

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Bridgetown Nursing and Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, staff interview, and review of job description, the facility failed to ensure there was sufficient qualified nursing staff available to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. This directly affected seventeen residents (#1, #3, #11, #14, #17, #19, #20, #22, #26, #28, #29, #30, #32, #33, #36, #37, and #38) and had the potential to affect all residents. The facility census was 41. Medical record review for seventeen residents (#1, #3, #11, #14, #17, #19, #20, #22, #26, #28, #29, #30, #32, #33, #36, #37, and #38) revealed their Minimum Data Set assessments were not submitted timely. Interview on 09/02/25 at 2:00 P.M., with the Administrator in Training (AIT) #102 verified he had previously been the Director of Nursing (DON) for the building but was now the AIT. He stated he still helped out the acting Director of Nursing (DON) with her duties, as she was still the Minimum Data Set (MDS) nurse and the Infection Control Preventionist (ICP). Interview on 09/04/2025 at 10:58 A.M., with the Director of Nursing (DON)/Minimum Data Set (MDS) Nurse #112 verified there were many Resident MDS assessments that were late due to staffing issues she had to address as DON. DON #112 verified she was doing MDS duties, training staff to ensure resident care was being performed properly, performing infection control monitoring and ICP duties, and was the acting Director of Nursing, which started officially on 07/01/25. DON #112 stated since the MDS assessments weren't complete, the facility didn't have to submit them until the assessments were complete, which meant many were started but not completed and over 120 days past due. DON #112 stated she could not do it all of the tasks assigned to her and had to prioritize what she did and when, she prioritized new admissions assessments over quarterly and annuals, and other tasks over doing MDS assessments. DON #112 verified care plans were created from the MDS assessments. Review of the undated job description for the Director of Nursing (DON), revealed DON's duties and responsibilities included to implement and evaluate the overall operations of the Nursing Services Department while in accordance with federal, state, and local regulations.		

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and record review, the facility failed to provide meals that were attractive and appetizing. This affected three Residents (#03, #05, and #20,) however, it had the potential to affect all 36 residents who receive food at the facility. The facility identified five Residents (#08, #15, #30, #33, and #45) who do not receive food from the kitchen. The facility census was 41. Findings include: 1. Medical record review for Resident #03 revealed he was admitted to the facility on [DATE]. His diagnoses included, essential primary hypertension, emphysema, interstitial pulmonary disease, traumatic arthropathy, chronic fatigue, diabetes mellitus (DM), post-traumatic stress disorder (PTSD), chronic fatigue, gastro-esophageal reflux disease (GERD), and bipolar disorder. Review of Minimum Data Set Assessment (MDS) for Resident #03 dated 04/10/25 revealed he was cognitively intact. Resident #03 required set up assistance from staff with meals. Interview on 09/02/25 at 11:00 A.M., with Resident #03 revealed the food is always served cold and dose not taste good. 2. Medical record review for Resident #05 revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder, obesity, diabetes mellitus (DM), anxiety disorder, gastro-esophageal reflux disease (GERD), and schizoaffective disorder. Review of the MDS assessment dated [DATE] revealed she was cognitively intact. Resident #05 required set up assistance from staff for meals. Interview on 09/02/25 at 10:40 A.M., with Resident #05 revealed the food at the facility is always served cold and it does not always have a pleasant taste. 3. Medical record review for Resident #20 revealed she was admitted to the facility on [DATE]. Her diagnoses included, sepsis, intestinal obstruction, cellulitis, acute kidney failure, lymphedema, absence of left leg above ankle, urinary tract infection, anemia, supraventricular tachycardia, and major depressive disorder. Review of the most recent MDS assessment 04/18/25 revealed Resident #20 was cognitively intact. Resident #20 set up assistance from staff with eating. Interview on 09/02/25 at 12:25 P.M., with Resident #20 stated the food is terrible at the facility and the facility does not have what they list for alternatives on the menu. Observation on 09/02/25 at 12:35 P.M., revealed Certified Nurse Aide (CNA) #147 brought Resident #20 her lunch and uncovered the meal. Observed CNA #147 apologized to Resident #20 for the way her potato wedges looked. Resident #20 stated she was unsure what they were and CNA #147 stated she was not sure why they looked the way they did. 4. Observation of the test tray leaving the facility kitchen on 09/03/25 at 5:23 P.M. The test tray arrived on the second floor cart at 5:25 P.M. and all the trays were passed on the cart. Once all the trays were passed the test tray was obtained by Kitchen Consultant (KC) #500. KC #500 tested the temperature of the test tray. The coleslaw temperature was 65 degrees Fahrenheit (F), the macaroni and cheese was 115 degrees F, the pulled pork was at 124 degrees F, and the milk was 51 degrees F and the ice cream cup was at 19 degrees F. Interview KC #500 on 09/03/25 at 5:25 P.M., with Kitchen Consultant KC #500 stated the coleslaw tasted as if it was at a room temperature and the hot food did not taste hot. KC #500 stated the dinner tray was unappealing because it was not maintained at an appetizing temperature.