STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00387028, IN00387912, IN00388083, IN00391751, IN00392088, IN00394735, IN00396445, IN00396439, IN00398004, IN00401290, IN00404230 and IN00405925. Complaint IN00387028 - No deficiencies related to the allegations are cited. Complaint IN00387912 - No deficiencies related to the allegations are cited. Complaint IN00388083 - No deficiencies related to the allegations are cited. Complaint IN00391751 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00392088 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00394735 - No deficiencies related to the allegations are cited. Complaint IN00396445 - No deficiencies related to the allegations are cited. Complaint IN00396439 - No deficiencies related to the allegations are cited. Complaint IN00398004 - No deficiencies related to the allegations are cited. Complaint IN00401290 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00404230 - Federal/State deficiencies related to the allegations are cited at F690 and F842. Complaint IN00405925 - No deficiencies related to the allegations are cited. Survey dates: April 10, 11, 12, 13, 14 and 17, 2023 Facility number: 012548 Provider number: 155790	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider for any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Burdsall	Executive Director	05/02/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	AIM number: 201023760 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 14 Medicaid: 64 Other: 16 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 24, 2023.			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility	F 0644	**F644- Coordination of PASARR**	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure a Preadmission Screening and Resident Review (PASARR) was submitted to request a level II screening for mental illness for 1 of 3 residents reviewed for PASARR screening. (Resident 16) Finding includes: The record for Resident 16 was reviewed on 04/12/23 at 2:51 p.m. Diagnoses included, but were not limited to, dementia without disturbance, depressive episodes, bipolar disorder, and anxiety. A PASARR, dated 2/12/18, indicated the resident did not have a serious mental illness or an intellectual/developmental disability. If changes occur or new information refutes these findings a new screen must be submitted. A physician's order, dated 10/11/22, indicated Zyprexa (medication used for bipolar) 7.5 milligrams at bedtime for bipolar (a mental illness) A care plan, dated 11/11/22, indicated the resident used an antipsychotic medication for Bipolar. There was not another level I or a level II (screening for residents with serious mental illness) PASARR in the electronic medical record. During an interview, on 04/17/23 at 2:15 p.m., the Admission Coordinator indicated a level one should have been resubmitted with the new diagnosis. A current policy, titled "Indiana PASRR," dated 8/25/20 and received from the Clinical Support on 4/17/23 at 3:32 p.m., indicated "...all individuals who apply for admission to a Medicaid certified		**and Assessments** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** There were not any residents harmed by the alleged deficient practice. The status change assessment was completed for resident 16 to trigger the level 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents have the potential to be affected. The facility will complete an audit for all residents to ensure all status change assessments have been completed. Any new admission with related condition will be included in the preadmission screening. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on Indiana PASSRR with an emphasis on status change assessments was completed with the Social Services Director and Designee. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nursing facility must be screened for a PASRR disability and if so, whether they need specialized services to address their PASRR-related needs and offer all applicants the most appropriate setting for their needs...a Level I screen requirements... for nursing facility residents who have a significant change in mental status indicating the need for an updated Level one screen, a subsequent level one screen, or an updated Level II evaluation...the PASRR level II evaluation process identifies rehabilitative services that an individual may require...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		Facility will complete an audit of 5 residents with related conditions per week for 6 months to ensure status change assessments are being completed. Any discrepancies will be immediately corrected and re-education provided. Results of the audit will be reviewed by the QAPI committee for 6 months or until 100% compliance is achieved. Any discrepancies will be corrected immediately.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to develop a care plan for a resident with cirrhosis of the liver who was waiting to get on the transplant list and to address the use of a prophylaxis antibiotic for 1 of 3 residents reviewed for care planning. (Resident 304) Finding includes: The record for Resident 304 was reviewed on 04/11/23 at 4:25 p.m. Diagnoses included, but were not limited to, ascites (fluid collected in spaces within the abdomen), pleural effusion (collection of fluid between the lungs and chest) and cirrhosis (late-stage liver disease) of the liver. A physician's order, dated 04/01/23, indicated to give Ciprofloxacin (an antibiotic) 500 mg (milligrams) by mouth in the morning prophylactic for spontaneous bacterial peritonitis. There was no end date for the order. The resident did not have a care plan addressing the antibiotic being used while the resident was waiting to get on the transplant list. During an interview, on 04/17/23 at 9:44 a.m., the Director of Nursing indicated Resident 304 should have had a care plan addressing the resident being on an antibiotic prophylaxis while waiting to get on the transplant list. Any resident on an antibiotic needed to have a care plan.	F 0657	**F657- Care Plan timing and revision** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** There were not any residents harmed by the alleged deficient practice. The care plan for resident 304 was updated to reflect the use of a prophylaxis antibiotic. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents have the potential to be affected. The facility will complete an audit for all residents to ensure each resident has a care plan to address the use of the antibiotic. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on our plan of care overview policy was completed with our MDS coordinator to ensure all residents receive a	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A current policy, titled "Plan of Care Overview," undated and received from the Director of Nursing on 04/17/23 at 1:50 p.m., indicated "...the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care...." 3.1-35(b)(1)		written plan of care that is resident focused and optimizes personalized care. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place;** Facility will complete an audit of 5 residents with related conditions per week, for 6 months, to ensure care plans are in place to reflect the usage of antibiotics. Any discrepancies will be immediately corrected and re-education provided. Results of the audit will be reviewed by the QAPI committee for 6 months or until 100% compliance is achieved. Any discrepancies will be corrected immediately.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to ensure the catheter bag was positioned below the bladder and the catheter bag was changed for 2 of 2 residents observed for catheters. (Residents 4 and 61) Findings include: 1. During an observation, on 04/10/23 at 3:53 p.m., a supra pubic catheter with dark urine and sediment in the tubing was hanging on the side of the resident's bed. During an observation, on 04/12/23 at 11:06 a.m., the resident was in bed with the head of the bed elevated. A strong urine odor was noted in the room. The catheter tubing had dark amber urine present in the tubing and the catheter bag was purple in color with dark amber urine present. During an observation, on 04/13/23 at 1:40 p.m.,	F 0690	**F690- Bowel/Bladder Incontinence, Catheter, UTI** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** The catheters for both resident 4 and 61 were changed and positioned below the resident's bladder. