

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Bridgeport Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed. This affected four residents (#9, #11, #27, and #86) out of the 26 residents whose MDS assessments were reviewed during the annual survey. The facility census was 85. Findings include: 1. Record review for Resident #9 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included major depressive disorder, schizophrenia, and morbid obesity. Review of Section K of the quarterly Minimum Data Set (MDS) assessment, dated 08/05/25, revealed the resident was assessed to weight 208 pounds and to not have had a weight loss of over five percent in the past month or ten percent or more in the last six month. Review of the documented weights for the resident revealed the resident weighed 228.4 pounds on 07/01/25 and 207.6 pounds on 08/01/25 resulting in a loss of 20.8 pounds or 9.11 percent of the residents body weight. Interview with Registered Dietitian #233 on 08/27/25 at 1:45 P.M. confirmed Resident #9 had experienced a weight loss of 20.8 pounds from 07/01/25 to 08/01/25 which was equal to a 9.11 percent body weight loss in one month. Registered Dietitian #233 confirmed the quarterly MDS assessment for Resident #9 was dated 08/05/25 and the resident had experienced a weight loss of more than five percent in the 30 days prior to the assessment. 2. Record review for Resident #86 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included heart disease, Chronic Obstructive Pulmonary Disorder (COPD), and chronic respiratory failure. Review of Section O of the quarterly MDS assessment, dated 08/08/25, revealed the resident was assessed to have not received oxygen while a resident of the facility during the 14-day lookback period. Review of the physicians order, dated 05/30/25, revealed the resident was to be administered oxygen at a rate of three liters per minute by nasal cannula continuously. Interview with MDS Licensed Practical Nurse (LPN) #63 on 08/26/25 at 2:03 P.M. confirmed Resident #86 was documented to have been administered oxygen as ordered during the 14-day lookback period for the MDS assessment dated [DATE]. MDS LPN #63 confirmed Section O of the MDS assessment had been completed inaccurately. 3. Review of the medical record for Resident #27 revealed an admission date of 04/23/25 with (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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(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 - Some	diagnoses including hemiplegia, hemiparesis, dementia, hyperlipidemia, depression and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was cognitively intact and had impaired range of motion to one side upper extremities and lower extremities. Resident #27 needed supervision of staff to complete oral hygiene and partial to moderate assistance with personal hygiene. Resident #27 had no weight loss and no broken or loosely fitting dentures or partials. Review of the dental consult form completed by on site dentist dated 03/31/25 (prior admission) revealed Resident #27 had heavy plaque, moderate calculus, and missing teeth. Resident #27 had a upper and lower partial that did not fit. No follow up visit scheduled. Review of the nursing admission assessment dated [DATE] revealed Resident #27 had no natural teeth or tooth fragments and was edentulous. The assessment did not include Resident #27 had upper and lower partial. Observation on 08/26/25 at 10:16 A.M. of Resident #27 revealed he had approximately six or seven teeth that had heavy plaque. He was not wearing a partial. Interview on 08/27/25 at 3:01 P.M. with Resident #27 revealed he had an upper and lower partial that did not fit. Resident #27 stated he did not wear them because they were loose in his mouth. The resident denied any pain at this time or chewing problems with his teeth. Interview on 08/28/25 at 11:00 A.M. with Minimum Data Set (MDS) Registered Nurse (RN) #65 confirmed Resident #27 had few teeth remaining and per Resident #27 record he had an upper and lower partial. MDS RN #65 also confirmed the MDS quarterly assessment dated [DATE] was incorrectly marked that Resident #27 was edentulous and did not have broken or loosely fitting partial. 4. Review of the medical record for Resident #11 revealed an admission date of 04/15/25 with diagnosis including hypertensive heart failure, hemiplegia, hemiparesis, diabetes mellitus type two, ischemic cardiomyopathy, anxiety, depression and mood disorder. Review of the physician orders dated 08/25 revealed Resident #27 did not have any active orders for insulin. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was cognitively impaired and required assistance to complete activities of daily living. Review of the medication section of the MDS revealed Resident #27 received seven injections of insulin during the look back period of the assessment. Interview on 08/28/25 at 12:15 P.M. with MDS RN #65 confirmed Resident #11 was coded on the MDS dated [DATE] that he received seven injections of insulin during the look back period.