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and policy review, the facility failed to maintain a maintain, store, and prepare food in a sanitary manner. This had the potential to affect all residents at the facility, who received food from the kitchen. The facility identified five Residents (#08, #15, #30, #33, and #45) who do not receive food from the kitchen. The facility census was 41. Findings include: Observation on 09/02/25 at 9:01 A.M., with the facility Administrator during the initial tour of the kitchen revealed the lights over the food preparation and steam table areas had multiple unknown brown items with legs attached inside the light. The ceiling fans had black fuzzy substance and debris all over them hanging over the food preparation area. The facility coffee pot was identified on the food preparation table with an electric socket hanging out from the wall and dry wall was observed in a pile around the back side of the coffee pot on the counter. Observation of the wall as you walk into the kitchen had a large hole in the dry wall as you approach the counter with the coffee pot. The wall was soiled with food splatter. The floor was heavily soiled and all along the wall and under the counters were heavily soiled with a black substance and food crumbs. The facility refrigerator contained a large clear plastic gallon tub of what appeared to be about forty hot dogs in water with no cover, no date, no label. The facility refrigerator contained three small containers of coleslaw with no label or date and six red drinks with lids no label or dates. A large cookie sheet of what appeared to be brownies no label or date. Located in front of the walk-in refrigerator was a metal shelf full of pans and behind the shelf was crumbs, food build up, dirt, debris, black grime. The kitchen knives in a container that hung above the metal shelves in front of the fridge had large crumbs and dirt build up on top of the container. Interview on 09/02/25 at 09:01 A.M., with the Administrator, during the initial tour of the kitchen, confirmed the lights over the food preparation and steam table areas had multiple brown items with legs attached inside the light. The ceiling fans had black fuzzy substance and debris all over them hanging over the food preparation area. The facility coffee pot was identified on the food preparation table with an electric socket hanging out from the wall and dry wall was observed in a pile around the back side of the coffee pot on the counter. The Administrator confirmed the wall as you walk into the kitchen had a large hole in the dry wall as you approach the counter with the coffee pot. The wall was soiled with food splatter. The floor was heavily soiled and all along the wall and under the counters were heavily soiled with a black substance and food crumbs. The Administrator confirmed the facility refrigerator contained a large clear plastic gallon tub of what appeared to be about forty hot dogs in water with no cover, no date, no label. The Administrator also confirmed refrigerator contained three small containers of coleslaw with no label or date and six red drinks with lids no label or dates. She confirmed a large cookie sheet of what appeared to be brownies no label or date. The Administrator confirmed the metal shelf located in front of the walk -in refrigerator was full of pans and behind the shelf was crumbs, food build up, dirt, debris, black grime. The Administrator confirmed the kitchen knives and container that hung above the metal shelves in front of the fridge had large crumbs and dirt build up top of the container. The Administrator confirmed the floor along the stove and under the stove had a large amount of food crumbs, dirt, and debris under [NAME] and round the stove and food preparation area. The trash cans did not have lids on them. The Administrator confirmed no lid was available. The Administrator confirmed the hallway outside the dry food storage area had a soiled floor with food crumbs dirt and debris, the dry food area under the metal shelf had dead bugs, live spiders, dried food, soiled spills, dirt, debris, and crumbs all over along with crumbs and debris. The ice machine has a wall with dirt debris and flood splatter all over it. Observation on the initial tour of the kitchen continued on 09/02/25 at 10:28 A.M. with the Administrator in the dishwasher machine room. The light over the three compartment sink did not have a cover on it and exposed florescent light bulbs. Observed the ceiling paint was chipped and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hanging down over the three compartment sink. Observed the dish machine was a high temperature machine and the was should reach 160 degrees Fahrenheit (F) and 180 F for the rinse. Observed the dishwasher was ran a total of three times and never reached a temperature above 165 for both a wash and rinse. The Administrator confirmed the facility failed to keep a dishwasher temperature log. Interview with the Administrator when the initial tour of the kitchen continued on 09/02/25 at 10:28 A.M. into the dishwasher machine room. The Administrator confirmed the light over the three compartment sink did not have a cover on it and exposed florescent light bulbs. The Administrator confirmed the ceiling paint was chipped and hanging down over the three-compartment sink. The Administrator confirmed the dish machine was a high temperature machine and the was should reach 