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents with a urinary drainage device have the potential to be affected. The facility will complete an audit for all residents to ensure catheters are positioned	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident was in bed. A strong odor of urine was noted. The catheter bag was purple in color with dark amber urine present. During an observation, on 04/14/23 at 10:30 a.m., the resident was lying in bed, a strong odor of urine was noted in the room. The catheter bag was purple in color with amber urine. The tubing contained a thick sediment. During an observation and interview, on 4/14/23 at 10:39 a.m., LPN 4 indicated the catheter bag was purple in color, had an odor, and a large amount of grayish sediment in the tubing at the loop. The record for Resident 4 was reviewed on 04/12/23 at 11:06 a.m. Diagnoses included, but were not limited to, acute kidney failure, obstructive and reflux uropathy (disorder of the urinary tract) and urinary tract infection. A physician's order, dated 12/20/22, indicated to change the suprapubic catheter and drainage bag as needed. A physician's order, dated 12/20/22, indicated to change the suprapubic catheter leg bag and accessories every 2 weeks and as needed. A progress note, dated 4/2/23 at 2:47 p.m., indicated the resident had amber colored urine, slight odor, with cloudy sediment. The catheter bag was changed, and the catheter was irrigated. The urine was draining to gravity. During an interview, on 4/14/23 at 10:39 a.m., LPN 4 indicated the catheter bag needed changed.2. During an observation, on 4/10/23 at 10:10 a.m., Resident 61 was lying in bed, his catheter was hanging on his wheelchair's left arm rest. The		below the bladder and changed in accordance with physician's orders. Any new admission with related condition will be included in the audit for catheter care. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on our catheter care policy with emphasis on drainage bag placement and changing of the catheter bag was completed with our nursing staff to ensure residents with an indwelling catheter receive catheter care in accordance to policy. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place;** Facility will complete observations of 5 residents with related conditions per week, for 6 months, to ensure catheter care is completed according to policy. Any discrepancies will be immediately corrected and re-education provided. Results of the observations will be reviewed by the QAPI committee for 6 months or until 100% compliance is achieved. Any discrepancies will be corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	catheter bag was positioned above the resident's bladder level. The record for Resident 61 was reviewed on 4/14/23 at 2:45 p.m. Diagnoses included, but were not limited to, heart failure, chronic kidney disease, obstructive and reflex uropathy (urine cannot flow through the ureter, bladder, or urethra) and hypertension. A care plan, dated 5/19/22, indicated the resident had a suprapubic catheter (a hollow flexible tube used to drain urine from the bladder) and had frequent urinary tract infections (UTI). Interventions included, but were not limited to, antibiotic treatment as ordered for urinary tract infection, encourage, and assist resident to place urinary drainage bag below the bladder as needed, provide catheter care every shift and when needed, notify the medical provider if urine was of abnormal color, consistency, or odor. A physician's order, dated 8/12/22, indicated suprapubic catheter care every shift. A physician's order, dated 4/3/23, indicated Bacterium DS (an antibiotic) 800 mg (milligram) -160 mg tablet, give 1 orally two times a day for 14 days. During an interview, on 4/10/23 at 10:15 a.m., CNA 3 indicated she would change the catheter bag location but was not sure where to put the catheter bag. CNA 3 was unaware of the policy for catheter care. She put on gloves and removed the catheter bag off the wheelchair and attempted to attach the bag to the upper part of the bed. She could not find an area to attach the catheter, so she attached the catheter to the bottom rail of the bed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 4/10/23 at 10:30 a.m., RN 2 indicated catheter care was provided every shift and the catheter should be kept below the bladder level to prevent the urine from flowing back into the bladder. During an interview, on 4/13/23 at 10:23 a.m., LPN 8 indicated the catheter should not be above the bladder and the resident was being treated with an antibiotic for a UTI. A current policy, titled "Catheter Care," not dated and received from the Executive Director on 4/10/23 at 3:50 p.m., indicated "...It is the policy of this facility to provide resident care that meets the psychosocial, physical and emotional needs and concerns of the residents. Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place. CAUTI (Catheter Associated Urinary Tract Infection) is the most common adverse event associated with indwelling urinary catheters, including those that are asymptomatic...The risk of bacteremia in residents with indwelling catheters is 3-36 times more likely than residents without an indwelling catheter...Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder...." This Federal tag relates to Complaint IN00404230. 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to ensure weight monitoring was followed as ordered to identify a weight loss at an earlier stage for 2 of 7 residents reviewed for nutrition. (Resident 82 and 49) Finding includes: 1. The record for Resident 82 was reviewed on 04/12/23 at 11:11 a.m. Diagnoses included, but were not limited to, encephalopathy, aphasia, dysphagia, hemiplegia left side, altered mental status, and type 2 diabetes. A physician's order, dated 1/20/23, indicated weekly weights indefinitely per dietitian related to G-tube feeding every Friday. A physician's order, dated 4/11/23, indicated regular diet, dysphagia mechanical texture, with	F 0692	**F692- Nutrition/Hydration Status Maintenance** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** There were not any residents harmed by the alleged deficient practice. The orders for resident 82 and 49 were updated to ensure weight monitoring was followed as ordered to identify weight loss. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents have the potential to be affected. The facility will	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	thin liquid consistency, and double portions. There was no order for supplemental feedings. A care plan, with a revision date of 4/11/23, indicated a potential for altered nutritional status/nutrition related problems related to dysphagia, status post cerebrovascular accident, right sided hemiparesis, hypertension, type 2 diabetes, and history of a feeding tube. Interventions included, but were not limited to, obtain weekly weights, provide meals per diet order, monitor meal intakes, and provide supplements per medical providers orders. A care plan, with a revision date of 4/11/23, indicated the resident had a history of a tube feeding related to dysphagia, now only received water flushes. A weights and vital signs record indicated the following weights: a. On 12/27/22, the weight was 205 pounds. b. On 1/10/23, the weight was 205 pounds. c. On 1/27/23, the weight was 199.8 pounds. d. On 2/8/23, the weight was 199 pounds. e. On 3/8/23, the weight was 205 pounds. f. On 4/6/23, the weight was 189 pounds. A dietitian note, dated 4/11/23 at 12:56 p.m., indicated the resident was weighed on 4/6/23, triggering a weight loss of 7.8% in 30 days. The resident's usual body range was typically 199-205 pounds. Nursing staff believed the weight may have been an error and reported the resident ate well and asked for bigger portions. The dietitian recommended a re-weight to confirm the weight and increase to double portions. There was no re-weight in the electronic record.		complete a weight monitoring audit to ensure each resident has an order to identify weight loss. Any new admission will be included in the audit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on our resident height and weight policy was completed with our NP, dietician, and nursing staff to ensure all residents have orders to identify weight loss in accordance to policy. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place;** Facility will complete observations of 5 residents with related conditions per week, for 6 months, to ensure weight monitoring is followed as ordered. Any discrepancies will be immediately corrected and re-education provided. Results of the observations will be reviewed by the QAPI committee for 6 months or until 100% compliance is achieved. Any discrepancies will be corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview, on 04/12/23 at 2:18 p.m., LPN 5 indicated the tube feeding was only if he was not eating and was weekly weights on Friday.

