STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495370	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewater Home , Inc.	302 North Second Street Bridgewater, VA 22812

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview, clinical record review, and facility document review, the facility staff failed to develop comprehensive care plans (CCPs) that included the residents current code status for all residents in the survey sample. The findings included:The facility staff failed to develop CCPs that included the residents current code status. During the clinical record review, the surveyors were unable to locate information on the resident's CCPs that referenced their current code status. On 01/21/26 at 5:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Infection Preventionist the issue with the code status not being on the resident's CCP was reviewed. On 01/22/26 at 10:00 a.m., the facility staff provided the survey team with a copy of their policy titled, Comprehensive Person-Centered Care Planning. This policy read in part, .will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. On 01/22/26 at 10:30 a.m., during an interview with the Social Worker (SW) this staff stated they did not realize they needed to include the code status on the CCP and felt as if the resident's code status order was part of the CCP. No further information regarding this issue was provided to the survey team prior to the exit conference.

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident interview, staff interview, and facility document review, the facility staff failed to recognize and respect the residents' right to exercise their rights as a resident/citizen of the United States to send/receive mail. The findings included:For the facility, the facility staff failed to recognize and respect the residents' right to exercise their rights as a resident/citizen of the United States to send/receive mail on Saturdays. On 1/21/2026 at 2:50 PM, this surveyor met with six members of the Resident Council, Resident #12, Resident #77, Resident #85, Resident #101, Resident #104, and Resident #117. The residents' concurred mail is not delivered to them on Saturdays at the facility. This concern was discussed at the end of day meeting on 1/21/26 at 5:08 PM with the administrator, director of nursing, and infection preventionist. On 1/22/26 at 8:41 AM, this surveyor interviewed other staff #4 (OS#4) and OS#4 informed surveyor the post office takes the mail to the main desk in the main lobby and the post office does not deliver mail on Saturdays because there is no one available to receive the mail. The receptionist brings the mail up to the units every day but Saturday. On 1/22/26 at 12:31 PM, this surveyor interviewed other staff #6 (OS#6) via phone conversation and OS#6 informed surveyor the postal service does not deliver to the facility on Saturdays because there is no one in the reception area of the facility and the lights are out. OS#6 informed surveyor that someone from the facility could pick-up the mail from the post office on Saturdays if they wanted to as the mail carriers are there until 11:30 AM. OS#6 also informed surveyor the post office could deliver the mail to the facility on Saturdays if they had a big mailbox to leave it in or a staff member there to receive it. On 1/22/26 at 12:39 PM, this surveyor interviewed other staff #7 (OS#7) and OS#7 informed this surveyor the receptionist works from 9:00 AM-5:00 PM Monday through Friday. OS#7 informed surveyor they had spoken with the post office and the postal carrier would deliver the mail on Saturdays, but there is no one available to take the mail. OS#7 agreed the facility residents could receive mail on Saturdays if someone was at the reception area and informed surveyor Saturdays are not the receptionist's hours. Surveyor requested and received a facility policy titled, Resident's Rights with a created date of 1/2019 which read in part, .[name of facility omitted] recognizes and respects that each resident has the right to exercise his or her rights as a resident of this community and as a citizen or resident of the United States.The resident has the right to send and receive mail. No further information was provided to the survey team prior to exit on 1/22/26.