160 degrees Fahrenheit (F) and 180 F for the rinse. The Administrator confirmed the dishwasher was ran a total of three times and never reached a temperature above 165 for both a wash and rinse. The Administrator confirmed the facility failed to keep a dishwasher temperature log. The Administrator stated the plan will be for the facility to utilize plastic ware and paper until the dishwasher is repaired. The Administrator confirmed the dishwasher had a pile of food crumbs dirt debris and food splatter all over the top of the dishwasher. The Administrator confirmed the floor around the dishwasher was heavily soiled with a black substance food crumbs and debris. Observation on the lunch time meal on 09/02/25 at 12:35 P.M. revealed Resident # 20 was served her lunchtime meal on regular plates and silverware even though the facility stated they would utilize paper products until the dishwasher was repaired. Interview on 09/02/25 at 12:35 A.M. with certified nurse aide (CNA) #147 confirmed the lunchtime meals was served on regular facility plates, hot plates, and silverware. Interview on 09/02/25 at 3:08 P.M., in a follow up interview with the Dietary Manager (DM) #499 confirmed the facility utilized the facility plates and silver for lunch meal and will utilize for dinner meal even though the facility dishwasher has not been repaired and is not reaching a temperature to properly sanitize the dishes. A request was made for the dishwasher temperature log for the past three months. There was no records provided. Observation on 09/02/25 at 4:22 P.M. with DM #499 revealed the dishwasher reached a wash temperature of 145 F (should reach a minimum of 160 F) and a rinse temperature of 175 F (should reach a minimum of 180). Interview at this time with DM #499 confirmed the facility failed to obtain and log dishwasher temperature logs for the past three months. Review of the undated and untitled policy for the kitchen stated the purpose of the policy was to establish sanitation standards that prevent foodborne illness, ensure compliance with Ohio food safety laws, and maintain a clean, safe environment for service operations. Further review of the policy confirmed dish machines must be monitored for final rinse temperature or sanitizer concentration. For labeling and dated the facility has foods held in the refrigerator for more than twenty-four hours must be clearly marked with the date they must be consumed or discarded within seven days of preparation counting preparation day as day one. Items from manufacturer should be re-dated when opened. Labels should not extend beyond the manufacture's use by date. The facility must maintain logs for inspections and audits.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and policy review, the facility failed to ensure staff doffed personal protection equipment (PPE) appropriately, failed to perform hand hygiene after providing direct care, and failed to ensure there was a proper receptacle for disposing of PPE for residents in Enhanced Barrier Precautions. This affected one (#8) of 14 residents sampled for infection control. The census was 41. Findings include: Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Diagnoses included type II diabetes, recurrent major depressive disorder, and aphasia following cerebral infarction. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 had severely impaired cognition, had physical behaviors, did not wander, and occasionally rejected care. Review of care plan dated 09/02/25 revealed Resident #8 required tube feeding. Interventions included elevating head of bed during and following feeds, checking residual volume and gastric contents, maintaining enhanced barrier precautions, and monitoring/reporting adverse effects and signs of infection. Observation on 09/03/25 at 3:27 P.M., revealed Certified Nurse Aides (CNA's) #129 and #145 donned PPE including gloves, isolation gowns, and faces masks to provide incontinence care and repositioning to Resident #8. After direct care was completed, CNA #145 doffed her gloves and washed her hands in the resident's bathroom. CNA #129 doffed her dirty gloves and carried them with tied bags of soiled lined and trash out of the resident's room. Both CNA #129 and #145 exited Resident #8's room wearing isolation gowns and facemasks, doffed these items in the hallway, and carried the items in their hands down the hallway to the soiled utility room. There was no trash receptacle near the door designated for PPE disposal, and there was no accessible hand sanitizer located inside or directly outside of Resident #8's room. During concurrent interviews on 09/03/25 at 3:42 P.M. with CNA's #129 and #145 each confirmed they did not doff PPE prior to exiting Resident #8's room. Each stated they put PPE in the soiled utility down the hall and verified there was no special trash can in Resident #8's room to doff PPE before exiting. CNA #129 stated I wish there was a hand sanitizer dispenser nearby and gestured towards the wall by Resident #8's room door. Review of policy titled Enhanced Barrier Precautions, dated 2024, revealed regarding the implementation of Enhanced Barrier Precautions (EBP), the facility ensured access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room) and positioned a trash can inside the resident room near the exit for discarding PPE after removal and prior to exit of the room.