approximately 8:00 P.M. on 06/01/26 reporting the resident had left the facility and was at the group home. The DON confirmed Resident #90 leaving the facility without staff knowledge and staff not having knowledge of his whereabouts until they were notified by RR #888 was determined to not be an elopement, despite the incident matching the definition of elopement contained in the facilities policy. During an interview on 06/26/26 at 12:28 P.M., the Administrator confirmed Resident #90 had left the faciity on [DATE] at approximately 6:45 P.M. unbeknownst to staff and returned to the group home. The Administrator confirmed staff were not aware of the resident's whereabouts until notified (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by RR #888 at approximately 8:00 P.M. on 06/01/26. The Administrator confirmed Resident #90 leaving the facility without staff knowledge and staff not having knowledge of his whereabouts until they were notified by RR #888 was determined to not be an elopement, despite the incident matching the definition of elopement contained in the facilities policy.Review of the facility policy titled Elopement Prevention and Management Overview, printed on 06/11/26, revealed elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident at risk for harm or injury. A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. This deficiency represents non-compliance investigated under Complaint Number 3032299.