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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. Based on observation, staff interview, and clinical record review, the facility staff failed to maintain a comfortable homelike environment for 1 of 28 residents in the survey sample, Resident #105.The findings included:A large area of drywall/sheetrock next to the resident's bed was visibly scuffed and damaged.Resident #105's diagnoses included Alzheimer's disease and dementia.Section C (cognitive patterns) of Resident #105's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/24/25 had been coded to indicate this resident was moderately impaired in cognitive skills for daily decision making.On 01/20/26 during initial tour of the facility the surveyor observed a large area of drywall beside the resident's bed to be scuffed and damaged.A second observation was made of this area on 01/21/2026 at 4:39 p.m. On 01/21/2026 at 5:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Infection Preventionist the issue with Resident #105's drywall being damaged and in need of repair was reviewed. On 01/22/2026 at 8:30 a.m., the Home Maintenance Supervisor was interviewed regarding the damaged area on Resident #105's wall. This staff stated they were not aware of the area, and they do patch and paint upon request. The Home Maintenance Supervisor stated he did not have a work order for this area. On 01/22/2026 at 9:15 a.m., Maintenance Personnel #1 was observed by the surveyor patching this area. This staff stated he did not have a work order prior to today. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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 staff interview, clinical record review, and facility document review, the facility staff failed to provide written notification of the reason(s) for transfer/discharge to the resident's representative and/or failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer/discharge for (2) two of (28) twenty-eight sampled residents, Resident #121 and Resident #2. The findings included:1.For Resident #121 the facility staff failed to provide written notification of the reason(s) for transfer/discharge to the resident's representative and failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer/discharge for a transfer/discharge that occurred on 12/8/25. Resident #121's diagnosis list indicated diagnoses that included, but were not limited to, neoplasm of the brain, hydrocephalus, hypertension, urinary retention, and hyponatremia. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 11/20/25, Section C (Cognitive Patterns) was coded to reflect the resident was never/rarely understood, exhibited short and long-term memory problems, and was severely impaired in decision making, indicating the resident was severely impaired in cognition. A review of the clinical record disclosed Resident #121 was transferred to the hospital on [DATE]. No evidence of a written notice of the reason(s) for the transfer/discharge being provided to the resident representative could be located and no evidence the bed hold policy was provided to the resident and/or resident representative could be located. Surveyor requested evidence of written notice for the reason(s) transfer/discharge was provided to the resident representative and requested evidence the bed hold policy was provided to the resident and/or resident representative for the transfer/discharge on [DATE]. On 1/22/26 at 10:06 AM, other staff #1 (OS#1) informed this surveyor that nothing in writing could be located for the bed hold, as this was verbal and the facility practice is to always hold the bed for residents. On 1/22/26 at 12:46 PM, the director of nursing (DON) informed this surveyor the bed hold would not have been sent with the resident and there was no evidence of written notice being sent to the resident's representative as she lives three hours away. This concern was discussed at the pre-exit meeting on 1/22/26 at 12:59 PM with the administrator and director of nursing. Surveyor requested and received a facility policy titled, .Initiated Transfer and Discharge with an origination date of 1/2019 which read in part, .will notify.the resident's representative(s) of the transfer or discharge and the reasons for the move in writing.b. Notice must be made as soon as practicable.iv) An immediate transfer or discharge is required by the resident's urgent medical needs.9. The written notice will include.a)The reason for transfer or discharge. Surveyor requested and received a facility policy titled, Acknowledgement of Bed-Hold Policy which read in part, .Our bed hold policy ensures that the resident has a bed to return to following a hospital (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stay.Reason for this notice.You are being transferred to the hospital for further evaluation and treatment. No further information regarding this concern was presented to the survey team prior to the exit on 1/22/26. 2. Resident #2 (R2) did not receive required bed hold policy upon discharge to the hospital with return to facility anticipated. R2 diagnoses include heart failure, venous embolism, edema, chronic kidney disease, and diabetes. The most recent MDS (minimum data set) was a quarterly dated 12/3/25 which indicated R2 was cognitively intact. Review of the clinical record indicated R2 was discharged to the hospital on [DATE] due to acute heart failure. Further review of the clinical record did not include evidence R2 received a written bed hold policy prior to leaving the facility. On 1/21/2026 at 3:41 p.m. license practical nurse (LPN #4, clinical coordinator) was interviewed. LPN #4 verbalized that the nursing staff doesn't typically present a bed hold policy, verbalizing the admission director would be the person to handle discharge information. On 1/21/2026 at 3:45 p.m. the admission director (other staff, OS #9) was interviewed. OS #9 verbalized that all private pay residents must keep paying for their room. If residents are under Medicaid, then residents will still have a room even if it's not the one they had when they left. OS #9 said that they always keep in touch with the hospital and if they have an extended stay, they will let the family know their options, but a bed hold policy is not given out upon discharge. On 1/22/26 at 1:45 p.m. the above information was presented to the administrator and director of nursing. No other information was provided prior to exit conference on 1/22/26.