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, staff interview, pest control contract review, and policy review, the facility failed to have an effective pest control program for the kitchen. This had the potential to affect all residents at the facility. The facility census was 41. Findings include: Observation during the tour of the kitchen on 09/02/25 at 9:01 A.M., with the facility Administrator revealed the lights over the food preparation and steam table area had multiple unknown brown items that appeared to be bugs. The dry food storage area had a soiled floor with food crumbs and debris scattered under the metal shelf with spider webs and cobs webs in the corners of the metal shelf. An observation of dirt, debris, food crumbs, liquid stains, along with dead bugs and live spiders were identified in between and under the shelves of dry food. Interview on 09/02/25 at 9:01 A.M., with the Administrator, during the initial tour of the kitchen, confirmed the lights over the food preparation area and steam table area had multiple brown items and the brown items scattered throughout the kitchen fluorescent lights had legs attached to them. The dry food storage area had a soiled floor with food crumbs and debris scattered under the metal shelf with spider webs and cobs webs in the corners of the metal shelf. The in between the shelves and the walls dead bugs and live spiders were identified. Observation on 09/03/25 at 4:40 P.M., revealed the kitchen light over the food steam table had multiple brown bugs throughout the light cover over food steam table. Interview with the Kitchen Consultant (KC) #500 on 09/03/25 at 4:40 P.M. confirmed the unidentified brown bugs throughout the light cover over the food steam table. Review of the facility pest control contract agreement, dated 07/01/19, revealed the kitchen will be treated with each service visit monthly. Review of the undated policy titled, Pest Control, confirmed the facility will maintain an effective pest control program. Further review of the facility policy stated the facility maintains an on-going effective pest control program to ensure that the building is kept free of insects and rodents. Review of the untitled and undated policy for the kitchen stated the purpose of the policy was to establish sanitation standards that prevent foodborne illness, ensure compliance with Ohio food safety laws, and maintain a clean, safe environment for service operations. Further review of the policy confirmed the facility will report signs of infestation immediately (droppings, gnaw marks, insects). Seal entry points and maintain screens/doors in good repair. This deficiency represents the noncompliance identified during the complaint investigation of Complaint Number 1348503		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure resident assessments were completed in a timely manner. This affected seventeen (#1, #3, #11, #14, #17, #19, #20, #22, #26, #28, #29, #30, #32, #33, #36, #37, and #38) of seventeen residents reviewed for resident assessments. The facility census was 41. Findings include: 1. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included unspecified vascular dementia, combined heart failure, chronic obstructive pulmonary disease, and hemiplegia and hemiparesis following cerebral infarction. Review of the medical record revealed Resident #1 had an annual minimum data set (MDS) assessment created on 06/12/25 that was In progress and had not been submitted. There was a note written in red letters which indicated the Assessment Reference Date (ARD) for the fourth quarter date 06/13/25 was 69 days overdue and the ARD for 07/03/25 was 49 days overdue. 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with a diagnosis of epilepsy. Review of the quarterly MDS revealed dated 07/09/25 was still In Progress. There was a note written in red letters which indicated the ARD for the second quarter dated 07/11/25 was 41 days overdue. 3. Review of the medical record revealed Resident #11 had an admission date 05/31/24, with diagnoses including Chronic respiratory failure with hypoxia and dependence on respirator status. Review of the Annual MDS dated [DATE], Discharge Return Anticipated dated 08/19/25, and Entry dated 08/23/25 showed as In Progress. 4. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE]. Diagnoses included unspecified Parkinsonism, anxiety disorder, unspecified dementia, type II diabetes, and obesity. Review of the annual MDS assessment created on 06/18/25, that was in progress and was not submitted. 5. Review of the medical record revealed Resident #17 had an admission date of 03/12/25, with diagnoses including sepsis and bacteremia. Review of the quarterly MDS revealed a review date of 06/19/25 was marked In Progress. There was a note written in red letters which indicated the ARD for the first quarter dated 06/19/25 was 63 days overdue. 6. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE]. Diagnoses included unspecified malignant neoplasm of the mouth, unspecified malignant neoplasm of the tongue, unspecified anxiety disorder, type II diabetes, major depressive disorder, and epilepsy. Review of the annual assessment dated [DATE] was in Progress and was not completed or (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	submitted. There was a note written in red letters which indicated the ARD for the fourth quarter on 07/10/25 was 42 days overdue. 7. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included cellulitis of the right lower limb, malignant neoplasm of unspecified breast, unspecified heart failure, major depressive disorder, chronic obstructive pulmonary disease, and morbid obesity. Review of the quarterly assessment dated [DATE] was in progress and was not submitted. There was a note written in red letters which indicated the ARD for quarter one dated 07/10/2025 that was 42 days overdue. 8. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE]. Diagnoses included recurrent major depressive disorder, Parkinson's disease, unspecified dementia, unspecified anxiety disorder, and type II diabetes. Review of the quarterly MDS assessment created on 08/02/25 was in progress and was not submitted. There was a note in red letters which indicated the ARD for third quarter dated 08/02/25 was 19 days overdue. 9. Review of the medical record revealed Resident #26 had an admission date of 05/17/23, with diagnoses including pulmonary edema and epilepsy. Review of the quarterly MDS with review dated 08/01/25 and was still In Progress. There was a note written in red letters which indicated the ARD for the for the first quarter dated 08/02/25 was 19 days overdue. 10. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE]. Diagnoses included cerebral palsy, unspecified anxiety disorder, visual hallucinations, unspecified intellectual disabilities, localization-related symptomatic epilepsy, and unspecified paralytic syndrome. Review of the quarterly MDS assessment dated [DATE] was in progress and was not completed or submitted. There was a note written in red letters which indicated the ARD for the third quarter dated 07/05/25 was 47 days overdue. 11. Review of the medical record revealed Resident #29 had an admission date of 05/30/19, with diagnoses including chronic obstructive pulmonary disease and vascular dementia. Review of the quarterly MDS review dated 08/01/25 was still In Progress. There was a note written in red letters which indicated the ARD for the first quarter dated 08/02/25 was 19 days overdue. 12. Review of the medical record revealed Resident #30 had and admission date of 07/22/24 with diagnoses including sepsis and non-ST elevation (NSTEMI) myocardial infarction. Review of the annual MDS review was In Progress. There was a note written in red letters which indicated the ARD for the fourth quarter dated 08/01/25 was 20 days overdue. 13. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses included type II diabetes, diastolic heart failure, and chronic kidney disease stage III. Review of the quarterly MDS assessment was created on 07/18/25, was still in progress and had not been submitted. There was a note written in red letters which indicated the ARD for the first quarter on 07/23/25 was 29 days overdue. 14. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure, cerebral palsy, dependence on a ventilator, interstitial pulmonary disease, generalized anxiety disorder, major depressive disorder, post-traumatic stress disorder, type II diabetes, and morbid obesity. Review of the annual MDS assessment created 06/16/25 and was in progress and was incomplete. Additionally, Resident #33 had an MDS for Discharge Return Anticipated dated 07/17/25 that was in progress and was not submitted. There was a note written in red letters which indicated the ARD for the third quarter was 47 days overdue. 15. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, severe depressive-type bipolar disease, major depressive disorder, and prediabetes. Review of the quarterly assessment dated [DATE] that was in progress and was not submitted. There was a note written in red letters which indicated the ARD for the first quarter dated 06/26/25 that was 56 days overdue. 16. Review of the medical record revealed Resident #37 was admitted on [DATE]. Diagnoses included type II diabetes, chronic obstructive pulmonary disease, unspecified bipolar disorder, unspecified anxiety disorder, and unspecified heart failure. Review of the quarter MDS created 07/14/25 was in progress and was not completed or submitted. There was a note written in red letters which indicated the ARD for the first quarter dated 07/15/25 was 37 days overdue. 17. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE]. Diagnoses included unspecified bipolar disorder, unspecified major depressive disorder, type II diabetes, unspecified anxiety disorder, and stage IV chronic kidney disease with dependence on renal dialysis. Review of the quarterly MDS dated [DATE] that was in progress and was not submitted. There was a note written in red letters which indicated the ARD for the second quarter dated 06/28/25 was 54 days overdue. Interview on 09/04/25 at 10:58 A.M., with Registered Nurse (RN) #112 confirmed there were multiple MDS assessments that were late due to staffing issues as she was doing MDS, training staff, doing infection control, and acting Director of Nursing - starting officially on 07/01/25. Some of the MDS were completed on paper and not in the electronic record. RN #112 stated she couldn't do it all and had to prioritize what she did and when. She prioritized new admissions over quarterlies and annuals. Review of the undated policy titled Electronic Transmission of the MDS revealed all MDS assessments were completed and electronically encoded into the facility's MDS information system (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Bridgetown Nursing and Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 4307 Bridgetown Road Cheviot, OH 45211	