2. The record for Resident 49 was reviewed on 04/13/23 at 3:39 p.m. Diagnoses included, but were not limited to, hypertension, heart failure, and chronic obstructive pulmonary disease.

A note written by Nurse Practitioner (NP) 8, on 04/05/23, indicated "...Plan...CXR 2 views STAT (immediately) Lasix (a diuretic) 40 mg (milligrams) BID (twice a day) x 3 days then resume the regular dose of 20 mg BID...CBC (complete blood count lab), CMP (complete metabolic panel lab) BNP (B-type natriuretic peptide a lab test to check how the heart is working)...Daily weight...."

An order written by NP 8, on 04/05/23, indicated to give Lasix 40 mg twice a day for edema (too much fluid trapped in body tissues).

There was no order for daily weights written prior to 4/13/23.

During an interview, on 04/13/23 at 2:19 p.m., Unit Manager 4 indicated the resident was seen by Nurse Practitioner 8 on 04/05/23. NP 8 did see the resident and put a note in the record indicating to get daily weights. The daily weights were not entered into the system. UM 4 was not aware of the new order as it was put into a note and nursing was not informed. She indicated NP 8 would put in her own orders, but she did not put the weight order into the system. The new order should have also showed up on the daily reports.

During an interview, on 04/13/23 at 2:30 p.m., NP 8 indicated when a resident transferred from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hospital with heart failure, daily weights were a standing order. The nurse should know a resident with heart failure which was on Lasix was a daily weight, as a standing order. She put the daily weights in her note (on 4/05/23) and it was an order. During an interview, on 04/13/23 at 2:34 p.m., the Director of Nursing indicated when a resident admitted to the facility, they were on weekly weights for four (4) weeks. If there was to be a change, nursing was to make the order change. NP 8 had the ability to put her orders into the system, then nursing would confirm the order. That was how the order showed up on the Medication and Treatment Administration Record (MAR/TAR). During an interview, on 04/14/23 at 3:16 p.m., the Executive Director indicated weekly weights for four (4) weeks was the standing order and if NP 8 wanted daily weights she needed to write the order. Putting the information in a note was not writing an order, and the information would not get on the MAR/TAR. A current policy, titled "Resident Height and Weight," not dated and received from the Director of Nursing on 4/11/23 at 2:45 p.m., indicated "...Policy: Weights will be obtained monthly or as ordered by the physician or Practitioner...Procedure for obtaining weight: Obtain weight on scales that have been calibrated per the manufacturing recommendations...Weekly Weights: a) Recommend that residents with tube feedings be weighed weekly unless otherwise indicated in care plan or by physician order...9) A plus/minus of 5 pounds of weight in one week will result in: i) Reweigh within 24 hours (1) Validation with nurse for accurate weight (2) Notify IDT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	team/doctor/family, if indicated. 10) Reporting Weights, a) Weight loss concerns will be discussed at the weekly clinical meetings...." 3.1-46(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated and oxygen was set at the physician prescribed levels for 3 of 3 residents reviewed for oxygen. (Resident C, 30 and 41) Findings include: 1. During an observation, on 4/12/23 at 11:11 a.m., Resident C was in her bed on 2 LNC (2 liters per nasal cannula). The oxygen tubing was not dated. The record for Resident C was reviewed on 4/12/23 at 11:25 a.m. Diagnoses included, but were not limited to, hypertension, depressive episodes, cardiac pacemaker, and osteoarthritis. A care plan, revised on 7/11/22, indicated the resident had oxygen therapy related to ineffective gas exchange. The interventions included, but were not limited to, monitor for signs and	F 0695	**F-695 Respiratory/Tracheostomy Care and Suctioning** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** Resident C was not included in the resident sample. The oxygen tubing was dated and oxygen was set at the physician prescribed level for resident 30 and 41. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents receiving oxygen have the potential to be affected. The facility will complete an audit	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms of respiratory distress and oxygen therapy per orders. A physician's order, dated 2/12/23, indicated oxygen at 2 LNC when needed to keep oxygen saturation greater than 92%. During an interview, on 4/12/23 at 11:08 a.m., RN 2 indicated Resident C's oxygen tubing was not dated and the tubing needed to be dated. During an interview, on 4/14/23 at 11:28 a.m., LPN 8 indicated oxygen tubing should be dated when opened. 2. During an observation, on 4/12/23 at 11:20 a.m., Resident 30 was lying in bed wearing 2 LNC. The oxygen tubing was not dated. The record for Resident 30 was reviewed on 4/12/23 at 9:07 a.m. Diagnoses included, but were not limited to, congestive heart failure, dementia, depression disorder, and anxiety disorder. A care plan, revised on 7/11/22, indicated the resident had oxygen therapy related to ineffective gas exchange. The interventions included, but were not limited to, monitor for signs and symptoms of respiratory distress and oxygen therapy per orders. A physician's order, dated 1/21/22, indicated provide supplemental oxygen at 2 LNC to keep oxygen saturation greater than 94% as needed for shortness of breath. A physician's order, dated 1/21/22, indicated change oxygen tubing every week and when needed every night shift on Sunday for oxygen tubing care.		to ensure each resident is receiving oxygen consistent with our supplemental oxygen and nasal cannula policy. Any new admission will be included in the audit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on our supplemental oxygen and nasal cannula policy with emphasis on dating tubing and ensuring oxygen is delivered at rate per MD order was provided to nursing staff to ensure oxygen tubing is dated appropriately and set at the physician prescribed level. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place;** Facility will complete an audit of 5 residents with related conditions per week, for 6 months, to ensure oxygen is administered in accordance to company policy. Any discrepancies will be immediately corrected and re-education provided. Results of the observations will be reviewed by the QAPI committee for 6 months or until 100% compliance is achieved. Any discrepancies will be corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 4/12/23 at 11:20 a.m., RN 2 indicated the oxygen tubing was not dated. The tubing was changed Monday and needed to be dated when opened. During an interview, on 4/14/23 at 11:12 a.m., LPN 8 indicated the resident was on oxygen. The tubing should be labeled with the opened date and was changed on Sunday nights. 