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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** Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure accurate minimum data set (MDS) assessments for two of twenty-eight residents in the survey sample (Residents #3 and #13).The findings include:1. Resident #3's quarterly MDS dated [DATE] inaccurately documented the resident took anticoagulant medication and failed to indicate the resident took an antiplatelet medication.Resident #3 (R3) was admitted to the facility with diagnoses that included hypertension, hypothyroidism, anxiety, osteoarthritis, osteoporosis, vascular dementia, cerebral infarction, psychotic disturbance, mood disorder, chronic kidney disease, atrioventricular block, heart failure and hypoxia. The MDS dated [DATE] assessed R3 with severely impaired cognitive skills.R3's clinical record documented a physician's order dated 6/22/22 for aspirin 81 milligrams each day for treatment of cerebral infarction. R3's clinical record documented no physician's order for any anticoagulant medication. R3's medication administration record for November 2025 listed the daily administration of aspirin and no administration of anticoagulant medicines.Review of R3's clinical record revealed a quarterly MDS assessment with reference date of 11/13/25. Section N0415 of this MDS listed the resident had taken anticoagulant medication during the last seven days and that the indication for the medication was noted in the record. This MDS did not indicate the resident's use of an antiplatelet medication (aspirin).On 1/22/26 at 8:10 a.m., the registered nurse responsible for MDS assessments (RN #1) was interviewed about R3's MDS indicating anticoagulant use and no antiplatelet use. RN #1 stated she reviewed R3's clinical record and the resident had no order for an anticoagulant. RN #1 stated the resident was prescribed daily aspirin, which was an antiplatelet medication, not an anticoagulant. RN #1 stated the aspirin was inaccurately categorized on the 12/11/25 MDS as an anticoagulant.The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on pages N-6 through N-8 documents regarding high-risk drug use and indications, .Code all high-risk drug class medications according to their pharmacological classification, not how they are being used .Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period .Check if there is an indication noted for all anticoagulant medications taken Antiplatelet: Check if there is an indication noted for all antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period .Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period . (1) 2. Resident #13's quarterly MDS dated [DATE] inaccurately listed the resident's urinary continence as always continent when the resident had an indwelling catheter.Resident #13 (R13) was admitted to the facility with diagnoses that included dysphagia, neuromuscular dysfunction of bladder, chronic respiratory failure, dementia, psychotic disturbance, mood disturbance, anxiety, dysarthria, hypertension and depression. The MDS dated [DATE] assessed R13 as cognitively intact.R13's clinical record documented a physician's order dated 7/1/25 for a Foley urinary catheter due to neuromuscular bladder dysfunction. R13's treatment administration records reviewed from October 2025 through 1/20/26 revealed care/monitoring related to use of the Foley catheter.Section H0100 of R13's quarterly MDS dated [DATE] documented the resident had an indwelling urinary catheter. Section H0300 of this MDS inaccurately listed the resident as always continent (code 0) instead of indicating use of the indwelling catheter (code 9).On 1/22/26 at 8:10 a.m., the registered nurse responsible for MDS assessments (RN #1) was interviewed about the conflicting continence assessment on R13's MDS dated [DATE]. RN #1 stated R13 had an indwelling catheter and that coding under section H0300 should not have indicated the resident as always continent. RN #1 stated coding for section H0300 should have been code 9, indicating use of the indwelling catheter.The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on page H-10 documents (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding coding of urinary continence, .Code 0, always continent: if throughout the 7-day look back period the resident has been continent of urine, without any episodes of incontinence .Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter .for the entire 7 days . (1) These findings were reviewed with the administrator and director of nursing on 1/22/26 at 1:00 p.m. with no further information presented prior to the end of the survey. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, Centers for Medicare & Medicaid Services, Revised October 2025.

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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 staff interviews and clinical record review, the facility staff failed to review and revise a care plan for one of twenty-eight residents in a survey sample.The Findings Include:Resident #56 (R56) care plan was not updated to include hearing aids.R56 diagnoses included communication deficit related to hard of hearing, depression, and pulmonary embolism. The most current MDS (Minimal Data Set) was a quarterly with an ARD (Assessment Reference Date) of 11/10/25. R56 was assessed with a cognitive score of 13 indicating cognitively intact. Review of R56's admission assessment dated [DATE] and section B (hearing and vision) of the MDS documented R56 used hearing aids.Review of R56's care plan for communication related to hearing deficit indicated how to speak with R56 (face to face without limited background noise) but did not indicate R56 wore hearing aids or any interventions regarding hearing aid usage and monitoring.On 1/22/2026 at 10:37a.m. registered nurse (RN # 1, MDS coordinator) was interviewed. RN #1 reviewed R56's care plan and verbalized that the hearing aids should be part of the care plan and would update the care plan to include the hearing aids.On 1/22/26 at 1:15 p.m. the above finding was presented to the administrator and director of nursing.No other information was presented prior to exit conference on 1/22/26.