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview the facility failed to ensure the dental status care plan was completed accurately. This affected two residents (#27 and #35) of three residents reviewed for dental care. The facility census was 85. Findings include: 1. Review of the medical record for Resident #27 revealed an admission date of 04/23/25 with diagnoses including hemiplegia, hemiparesis, dementia, hyperlipidemia, depression and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 was cognitively intact and had impaired range of motion to one side upper extremities and lower extremities. Resident #27 needed supervision of staff to complete oral hygiene and partial to moderate assistance with personal hygiene. Resident #27 had no weight loss and no broken or loosely fitting dentures or partials. Review of the dental consult form completed by on site dentist dated 03/31/25 (prior admission) revealed Resident #27 had heavy plaque, moderate calculus, and missing teeth. Resident #27 had a upper and lower partial that did not fit. No follow up visit scheduled. Review of the nursing admission assessment dated [DATE] revealed Resident #27 had no natural teeth or tooth fragments and was edentulous. The assessment did not include Resident #27 had upper and lower partial. Review of the plan of care initiated on 06/18/25 and revised on 08/28/25 (after surveyor confirmed plan was incomplete) revealed Resident #27 had oral/dental problems. The goal stated Resident #27 would be free of infection, pain, or bleeding in the oral cavity through the target date of 09/16/25. The interventions included to observe for signs and symptoms of infection such as abscess, swelling, fever, pain or redness. Observation on 08/26/25 at 10:16 A.M. of Resident #27 revealed he had approximately six or seven teeth that had heavy plaque. He was not wearing a partial. Interview on 08/27/25 at 3:01 P.M. with Resident #27 revealed he had an upper and lower partial that did not fit. Resident #27 stated he did not wear them because they were loose in his mouth. The resident denied any pain at this time or chewing problems with his teeth. Interview on 08/27/25 at 3:20 P.M. with Social Services Designee #33 revealed she scheduled ancillary services/appointments. The dental service and vision service was random however she did receive an email from the dentist about making a schedule for next visit. Social Service Designee #33 stated she made an appointment with an outside provide for Resident #27 to see about getting new upper and lower partial plates, however, the resident did not quality. The facility failed to provide evidence of the visit. Interview on 08/28/25 at 11:00 A.M. with Minimum Data Set (MDS) Registered Nurse (RN) #65 confirmed Resident #27 had few teeth remaining and per Resident #27 record he had an upper and lower partial. MDS RN #65 also confirmed the dental plan of care was not completed accurately. 2. Record review for Resident #35 revealed the resident was admitted to the facility on [DATE] and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had diagnoses which included heart failure, dementia, and need for assistance with personal care. Review of the state optional Minimum Data Set (MDS) assessment, dated 07/09/25, revealed the resident was assessed to have mildly impaired cognition. Review of the care plan, dated 08/08/25, revealed the resident had oral/dental problems-dentures. Interventions included complete oral assessment upon admission and as needed, dental consult as needed, and provide oral care as needed. Observation and interview with the Director of Nursing (DON) on 08/28/25 at 9:00 A.M. confirmed Resident #35 had her own teeth present in her mouth and did not have dentures. Interview on 08/28/25 at 11:00 A.M. with Minimum Data Set (MDS) Registered Nurse (RN) #65 confirmed the care plan for Resident #35 was inaccurate as it had been completed as though the resident had dentures and not her own natural teeth.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure resident medications were not left at the bedside unattended. This affected one resident (#13) out of the 24 residents observed during the initial pool process. The facility census was 85. Findings include: Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] and had diagnoses which included epilepsy, hemiplegia and hemiparalysis affecting the left non-dominant side, and contracture of the left hand. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/18/25, revealed the resident was assessed to have impaired cognition. Observation on 08/25/25 at 10:27 A.M. revealed Resident #13 was lying in bed with a tray table placed over the residents abdomen. The resident had a clear plastic medicine cup which was empty sitting on top of the tray table. Several pills were lying on top of the tray table and the resident was pushing them around with his fingers. No facility staff were present in the room. Interview with Resident #13 at the time of the observation confirmed the pills were his and he was going to take them. At 10:32 A.M. Licensed Practical Nurse (LPN) #143 was walking down the hallway pushing a medication cart and was asked to come into Resident #13's room. LPN #143 entered the room and observed the pills lying on top of Resident #13's tray table. LPN #143 confirmed they were the residents morning medications and assisted the resident to take the medications. LPN #143 confirmed it was difficult to get Resident #13 to take his medications, and they had been left in his room without staff supervision. LPN #143 confirmed nurses were to remain with residents until they had taken all medications.		