3. During an observation, on 4/12/23 at 1:30 p.m., Resident 41 was lying in bed and receiving 3 liters of oxygen. She was wearing a nasal cannula and the oxygen tubing was not dated. The record for Resident 41 was reviewed on 4/12/23 at 1:33 p.m. Diagnoses included, but were not limited to, hypertension, depressive episodes, anxiety disorder, panic disorder, and muscle spasm. A care plan, revised on 8/18/22, indicated the resident had oxygen therapy. The interventions included, but were not limited to, oxygen at 2 liters nasal cannula. A physician's order, dated 8/18/22, indicated change oxygen tubing every week on Sunday night shift and when needed. A physician's order, dated 8/18/22, indicated oxygen at 2 liters nasal cannula continuously for shortness of breath. A physician's order, dated 1/18/23, indicated oxygen at 2 L per nasal cannula. During an interview, on 4/10/23 at 12:40 p.m., RN 2 indicated the resident was on 3 LNC and the order			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was for 2 LNC. The oxygen tubing should have been changed on Sunday the date was incorrect 3/27/23 should be 4/9/23. A current policy, titled "Supplemental Oxygen using Nasal Cannula," not dated and received from the Executive Director on 4/10/23 at 3:47 p.m., indicated "...A nasal cannula will be used when the physician orders supplemental oxygen to be administered by this route an at a specified rate of flow. Generally, oxygen can be delivered via a nasal cannula in low to moderate oxygen concentrations intra-nasally (1 LPM to 6 LPM). Oxygen in use signs will be posted whenever a resident is using supplemental oxygen including but not limited to the resident room and beauty shop...Oxygen is considered a "medication" and will be treated similarly including physician order, and placed on the MAR. A nurse or RT will administer the oxygen as prescribed. 1. Initial oxygen set up and use. a. Place a Oxygen in Use sign at or on the door. Maintenance a. Nasal cannula and tubing will be labeled and dated when opened. b. Nasal cannulas and tubing are changed weekly or when soiled and labeled with date opened...." 3.1-47(a)(6)			
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview and record review, the facility failed to ensure behavior health notes were available to staff to provide person centered and individualized care approaches which address the assessed needs for a resident requiring these services for 1 of 1 resident reviewed for behavioral health. (Residents 19) Finding includes: On 04/11/2023 at 9:31 a.m., Resident 19 was observed in her bed in her room. The room was disorganized and cluttered with clothing and other multiple personal items. The floor was littered with food particles around the circumference of the bed. The breakfast tray remained on the over-the-bed table, along with other snack foods. During an interview, at this time, the resident was unable to focus on questions being asked, required redirection back to the conversation multiple times, and her affect was flat. The record for Resident 19 was reviewed on 04/14/2023 at 1:23 p.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, major depressive disorder, congestive heart failure, diabetes mellitus, hypertension, and cognitive communication deficit. The progress notes indicated the following behaviors: On 08//21/2022 at 11:11 a.m., "...crawled out into the hallway and was yelling very loudly while lying on the floor..." On 10/21/2022 at 1:42 p.m., "...refused shower prior to appt (appointment)..."	F 0742	**F-742 Treatment/Services Mental/Psychosocial Concerns** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** There were not any residents harmed by the alleged deficient practice. The facility was able to obtain behavioral health notes for resident 19 to ensure staff provided person centered and individualized care approaches to address the needs of the resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents receiving psychosocial therapy have the potential to be affected. The facility will complete a 100% audit to ensure each resident's chart contains behavioral notes that address the assessed needs for residents receiving these services. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on psychosocial concerns with an emphasis on behavioral health documentation	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 10/27/2022 at 10:07 p.m., "...refused shower..." On 10/29/2022 at 1:28 p.m., "...Resident in room with call light in room. Resident is forgetful at times. Stated that no one had been into see her and this writer saw aid in room prior and refused shower. Resident had thrown old briefs on the floor and dirty clothes all around room. Has old food hidden in room. Room cleaned and old food disposed of and clothes to dirty clothes..." On 11/06/2022 at 6:30 p.m., "...came to dining area where she was served her dinner tray. Resident stated that she did not want to eat. Resident then later came in the hallway yelling stating that we did not provide her with a tray, reminded resident that she refused her tray but it was still sitting at the table. The resident continued to yell at writer and nurses aid, she then grabbed her tray and took it to her room..." On 11/17/2022 at 10:10 a.m., "...had incontinent episode in bed. cna (certified nursing assistant) offered to assist res (resident) with incontinent care/shower/and personal hygiene. res refused x3 to allow staff to give care. staff x2 approached x3. res refused each time and would become visible agitated whenever reapproached..." On 01/06/2023 at 4:16 a.m., "...screaming at staff as they are assisting her, toileted afterwards was verbally abusive using profanity and name calling declined to have staff assist back to bed wanted different care giver resident obliged..." On 01/09/2023 at 9:18 a.m., "...screaming at staff as they are assisting her, toileted afterwards was verbally abusive using profanity and name calling declined to have staff assist back to bed wanted different care giver resident obliged..." On 02/08/2023 at 3:10 a.m., "...refused to be cleaned or allow aides to change wet bed sheets despite several attempts. Resident has been combative with staff and yelling at them since start of shift with each attempt to get her cleaned		was completed with the Social Services Director and Designee. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place;** Facility will complete an audit of 5 residents with related conditions per week, for 6 months, to ensure behavioral health notes are readily available to staff. Any discrepancies will be immediately corrected and re-education provided. Results of the weekly audit will be reviewed by the QAPI committee for 6 months or until 100% compliance is achieved. Any discrepancies will be corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	up as she has been lying in urine since shift has started. (name of staff) came from another unit in an attempt to get resident up but was not successful either..." On 02/25/2023 at 6:00 p.m., "...entered resident room to administer medication writer noted resident's linens and depends were soiled writer attempted to change residents bed linens and depend resident refused 15 minutes later resident told Nurse she was calling for help for the last 2 hours to be cleaned up..." On 02/25/2023 at 7:00 p.m., "...resident requested a blanket CNA provided blanket after CNA left resident room resident began yelling stating she needed a blanket..." On 02/26/2023 at 4:36 a.m., "...resident requested to get dressed. CNA gathered materials