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview, clinical record review and facility policy review, the facility staff failed to follow physician's orders for 1 of 28 residents, Resident #11.The findings included:For Resident #11 the facility staff held the medication polyethylene glycol without a physician's order.Resident #11's clinical record listed diagnoses which included but not limited to major depressive disorder, recurrent, unspecified and other chronic pain.Resident #11's most recent minimum data set with an assessment reference date of 10/23/25 assigned the resident a brief interview for mental status score of 4 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired.Resident #11's comprehensive care plan was reviewed and contained a plan for The resident uses antidepressant medication r/t (related to) Depression and insomnia. Interventions for this plan include Monitor/document/report PRN (as needed) adverse reaction to ANTIDEPRESSANT therapy: . constipation, fecal impaction, diarrhea.Resident #11's clinical record contained a physician's order summary which read in part, Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION (R.15.0).Resident #11's electronic medication administration record for the month of December 2025 was reviewed and contained and entry which read in part, Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION (R.15.0). This entry was coded 5 on 12/21/25, 12/26/25, and 12/27/25 for evening shift, and 12/26/25 and 12/27/25 for day shift. This entry was coded 9 on 12/22/25 for day shift and 12/30/25 for evening shift. Chart code 5 is the equivalent of Hold/See Progress Notes and chart code 9 is the equivalent of Other/See Progress Notes.Resident #11's nurses notes were reviewed and contained notes which read in part, 12/21/2025 18:11 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. loose stools, 12/22/2025 09:22 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. loose stool, 12/26/2025 10:55 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. held r/t (related to) loose stools, 12/26/2025 16:10 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. resident is having loose stools, 12/27/2025 08:18 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. Loose stools, 12/27/2025 16:57 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. resident is having loose stools. Holding at this time, and 12/30/2025 18:33 Note Text: Polyethylene Glycol 3350 Powder. Give 17 gram by mouth two times a day for Constipation related to INCOMPLETE DEFECATION. held due to diarrhea. There is no note indicating that the physician had been notified to obtain a hold order.Surveyor spoke with the director of nursing (DON) on 01/21/26 at 2:30 pm regarding Resident #11. Surveyor asked DON if staff should be holding medications without an order, and DON stated they would have to look at the order. Surveyor asked DON specifically about Resident #11's polyethylene glycol order and DON stated staff should notify the physician to get an order to hold the medication.On 01/22/25 at 10:45 am, DON confirmed that staff had not called the physician to obtain a hold order for Resident #11's polyethylene glycol.Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, POLICY: This policy is designated to ensure that . (name omitted) provides pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering medications to meet each individual resident need.16. Resident's physician should be notified of any medication that was not administered.The concern of holding Resident#11's medication without a physician's order was discussed with the administrator and DON on 01/22/26 at 1:30 pm.No further information was provided prior to exit.

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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 observation, resident interview, staff interview and clinical record review, the facility staff failed to maintain a safe room environment for one of twenty-eight residents in the survey sample (Resident #99).The findings include:A portable heater was in use in Resident #99's room. The heater, placed during a heat outage, was not removed from the room when emergency use was no longer required.Resident #99 (R99) was admitted to the facility with diagnoses that included cerebral infarction, major depressive disorder, anxiety, benign prostatic hypertrophy, atrial fibrillation, chronic kidney disease, congestive heart failure, cervical disc disorder, neuromuscular dysfunction of bladder and osteoarthritis. The minimum data set (MDS) dated [DATE] assessed R99 as cognitively intact and as requiring the assistance of one person for safe transfers.On 1/20/26 at 2:39 p.m., R99 was observed in a chair in the resident's room. Positioned near the center of the room was an electric heater plugged into a wall outlet. The heater was on (light on display) but not actively blowing heated air. There were no items observed near or on the heater. R99 was interviewed at this time about the portable heater. R99 stated that he had complained about cool air coming from the ceiling vent positioned above his recliner. R99 stated the maintenance department provided the portable heater yesterday (1/19/26) because he complained