STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365462	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgetown Nursing and Rehabilitation Centre	4307 Bridgetown Road Cheviot, OH 45211

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital documentation, and staff interview, the facility failed to ensure admission medication orders were processed in a timely manner. This affected one (#80) of three residents reviewed for medication orders. The facility census was 43.Findings Include:Record review for Resident #80 revealed the resident was admitted to the facility on [DATE] and discharged on 06/12/26 with diagnoses including tracheostomy status, unspecified epilepsy, and unspecified convulsions. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 had impaired cognition and was assessed to be dependent on staff for all activities of daily living (ADLs). Review of Resident #80's hospital Discharge summary dated on 06/04/26 revealed the resident was to begin taking lacosamide, a medication to treat seizures, 10 milligrams per milliliter (mg/mL) with instructions for 20 mL (200 mg total) in the morning and 20 mL (200 mg total) before bedtime. The resident was also to begin taking levetiracetam (Keppra), a medication to treat seizures, 1000 mg with instructions for two (2) tablets (2000 mg total) in the morning and 2 tablets (2000 mg total) before bedtime; and valproic acid (Depakene), a medication to treat seizures, 15 mL (750 mg total) three times a day. Review of Resident #80's hospital after visit summary dated 06/04/26 revealed lacosamide, Keppra, and Depakene were not listed on the resident's medication list. Review of a nursing progress note revealed Resident #80 was admitted to the facility on [DATE] at approximately 2:15 P.M. Review of Resident #80's physician orders upon admission to the facility revealed the resident was not ordered lacosamide, Keppra, or Depakene on 06/04/26. The resident was ordered lacosamide 10 mg/mL with instructions to give 20 mL via gastrostomy tube (g-tube) twice daily on 06/05/26 at 8:12 A.M. No orders were initiated for the resident to be administered Keppra or Depakene. Review of Resident #80's June 2026 medication administration record revealed no evidence of the resident receiving Keppra or Depakene. Review of a progress note dated 06/06/26 revealed the resident was sent to the hospital and a progress note written on 06/12/26 revealed the facility was notified on 06/11/26 that Resident #80 would not be returning to the facility.Interview on 07/01/26 at 10:49 A.M. with Nurse Practitioner (NP) #114 confirmed she was not aware of Resident #80's orders for Keppra or Depakene from the hospital on [DATE]. Interview on 07/01/26 at 11:04 A.M. with MDS Coordinator #113 confirmed the facility was aware of Resident #80's seizure diagnoses prior to admitting the resident.Interview on 07/01/26 at 12:28 P.M. with the Director of Nursing (DON) confirmed the facility was to admit Resident #80 and the facility was only presented with the after visit summary dated 06/04/26. The DON stated NP #113 verified the orders the facility had at the time and put them in place. The DON confirmed Resident #80 had additional paperwork with him that was discovered by Licensed Practical Nurse (LPN) #43. LPN #43 went through the additional paperwork and notified the oncoming nurse, LPN #27.Interview on 07/01/26 at 12:41 P.M. with LPN #27 confirmed LPN #43 notified her of Resident #80 needing an order for lacosamide due to the order not being added. LPN #27 stated she notified the NP on 06/05/26 of the need for an order for lacosamide for Resident #80, but did not notify the provider of the need for Resident #80 to be ordered Keppra or Depakene. Interview on 07/01/26 at 1:28 P.M. with the DON confirmed the facility staff should have notified NP #114 of the need for Resident #80 to have orders for Keppra and Depakene.This deficiency represents non-compliance investigated under Complaint Number 3048797.

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