upon returning to get resident dressed resident called staff members bitches and clammed (sic) no care has provided all shift as CNA attempted to dress resident she complained of pain and made false allegations stating second shift broke her neck..." On 03/02/2023 at 10:32 a.m., "...went in to pt (patient) room. pt did not have 02 on. educated pt on importance of wearing oxygen, attempted to have pt put o2 on, pt still refused and did not want to put o2 on..." On 03/13/2023 at 11:44 a.m., "...was incontinent, CNA went in room three different times to attempt to take care of pt and clean her up. pt refused and did not want anyone to clean her up..." On 04/08/2023 at 10:31 a.m., "...Staff in room multiple times a shift and incontinent care provided. Resident yelling at aid during care..." On 04/10/2023 at 7:35 a.m., "...entered room while wound NP (nurse practitioner) in room. Resident yelling about water. Wound NP offered water. Than (sic) resident stated she wanted a wet washcloth for her face. This writer brought in wet wash cloth and placed in hand and resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	remained yelling. Nurse asked her if she could stop yelling. Resident began yelling louder. This writer left room and notified her floor nurse that (resident name) was given what she asked for and remained yelling at staff..." A "Psychotherapy Progress Note," dated 11/02/2022, indicated the resident was being seen for "agitation, confusion, poor hygiene, sadness, uncooperative with nursing care" Treatment plan goals included, decrease depression, and increase adjustment to facility. No further psychotherapy notes were observed in the resident's record during review of the clinical record at this time. During an interview, on 04/14/2023 at 3:31 p.m., the Social Service Director (SSD 6) was interviewed regarding Resident 19's behaviors and psychiatric services. SSD 6 indicated the resident was receiving psychiatric services routinely. The resident was a "hoarder" and the facility had difficulty cleaning the resident's room. The resident often refused to allow housekeeping to clean the room and refused assistance from nursing staff. The resident did not have a diagnosis of dementia but "consistently acts as if she has dementia" Resident 19 "likes only certain nurses and refuses care from others" SSD 6 was notified the only psychiatric note found in the clinical record was a single note, dated 11/02/2022, over four months ago. When questioned about psychiatric services, SSD 6 indicated the resident was receiving psychiatric services however she denied having received or reviewed these notes. Psychiatric notes were requested to be placed in the clinical record to be viewed. During a review of Resident 19's record, on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	04/17/2023 at 10:17 a.m., eight additional psychiatric progress notes, ranging from 11/02/2022 through 02/07/2023, had been updated in the record. No notes for March 2023 were available for review. A review of the psychiatric progress notes indicated additional diagnoses of dementia, PTSD (post-traumatic stress disorder), bipolar disorder, unspecified mood (affective) disorder, and anxiety disorder. During an interview, on 04/17/2023 at 2:15 p.m., SSD 6 and SSD 7 both denied knowledge of the additional diagnoses seen on the psychiatric notes. A policy and procedure regarding psychiatric behavioral services was requested on 04/17/2023, however no policy and procedure was received prior to or at the time of exit. 3.1-43(a)(1)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure the medication/treatment records were documented after the administration of medications or treatments and failed to ensure the correct diagnoses was linked to a medication for 5 of 5 residents reviewed for complete and accurate documentation. (Residents F, C, D, E and 89) Findings include: 1. The record for Resident F was reviewed on 04/17/23 at 1:30 p.m. Diagnoses included, but were not limited to, chronic kidney disease, acute kidney failure, and type 2 diabetes mellitus. During the review of the Medication and Treatment records, the following were missing documentation in the January, February, and March records. Admelog (an insulin) was missing documentation on 01/13/23, 01/14/23 and 01/15/23 at 8:00 a.m., and 5:00 p.m. This order was initiated on 01/12/23 at 5:00 p.m. Admelog before meals and at bedtime was missing	F 0842	**F-842 Resident records-Identifiable information** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** Residents F, C, D, E, and 89 were not harmed by the deficient practice. A medication review was completed on Resident 89 to ensure the correct diagnosis was linked to current medications. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be take;** All residents have the potential to be affected. An audit of the last 7 days was performed on resident's medical record to ensure the medication/treatment records were documented after the administration of medications and treatments and the correct	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation on 01/05/23 at 11:30 a.m., 4:00 p.m., and 9:00 p.m. This order was initiated on 01/05/23 at 7:30 a.m. Colostomy output amount was missing documentation on 01/07/23 for the night shift, and on 01/20/23 on the evening shift. The daily wound assessment of the buttocks was missing documentation on 01/17/23 on the day and evening shifts, 01/11/23 on the night shift, 01/21/23 on the night shift, and on 01/28/23 on the day shift. The daily wound assessment of the groin area was missing documentation on 01/11/23 for the night shift, 01/17/23 for the day and evening shifts, 01/20/23 on the evening shift, 01/21/23 on the night shift, and 01/28/23 on the day shift. The daily wound assessment of the right buttocks was missing documentation on 01/17/23 on the day and evening shifts, 01/20/23 on the evening shift, 01/21/23 on the night shift, and 01/28/23 on the day shift. The daily wound assessment of the left buttocks was missing documentation on 1/11/23 on the night shift, 01/17/23 on the day and evening shifts, 01/20/23 on the evening shift, 01/21/23 on the night shift, and 01/28/23 on the day shift. The daily wound assessment of the groin/ischium was missing documentation on 01/17/23 on the day and evening shifts, 01/20/23 on the evening shift, and 01/28/23 on the day shift. The indwelling catheter care of cleaning with soap and water was missing documentation on 01/20/23 on the evening shift.		diagnosis is linked to the medication. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were educated using the "Medication Administration" policy with emphasis on ensuring proper documentation is completed in resident's medical records after the administration of medications and the correct diagnosis is linked to the medication. **How the corrective action will be monitored to ensure the deficient practice does not recur, what quality assurance program will be put in place;** Facility will audit 5 residents per week for 6 months to ensure accurate medication and treatment documentation has occurred in the resident's medical record. The results of the audit will be reported, reviewed and trended for compliance thru the facility QAPI for a minimum of 6 months or until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The indwelling catheter output was missing documentation on 01/17/23 for the day and evening shifts, 01/17/23 for the day and evening shifts, and 01/20/23 for the evening shift. Colostomy output amount was missing documentation on 02/02/23 for the night shift, 02/05/23 for the evening shift, and on 02/13/23 on the night shift. The daily wound assessment of the left buttocks was missing documentation on 02/03/23 for the evening and night shifts, 02/05/23 for the evening shift, and 02/12/23 for the evening shift. The daily wound assessment of the right groin was missing documentation on 02/03/23 for the evening and night shifts, 02/05/23 for the evening shift, and 02/12/23 for the evening shift. Colostomy output amount on 03/02/23 for the day shift was not documented. The indwelling catheter output on 03/01/23 for the day shift was not documented.2. The record for Resident C was reviewed on 4/12/22 at 11:25 a.m. Diagnoses included, but were not limited to, hypertension, depressive episodes, cardiac pacemaker, and osteoarthritis. A Medication Administration Record (MAR), dated for the month of March 2023, indicated the following were not signed as administered or not administered: a. monitor antidepressant side effects every shift on 3/28/2023. b. behavior monitoring for antidepressant every shift on 3/28/23. c. behavior monitoring interventions every shift			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 3/28/23. d. monitor for pain every shift on 3/28/23. e. provide cup with lid for hot liquids every shift on 3/23/23. A MAR, dated for the month of April 2023, indicated the following were not signed as administered or not administered: a. Docusate Sodium (stool softener) 100 mg (milligrams) on 4/18/23 through 4/30/23. b. blood pressure twice a week every shift on 4/18, 4/20, 4/25 and 4/27/23. A Treatment Administration Record (TAR), dated for the month of February 2023, indicated the following were not signed as administered or not administered: a. monitor for bilateral lower extremities edema on 2/4, 2/13, 2/25 and 2/26/23. b. monitor for heart failure every shift on 2/4, 2/13, 2/25 and 2/26/23. c. monitor for shortness of breath every shift 2/4, 2/13, 2/25 and 2/26/23. A TAR, dated for the month of March 2023, indicated the following were not signed as administered or not administered: a. monitor for bilateral lower extremities edema on 3/19 and 3/21/23. b. monitor for heart failure every shift on 3/19, and 3/21/23. c. monitor for shortness of breath every shift 3/19 and 3/21/23. A TAR, dated for the month of April 2023, indicated the following were not signed as administered or not administered: a. monitor for bilateral lower extremities edema on 4/16/23. b. monitor for heart failure every shift on 4/16/23.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. The record for Resident D was reviewed on 4/17/22 at 1:48 p.m. Diagnoses included, but were not limited to, spinal stenosis, cervical region, unspecified injury at C3 and C4 level of cervical spinal cord, paraplegia, and neuromuscular dysfunction of bladder. A MAR, dated for the month of January 2023, indicated the following were not signed as administered or not administered: a. behavior monitoring and interventions every shift 1/12/23 (night shift), 1/18 (evening shift), 1/27/23 (night shift), 1/28/23 (night shift), and 1/29/23 (night shift). A TAR, dated for the month of January 2023, indicated the following were not signed as administered or not administered: a. Triad Cream to sacrum twice a day on 1/20/23 (day shift). b. Triad Cream to sacrum twice a day on 1/20/23 (evening shift). c. Daily wound assessment to sacrum every shift 1/17/23 and 1/20/23 (day shift). d. Daily wound assessment to sacrum every shift 1/21/23 (evening shift). e. Indwelling urinary catheter care every shift 1/20/23 (evening shift). f. Indwelling urinary catheter measure and record output every shift 1/17/23 (evening shift). g. Indwelling urinary catheter measure and record output every shift 1/20/23 (evening shift). h. Indwelling urinary catheter measure and record output every shift 1/21/23 (night shift). i. Low air loss mattress check for proper placement and function every shift 1/20/23 (evening shift). A TAR, dated for the month of February 2023, indicated the following were not signed as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administered or not administered: a. Triad Cream to sacrum twice a day on 2/5/23 (evening shift). b. Daily wound assessment every shift 2/5/23 (day shift). c. Flush catheter every shift 2/5/23 (evening shift). d. Indwelling urinary catheter measure and record output every shift 2/2/23, 2/5/23, and 2/13/23. A MAR, dated for the month of February 2023, indicated the following were not signed as administered or not administered: a. behavior monitoring and interventions every shift on 2/1/23 and 2/9/23. A MAR, dated for the month of April 2023, indicated the following were not signed as administered or not administered: a. Docusate Sodium (stool softener) 100 mg on 4/18/23 through 4/30/23. b. blood pressure twice a week every shift on 4/18, 4/20, 4/25, and 4/27/23. A TAR, dated for the month of February 2023, indicated the following were not signed as administered or not administered: a. monitor for bilateral lower extremities edema on 2/4, 2/13, 2/25, and 2/26/23. b. monitor for heart failure every shift on 2/4, 2/13, 2/25, and 2/26/23. c. monitor for shortness of breath every shift 2/4, 2/13, 2/25, and 2/26/23. A TAR, dated for the month of March 2023, indicated the following were not signed as administered or not administered: a. monitor for bilateral lower extremities edema on 3/19 and 3/21/23. b. monitor for heart failure every shift on 3/19, and 3/21/23.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	c. monitor for shortness of breath every shift 3/19 and 3/21/23. A TAR, dated for the month of April 2023, indicated the following were not signed as administered or not administered: a. monitor for bilateral lower extremities edema on 4/16/23. b. monitor for heart failure every shift on 4/16/23. 4. The record for Resident E was reviewed on 4/13/23 at 1:39 p.m. Diagnoses included, but were not limited to, protein calorie malnutrition, hypertension, thrombocytopenia (low platelet level), and colostomy. A MAR, dated for the month of December 2022, indicated the following medications were not signed as administered or not administered: a. omeprazole 20 mg daily on 12/2 and 12/3/22. A TAR, dated for the month of December 2022, indicated the following medications were not signed as administered or not administered: a. daily wound assessment every shift 12/5/22. A TAR, dated for the month of January 2023, indicated the following medications were not signed as administered or not administered: a. daily wound assessment every shift 1/5/23. b. colostomy output every shift 1/20/23. 