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and transmitted to the CMS Internet Quality Improvement and Evaluation System (IQIES) in accordance with OBRA regulations governing the transmission of MSD data.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, staff interview, and policy review, the facility failed to provide a clean and sanitary homelike environment. This affected two (#01, #05) out of two residents reviewed for environment. The facility census was 41. Findings include: 1. Medical record review for Resident #01 revealed he was admitted to the facility on [DATE]. His diagnoses included atrial fibrillation (AFIB), sepsis, gastro-esophageal reflux disease (GERD), primary generalized arthritis, vascular dementia, anxiety, congestive heart failure (CHF), chronic obstructive pulmonary disease, asthma, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed he had impaired cognition. Resident #01 was dependent on staff for medication administration, toilet use, bathing, and personal hygiene. He required maximum assistance from staff with oral hygiene. He required supervision from staff regarding eating. Observation on 09/04/25 at 12:16 P.M., revealed Resident #01's room had a privacy curtain that had a large brown stain, the floor was soiled throughout the room, with food crumbs and debris were identified under the bed. Resident #01's bed frame appeared to be heavily soiled with a build up outside the mattress and on the bed rails. Resident #01 had heavily soiled bedside table. Observed food crumbs and debris under the bed and Resident #01's pillow had a heavily soiled pillowcase. Interview on 09/04/25 at 12:17 P.M., with Certified Nurse Aide (CNA) #147 confirmed the heavily stained privacy curtain in Resident #01's room. The curtain had a large unknown brown stain down the front of the curtain. CNA #147 pulled the curtain toward her and exposed several dried stains and splatters throughout the curtains. CNA #147 confirmed Resident #01 had a heavily soiled bed frame with dirt and debris built up throughout out the bed frame outside of the mattress near the bed rails. CNA #147 confirmed Resident #01's bedside table was heavily soiled with stains and debris. CNA #147 confirmed the floor in Resident #01's room had dirt and debris throughout the room and food crumbs identified under the headboard of the bed. CNA #147 confirmed Resident #147 had what appeared to be an unknown dried caked substance on his pillow. 2. Medical record review for Resident #05 revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder, obesity, diabetes mellitus (DM), anxiety disorder, gastro-esophageal reflux disease (GERD), and schizoaffective disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] revealed she was cognitively intact. Resident #05 was dependent on staff for medication administration, she required set-up assistance from staff for meals, oral hygiene, toilet use, dressing and personal hygiene. Observation on 09/07/25 at 12:13 P.M., revealed Resident #05 had an unknown fuzzy black and brown substance on the floor under her bathroom sink; the bathroom floor was heavily soiled with black buildup. The wall in the bathroom is a long smudge of black over the top of the handrail. The floor alongside the bed of Resident #05 was chipped and the flooring was ragged and chipped in spots with what appeared to have had pervious fall strips in place that were removed. Interview on 09/07/25 at 12:15 P.M., with CNA #147 confirmed Resident #05 had an unknown fuzzy black and brown substance on the floor under her bathroom sink, the bathroom floor was heavily soiled with black buildup. The wall in the bathroom is a long smudge of black over the top of the handrail. CNA #147 confirmed the floor alongside the bed of Resident #05 was chipped and the flooring was ragged and chipped in spots with what appeared to have had pervious fall strips in place that were removed. Review of the undated policy titled Environmental Services indicated all resident rooms will be cleaned each day. Further review of the policy confirmed that one of the daily tasks for housekeepers is to clean each resident room and bathroom daily. This deficiency represents the noncompliance identified during the complaint investigation of Complaint Number 1348503.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to provide a bed hold notification to a resident upon discharge to the hospital. This affected one (#20) out of two residents reviewed for discharge to the hospital. The facility census was 41. Finding include: Medical record review for Resident #20 revealed she was admitted to the facility on [DATE]. Her diagnoses included: sepsis, intestinal obstruction, cellulitis, acute kidney failure, lymphedema, absence of left leg above ankle, urinary tract infection, anemia, supraventricular tachycardia, and major depressive disorder. Review of the most recent Minimum Data Set assessment dated [DATE] revealed Resident #20 was cognitively intact. Resident #20 was dependent on staff for medication administration and toilet use. She required moderate assistance from staff with bathing, dressing, personal hygiene, and toilet use. Resident #20 required set up assistance from staff with eating and oral hygiene. Review of Resident of the progress notes for Resident #20 revealed she was discharged to the hospital on [DATE]. Resident #20 returned to the facility 04/30/25. The medical record contained no documentation of a bed hold notice being provided. Interview on 09/04/25 at 10:23 A.M., with the Administrator confirmed the facility does not provide residents with bed hold notifications upon discharge from the facility. The Administrator stated it was easier for the facility to provide each residents with a monthly note of their bed hold status. The Administrator confirmed if a resident were to admit or discharge from the facility throughout the month they would not receive notification of the bed hold until the end of the month. The Administrator confirmed there was no evidence of Resident #20 receiving bed hold information upon discharge. Review of the policy titled Nursing and Rehabilitation Bed-Hold Policy, dated 05/30/25 and signed by Resident #20 revealed Resident #20 had 19 bed hold days remaining for 2025. Further review of the policy revealed the Policy was a fill in the blank policy to be signed by the resident. The policy read as followed: I ____ (resident name) ____ receive Medicaid covered services and wish for a bed to be held for me. I understand that I have 30 days per year and I currently have ____ (number of days) ____ days remaining. A line was available for resident's signature.