about the cold air blowing. R99 stated he positioned the heater in the center of the floor to not interfere with his moving about in his room and set the thermostat to his preference.On 1/20/26 at 3:36 p.m., the maintenance director (other staff #3) was interviewed about the space heater observed in R99's room. The maintenance director stated there was an underground water line break on Friday night (1/16/26) and that several of the nursing units/halls had no heat on Saturday night (1/17/26) due to lack of hot water during the water line repair. The maintenance director stated the portable heaters were distributed to the nursing units and were in use on Saturday night (1/17/26) to provide heat while the hot water system was in repair. The maintenance director stated the heaters had an anti-tip safety feature and six heaters were provided to each nursing unit. The maintenance director stated the space heaters were in use for approximately 12 hours until the heat was restored around 10:00 a.m. on Sunday (1/18/26). The maintenance director stated he had his employees retrieved the portable heaters from the units/nursing offices on Monday morning (1/19/26). The maintenance director stated he was not sure if R99's heater was missed when the heaters were taken up or if nursing had put the heater back in R99's room. On 1/20/26 at 3:49 p.m., the maintenance director stated he verified that R99's heater had not been provided by nursing and that the maintenance staff missed R99's space heater when the units were collected on Monday (1/19/26).On 1/20/26 at 5:05 p.m., R99's room was observed with the electric heater no longer in the room. On 1/20/26 at 5:26 p.m., accompanied by the administrator, the collected electric heaters were observed in a storage room. The administrator was interviewed at this time about the heaters. The administrator stated the heaters were provided on Saturday night (1/17/26) due to the lack of heat during the water line repair. On 1/20/26 at 5:55 p.m., the administrator stated he accounted for all the portable heaters that were issued and that all resident rooms had been inspected with no other portable heaters found in use.On 1/21/26 at 3:05 p.m., the licensed practical nurse unit manager (LPN #6) caring for R99 was interviewed about the portable heater. LPN #6 stated, The heater got missed. LPN #6 stated R99's hall did not have heat on Saturday night (1/17/26). LPN #6 stated maintenance provided the heater in R99's room due to the heat outage. LPN #6 stated the portable heater should have been removed from the resident's room after the heat was repaired on Sunday (1/18/26).This finding was reviewed with administrator and director of nursing during a meeting on 1/21/26 at 5:00 p.m. with no further information presented prior to the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495370	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewater Home , Inc.	302 North Second Street Bridgewater, VA 22812

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 28 residents in the survey sample, Residents #10 and #84.The findings included:1. For Resident #10, the clinical record included provider orders for Acetaminophen and Milk of Magnesium by mouth. Resident #10 had a feeding tube and was NPO (nothing by mouth). Resident #10's diagnoses included, spastic quadriplegic cerebral palsy, epilepsy, and dysphagia. Section C (cognitive patterns) of Resident #10's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 10/28/25 was coded to indicate the resident was severely impaired in cognitive skills for daily decision making. Section K (swallowing/nutritional status) was coded to indicate this resident had a feeding tube. Resident #10's comprehensive care plan (CCP) included the focus area all nutrition and fluids via feeding tube. Resident #10's clinical record included the following provider orders. NPO/Tube Feeding diet NPO texture, no liquids by mouth consistency for dysphagia. Acetaminophen extra strength oral liquid give 20 ml (milliliters) by mouth every 24 hours as needed for pain mix with 15 mls of water. Milk of Magnesia oral suspension give 30 mls by mouth every 24 hours as needed. A review of the medication administration records for January 2026 and December 2025 revealed neither of these medications had been administered. On 01/21/2026 at 3:53 p.m., during an interview with Licensed Practical Nurse (LPN) # 2 this staff verified that Resident #10 was administered all their medications via a feeding tube. On 01/21/26 at 5:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Infection Preventionist the issue with Resident #10 having orders for medications by mouth when they were NPO was reviewed. On 01/22/2026 at 12:35 p.m., during an interview with the DON this staff stated they did not have a policy on documentation, and the expectation would be for the documentation to be entered correctly and per the provider's orders. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. A physician's order for Calcium 600 milligrams (MG) was incorrectly transcribed for resident number 84 (R84). R84 diagnoses include vitamin deficiency, osteoporosis, and muscle weakness. The most recent MDS (minimum data set) was a quarterly dated 12/24/25 and indicated R84 was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During medication pass observation conducted on 1/21/26 at 9:10 a.m. registered nurse (RN #2) gave R84 physician ordered Calcium 600 mg. The medication was reviewed for correct medication and dosage. After completing the medication pass observation, medications that were given to R84 were reviewed for accuracy via the physician's orders. Review of R84's Calcium order instructions documented Give 600 mg by mouth one time a day for Supplement Take 900mg by mouth once per day. On 1/21/2026 at 10:06 a.m. RN #2 was interviewed regarding the Calcium given. RN #2 reviewed the order and verbalized that R84 had always been given 600 mg of Calcium and the order needed to be rectified because the actual dose on the physician's order is for 600 mg. At this time RN #2 informed the clinical coordinator license practical nurse (LPN #4). On 1/21/2026 at 2:16 p.m. LPN #4 was interviewed. LPN #4 verbalized that she had spoken to the physician and verified that Calcium 600 mg was to be given but the instructions had a typographical error and would be corrected. On 1/21/26 at 5:00 p.m. the above finding was presented to the administrator and director of nursing. No other information was presented prior to exiting the facility on 1/22/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices during tracheostomy care for one of twenty-eight residents in the survey sample (Resident #13).The findings include:Infection control practices regarding hand hygiene and glove changes were not followed during Resident #13's tracheostomy care.Resident #13 (R13) was admitted to the facility with diagnoses that included dysphagia, neuromuscular dysfunction of bladder, chronic respiratory failure, dementia, psychotic disturbance, mood disturbance, anxiety, dysarthria, hypertension and depression. The MDS dated [DATE] assessed R13 as cognitively intact.R13's clinical record documented a physician order dated 7/1/25 for tracheostomy care each day that included cleaning around stoma with cotton swab wet with saline/hydrogen peroxide mix and an order dated 7/4/25 to insert new sterile inner cannula to tracheostomy (trach) daily.On 1/22/26 at 8:58 a.m., with R13's permission and accompanied by licensed practical nurse (LPN #6), tracheostomy care was observed. LPN #6 applied gloves, sanitized the bed tabletop and let dry. LPN #6 removed gloves, washed hands, put on gown, mask, and eye goggles. LPN #6 placed a clean field on the bed table and then placed trach care kit items on the field. LPN #6 put on sterile gloves and opened the care kit supplies/packets. LPN #6 then removed sterile gloves and without hand hygiene, put on a new pair of sterile gloves before opening the package with the new cannula. LPN #6 removed gloves and without hand hygiene, put on a new pair of sterile gloves. LPN #6 removed the speak valve then removed/discarded the used split gauze around the trach opening. Without glove change and hand hygiene, LPN #6 then removed the inner cannula from the trach and inserted/secured the new inner cannula into the tracheostomy. LPN #6 cleansed around the stoma with use of a cotton swab wet with sterile saline mix, repositioned the speak valve, and put a new split gauze around the trach device. LPN #6 then removed her gloves, gown, goggles and mask. LPN #6 did not change gloves after removing the soiled split gauze and prior to removal/insertion of the new inner cannula. LPN #6 sanitized the eye goggles with a wipe and then secured used/soiled items in a trash bag before disposal. LPN #6 did not wash her hands prior to leaving the room. LPN #6 discarded bagged used items and then sanitized hands after leaving the resident's room. R13's tracheostomy site was clean with no signs of infection or inflammation. R13's oxygen saturation percentage was monitored during the trach care with the resident reporting no difficulties during the care procedure.On 1/22/26 at 9:15 a.m., LPN #6 was interviewed about the observed trach care with lack of hand hygiene between glove changes and no glove change after removal of the soiled split gauze. Regarding placement of the new inner cannula, LPN #6 stated she held the cuff with her right hand, pulled the used cannula out with the left hand and then inserted the new cannula with the left hand, touching only the tip. LPN #6 stated, I didn't do hand sanitizer between glove changes. LPN #6 stated she should have washed hands or used hand sanitizer between glove changes and after removing the soiled dressing.On 1/22/26 at 9:25 a.m., the infection preventionist (RN #3) was interviewed about R13's observed trach care. RN #3 stated that hand hygiene was required between glove changes. RN #3 stated a glove change and hand hygiene should have been done after removal of the soiled dressing and prior to touching the inner cannulas. The facility's policy titled Tracheostomy Care (effective 6/28/25) documented regarding trach care when changing a disposable inner cannula, .Aseptic technique should be used .During tracheostomy tube changes, either reusable or disposable .Gloves must be used on both hands during any and all manipulation of the tracheostomy. Sterile gloves will be used during aseptic procedures .Wash hands .Put exam gloves on both hands .Inspect skin and stoma site for signs or symptoms of infection, leakage, subcutaneous crepitus, or dislodged tube .Remove old dressing. Pull soiled glove over dressing and discard into appropriate receptacle .Wash hands . This procedure documented regarding changing of disposable inner cannula, .Stabilize the neck of the tracheostomy tube and gently remove inner cannula. Discard inner cannula .Stabilize the neck plate of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the tracheostomy tube, then insert the sterile disposable inner cannula over the ridge on the outer cannula .Apply clean gloves .Clean the stoma .Remove gloves and discard into appropriate receptacle. Wash hands .Document the procedure, condition of the site, and the resident's response .This finding was reviewed with the administrator and director of nursing on 1/22/26 at 1:00 p.m. with no further information presented prior to the end of the survey.