5. The record for Resident 89 was reviewed on 04/14/23 at 9:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes, type 2 diabetes with diabetic neuropathy, and heart failure. A physician's order, initiated on 03/24/23, indicated to give Gabapentin (an anticonvulsant and nerve pain medication) 300 milligrams twice a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	day for health maintenance. During an interview, on 04/17/23 at 11:08 a.m., the Director of Nursing indicated Resident 89 had diabetic neuropathy. She then checked the order for Gabapentin and found the diagnosis for the medication was health maintenance. It was not a correct diagnosis. During an interview, on 04/17/23 at 8:59 a.m., the Director of Nursing (DON) indicated nurses were to sign off the MAR/TAR when service/care was provided, if the care/service was not provided the nurse needed to contact the physician and let them know. During an interview, on 04/17/23 at 9:00 a.m., the Corporate Support Nurse indicated missing documentation in the MAR/TAR did not necessarily mean service/care was not done. The facility did call nurses and ask if the care/service was completed. The facility did monitor for missing documentation. During an interview, on 04/17/23 at 9:10 a.m., Unit Manager 4 indicated the MAR/TAR was to be signed off when services had been provided. During an interview, on 4/17/23 at 4:40 p.m., the DON indicated if the MAR (Medication Administration Record) and TAR (Treatment Administration Record) had holes it was not done. They should be signed off on the MAR and TAR if they were given or not given and the reason not given should be documented. A current policy, titled "Physician Orders," undated and received from the Executive Director on 04/14/23 at 3:17 p.m., did not address ensuring the correct diagnosis was use for the medications			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to be administered. A current policy, titled "Clinical Documentation Standards," dated 2014 and received from the Director of Nursing on 04/17/23 at 10:25 a.m., indicated "...Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record...." This Federal tag relates to Complaint IN00404230, IN00401290, IN00392088, and IN00391751. 3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure a dressing change was completed using clean gloves and hand hygiene for 1 of 7 residents reviewed for wound changes (Resident 304) and failed to ensure soiled incontinence briefs were placed in trash cans for 1 of 5 residents reviewed for activities of daily living. (Resident 61) Findings include: 1. During a random observation, on 04/11/23 at 9:59 a.m., Resident 304 was observed in bed. He appeared to be having difficulty breathing. Resident 304 indicated he was having difficulty and the nurse was called to the room. Unit Manager 4 (UM) came to the room and assessed the resident. She indicated she knew what the issue was; the resident needed to be drained. She performed hand hygiene with an alcohol-based hand rub (ABHR) and donned gloves. While the nurse was monitoring the resident vital signs her phone rang. She reached into her pocket and removed the phone, turned off the ringer, and put the phone back into her pocket. She disconnected the vital sign machine from the resident and then exposed the dressing to his right side. She removed the gloves, performed hand hygiene with soap and water and donned a new set of gloves. She then auscultated (listened to) the resident's lung sounds with her stethoscope. She then walked over to the dresser, removed a towel, and	F 0880	**F880 (D) Infection Prevention and Control** **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** The facility will ensure personal protective equipment is donned and doffed correctly and hand hygiene is consistently implemented to potentially prevent the spread of infections. The facility will ensure all soiled briefs are disposed of properly and timely to eliminate the smell of odors and potentially prevent the spread of infections. Resident #304 required draining of their Plurex Catheter as per physician order, during the procedure UM # 4 failed to following correct hand hygiene with don/doffing gloves. Resident #304 was assessed by the DON and did not have a negative outcome as a result of the deficient practice.	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	placed it under the resident's right side. Returning to the dresser, she removed a biohazard bag and walked into the bathroom. She removed and discarded her gloves and put on a new pair of gloves. She was not observed to perform hand hygiene. She opened a Pleurx drainage set (used to remove fluid from the lung) went to the dresser and removed another towel from the bottom drawer. She returned to the bedside and then opened the drainage package wider and set it on the resident's legs on top of the towel. She removed the dressing from the resident's right side and discarded it, showing a tube which entered the resident into his right lung. She removed her gloves and discarded them and without being observed to perform hand hygiene, she donned a new set of gloves. At this time, the nurse indicated the kit was not sterile, it was not a sterile procedure. The nurse was then observed to wipe the furthest end of the drainage tube with an alcohol pad to clean it. She removed the cap from the drainage tube and attached it to the drainage container and placed the container on the floor. UM 4 then went to the bathroom, retrieved the biohazard bag, returned to the bedside, and placed it on the floor and put the drainage container into the biohazard bag. The fluids drained to gravity without incident and appeared to be dark amber in color. The nurse indicated the fluids removed were 1000 ml (milliliters). Without removing her gloves, she then used the vital sign machine to check the resident's vital signs. She then removed and discarded her gloves. She removed a clean pair of gloves from a box, then performed hand hygiene with soap and water. She then donned the gloves she had previously removed from the box prior to performing hand hygiene. She returned to the bedside and cleaned the drainage line with alcohol pads after disconnecting it from the drainage container. She		The facility had no additional resident with Plurex Catheters. Resident # 61 was observed to have a soiled brief left in the room. The brief was immediately removed from the resident room and disposed of properly. The Management team conducted room rounds to ensure no additional soiled briefs were found. UM #4 and CNA #3 were given education immediately by the DON following the observation of the deficient practice. As a result of the deficient practice the facility will: · The DON/IP nurse will provide education to Nursing staff on the proper disposal of soiled briefs by 5/10/23 · The DON/IP nurse will provide education to licensed nursing staff on standard precautions for the care of Plurex Catheters; utilizing the facility policies, Standard Precautions and General Hand Hygiene" The facility will also utilize the CDC guide for donning and doffing PPE. To assure continued compliance the facility will: · The DON/IP nurse will conduct rounds 5 times a week throughout the facility to ensure staff is exercising appropriate use of PPE, to ensure infection control procedures are followed, and all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	then placed a clean cap on the end of the line. Using a clean alcohol pad, the nurse cleaned the line beginning at the insertion site, into the body, and down the line. UM 4 ensured the drainage line was closed. She placed a split opening 4 x 4 (a square dressing with a split on one side to fit