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to properly assess a resident's Pre admission Screening and Resident Review (PASARR) screen. The facility failed to identify a mental health diagnosis. This affected one (#03) out of four residents reviewed for PASARR screening. The facility census was 41. Findings include: Medical record review for Resident #03 revealed he was admitted to the facility on [DATE]. His diagnoses included, essential primary hypertension, emphysema, interstitial pulmonary disease, traumatic arthropathy, chronic fatigue, diabetes mellitus (DM), post-traumatic stress disorder (PTSD), anxiety, chronic fatigue, gastro-esophageal reflux disease (GERD), and bipolar disorder. Review of Minimum Data Set Assessment (MDS) for Resident #03 dated 04/10/25 revealed he was cognitively intact. Resident #03 was dependent on staff for medication administration. Resident #03 required set up assistance from staff with meal set up, oral hygiene, and upper body dressing. Resident #03 required supervision from staff with personal hygiene, bathing, and toilet use. Review of Resident #03 Preadmission Screening and Resident Review Notice (PASARR) dated 12/27/24 revealed the facility failed to identify Resident #03's diagnoses of Post Traumatic Stress Disorder (PTSD) and anxiety disorder. Interview on 09/04/25 at 11:15 A.M., with Registered Nurse and Administrator in Training confirmed the facility failed to properly screen Resident #03 when the facility failed to complete an accurate PASARR screening and failed to properly identify the diagnoses of anxiety disorder and (PTSD).		

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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, resident interview, staff interviews, and policy review, the facility failed to ensure residents had complete and accurate comprehensive care plans. This affected three (#1, #3 and #44) of fourteen residents reviewed for care plans. The facility census was 41. Findings include: 1. Medical record review for Resident #01 revealed he was admitted to the facility on [DATE]. His diagnoses included atrial fibrillation (AFIB), sepsis, gastro-esophageal reflux disease (GERD), primary generalized arthritis, vascular dementia, anxiety, congestive heart failure (CHF), chronic obstructive pulmonary disease, asthma, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed he had impaired cognition. Resident #03 was dependent on staff for medication administration, toilet use, bathing, and personal hygiene. He required maximum assistance from staff with oral hygiene. He required supervision from staff with eating. Review of the care plans for Resident #01 revealed no care plan was in place for dementia or impaired cognition. Interview on 09/04/25 at 10:42 A.M., with the Director of Nursing (DON) confirmed the Resident #01 had a diagnosis of dementia. The DON confirmed the facility failed to develop and implement a plan for care for the Resident #01's dementia diagnosis. 2. Medical record review for Resident #03 revealed he was admitted to the facility on [DATE]. His diagnoses included, essential primary hypertension, emphysema, interstitial pulmonary disease, traumatic arthropathy, chronic fatigue, diabetes mellitus (DM), post-traumatic stress disorder (PTSD), chronic fatigue, anxiety, gastro-esophageal reflux disease (GERD), and bipolar disorder. Review of the MDS dated [DATE] revealed he was cognitively intact. Resident #03 was dependent on staff for medication administration. Resident #03 required set up assistance from staff with meal set up, oral hygiene, and upper body dressing. Resident #03 required supervision from staff with personal hygiene, bathing, and toilet use. Review of the care plans for Resident #03 revealed no care plan related to the diagnosis of PTSD or anxiety. Interview on 09/04/25 at 10:42 A.M. , with the DON confirmed the facility failed to complete a care plan for Resident #03 related to his diagnoses of PTSD and anxiety. 3. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, recurrent major depressive disorder, unspecified parkinsonism, and unspecified bipolar disorder. Review of the most recent MDS assessment dated [DATE] revealed Resident #44 had severely impaired cognition, had physical, verbal, and self-directed behaviors, did not wander, and occasionally rejected care. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/02/25 at 9:43 A.M., with Resident #44 indicated she was edentulous and had a full set of dentures. She stated she thought she needed a new set. Review of the care plans for Resident #44 dated 05/17/23 had no plan of care related to dental needs. Interview on 09/03/25 at 1:30 P.M., with Social Services (SS) #108 stated the facility used 360-care for dental services. They were last in the building in July. SS #108 stated Resident #44 was last seen by dental services on 04/06/25 for denture concerns. Interview on 09/03/25 at 2:54 P.M., Administrator-In-Training (AIT) #102 verified Resident #44's comprehensive care plan was incomplete and did not have any reference to dental needs. Review of the undated policy titled Care Plans, Comprehensive Person-Centered, revealed the comprehensive, person-centered care plans described services that were furnished to maintain a resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews, staff interviews, and policy review, the facility failed to ensure residents were provided care conferences and revise care plans as needed. This affected two (#05 and #44) of fourteen residents sampled for care plans. The census was 41. Findings include: 1. Medical record review for Resident #05 revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder, obesity, diabetes mellitus (DM), anxiety disorder, gastro-esophageal reflux disease (GERD), and schizoaffective disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE] revealed she was cognitively intact. Resident #05 was dependent on staff for medication administration, she required set up assistance from staff for meals, oral hygiene, toilet use, dressing and personal hygiene. Review of the progress for Resident #05 dated 05/29/25 revealed Resident #05 reported she rolled out of bed the previous Saturday (05/24/25). Resident #05 reported to the nurse she slipped when she attempted to stand. No immediate intervention was listed in the progress notes. Review of Resident the Fall Care Plan for Resident #05 dated 04/18/24 revealed Resident #05 was at risk for falls related to her above the knee amputation (aka), medication regimen, and comorbidities. Her interventions included, follow fall protocol and therapy as ordered physical and occupational. No other information was provided. Interview on 09/03/25 at 10:59 A.M., with the Director of Nursing revealed the facility completed an Interdisciplinary Team (IDT) team risk review on 05/30/25 and the facility determined that Resident #05's intervention from her fall would be non skid socks. The DON confirmed the facility failed to update Resident #05's care plan with fall intervention. 2. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, recurrent major depressive disorder, unspecified parkinsonism, and unspecified bipolar disorder. Review of the most recent MDS assessment dated [DATE] revealed Resident #44 had severely impaired cognition, had physical, verbal, and self-directed behaviors, did not wander, and occasionally rejected care. Review of the medical record revealed no documentation regarding quarterly care conferences. Interview on 09/02/25 at 9:46 A.M. , with Resident #44 stated she did not have regular care conferences and staff did not ask her what her care goals were. Interview on 09/03/25 at 1:35 P.M., with Social Services #108 verified she had no notes for care conferences with Resident #44 and/or family. SS #108 stated she had care conferences every time it was indicated on the MDS and spoke with the resident about concerns but did not document care conferences. Review of the undated policy titled Care Plans, Comprehensive Person-Centered, revealed the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was informed of his/her right to participate in treatment planning and was given advance notice of care planning conferences. If participation was determined not to be practicable, an explanation was documented in the resident's medical record.		

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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** Based on observation, record review and staff interview, the facility failed to ensure residents were wearing physician ordered splint devices. This affected one (#16) of one residents reviewed for range of motion. The facility census was 41. Findings include: Review of Resident #16's medical record revealed an admission date of 06/07/24, with diagnoses including peripheral vascular disease and supraventricular tachycardia. Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 had severe cognitive impairment and occasionally refused care. Review of physician orders dated 05/25/25 for a left resting hand splint to be applied in A.M. and check skin integrity every shift. Review of care plan dated 06/05/25 for the left wrist splint, to check skin every shift upon don and doff for signs and symptoms of skin break down. Review of care plan revealed no indication of refusal of care. Observation on 09/02/25 at 9:30 A.M. revealed Resident #16 did not have left hand splint. Observation on 09/02/25 at 11:00 A.M. revealed Resident #16 did not have left hand splint. Observation on 09/02/25 3:01 P.M. revealed Resident #16 did not have left hand splint. Observation on 09/03/25 at 10:43 A.M. revealed Resident #16 did not have left hand splint. Interview on 09/03/25 at 11:00 A.M. , with the Administrator in Training (AIT) #102 and Licensed Practical Nurse (LPN) #121 verified Resident #16 did not have her splint on. LPN #121 stated the night shift put the splint on her left hand, but Resident #16 frequently removed it. LPN #121 verified staff did not document when Resident #16 removed her splint or when it was reapplied.		

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of personnel files and staff interview, the facility failed to complete a performance review of Certified Nurse Aides (CNA) or annually. This had the potential to affect all 41 residents in the facility. The census was 41. Findings include: Review of personnel files revealed CNA #131 was hired on 09/08/08 and had no annual performance evaluation. Review of personnel files revealed CNA #136 was hired on 08/09/19 and had no annual performance evaluation. Interview with Administrator on 09/04/25 at 9:28 A.M. confirmed that no CNA evaluations were incomplete.		