around lines) around the insertion site and covered it with a clean adhesive cover. The nurse was not observed to have changed gloves and perform hand hygiene after cleaning the drainage line or prior to cleaning and dressing the insertion site. The nurse gathered her trash along with the full drainage container, removed her gloves and placed all the items into the biohazard bag and secured it closed. The nurse then performed hand hygiene using soap and water. During an interview, on 04/11/23 at 10:35 a.m., UM 4 indicated she should have performed hand hygiene between glove changes, and she should have changed gloves after removing the soiled dressing from the insertion site. 2. During an observation, on 4/10/23 at 10:10 a.m., Resident 61's room had a very strong bm (bowel movement) odor. There was a dirty brief sitting on the bedside dresser. The record for Resident 61 was reviewed on 4/14/23 at 2:45 p.m. Diagnoses included, but were not limited to, heart failure, chronic kidney disease, obstructive and reflex uropathy (urine cannot flow through ureter, bladder, or urethra) and hypertension. A care plan, revised 5/27/22, indicated the resident required assistance with ADL (Activities of Daily Living). Interventions included, but were not limited to, observe, and anticipate resident's toileting needs and required 1 assistance with toileting.		soiled briefs are disposed of properly. · Results of the audits will be reviewed by the QAPI committee monthly for 6 months to determine if current interventions are adequate or if additional action is needed to ensure infection prevention and control procedure are implemented appropriately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 4/10/23 at 10:15 a.m., CNA 3 indicated there was a foul odor in the room. The dirty brief left on the bedside dresser was from night shift and should have been thrown away. During an interview, on 4/10/23 at 10:30 a.m., RN 2 indicated a dirty brief should be thrown away when removed or when found in the room. During an interview, on 4/13/23 at 10:23 a.m., LPN 8 indicated dirty briefs should not be left on the bedside table or left in the rooms. A current policy, titled "PPE Gloves," dated as last reviewed on 06/24/21 and received from the Director of Nursing on 04/11/23 at 2:35 p.m., indicated "...Perform hand hygiene before and after the use of...gloves...perform hand hygiene before re-gloving...." A current policy, titled "Standard Precautions," dated as last reviewed on 02/25/22 and received from the Director of Nursing on 04/11/23 at 2:35 p.m., indicated "...When to perform hand hygiene...After glove removal...." A current procedure, titled "Pleurx Catheter," undated was received from the Director of Nursing on 04/11/23 at 2:35 p.m., indicated "...Remove old dressing and discard...Remove gloves and perform hand hygiene...AFTER DRAINAGE...Place the new cap over the catheter valve...Remove gloves and perform hand hygiene...REPLACING THE DRESSING...Apply clean gloves...Clean around the catheter site with alcohol pad...Place the foam catheter pad around the catheter...Cover the catheter with gauze pads...Remove gloves and perform hand hygiene...Take...adhesive dressing and peel			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	away...backing paper...Center the dressing over the gauze pads...Remove plastic covering from dressing...press it down...." A current policy, titled "Resident Rights," not dated and received from the Director of Nursing on 4/17/23 at 4:33 p.m., indicated "...a state worthy of honor or respect, includes but not limited to...providing safe and secure housing, sanitary, food and hydration...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of resident, visitors and employees is a top priority of care...." A current policy, titled "Infection Prevention Program," dated as reviewed 2/24/22 and received from the Executive Director on entrance, indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Residents have a right to reside in a safe environment that promotes health and reduces the risk of acquiring infections. The facility infection program is comprehensive in that it addresses detection, prevention, and control of infections among residents and employees. 3.1-18(b)(1) 3.1-18(l)			
F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to follow an antibiotic stewardship program which included antibiotic use protocols and a system to monitor antibiotic use for 6 of 12 months reviewed for antibiotic stewardship. Finding includes: A review of the Facility Assessment Tool, dated 11/2021 through 10/2022, indicated the facility had an antibiotic stewardship program. The Director of Nursing (DON) started gathering information, documenting, and tracking infections for the program on 4/14/23. During an interview, on 4/17/23 at 9:24 a.m., the DON indicated she did not have any information filled out or track infections and trends until a few days ago. She started to fill out the "Antibiotic Stewardship" binder on 4/14/23 and only had information from 4/2022 through 10/2022 filled out so far. During an interview, on 4/17/23 at 11:28 a.m., the DON provided a binder titled "Antibiotic Stewardship." The binder did not contain information of tracking infections past 10/2022. They were to use McGeer Criteria forms and she had not completed any McGeer Criteria forms and indicated they just started to gather information for the Antibiotic Stewardship on 4/14/23. A current policy, titled "Infection Prevention Program," dated as reviewed 2/24/22 and received from the Executive Director on entrance, indicated "...It is the policy of this facility to provide	F 0881	**F 0881 Antibiotic Stewardship Program** It is the standard practice of Bridgewater Healthcare Center to ensure the Infection Prevention control plan and Antibiotic Stewardship Program are implemented and followed. The RDCO/ED will education the DON, IP nurse and clinical management on the following programs and protocol by 5/10/23: · ATB Stewardship Plan · ATB Stewardship Overview · Infection Control Monitoring and Prevention Program · Minimum Criteria for ATB USE · Completion of the Infection Surveille Assessment in PCC (Follows McGeer's) · Completion of the ATB Time- Out Assessment in PCC · Surveillance and Tracking · Indiana Mandatory disease reporting · Daily Line listing tracking · Utilization of Pharmacy reports for antibiotic used in the facility overtime The RDCO/ED will educate the DON/IP nurse on use of these tools. The IP nurse will update the March and April line listing and tracking to include the rate infection by 5/10/23.	05/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Residents have a right to reside in a safe environment that promotes health and reduces the risk of acquiring infections. The facility infection program is comprehensive in that it addresses detection, prevention and control of infections among residents and employees...." 3.1-18(b)(3)		The DON will monitor all reporting and tracking weekly. The IP nurse or designee will bring all antibiotics in use and up to date line listing to weekly risk meeting. The Director of Nursing/designee will review and report these findings to the QAPI (Quality Assurance Performance Improvement) Committee for a period of 6 months or until 100% compliance is achieved.	