DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	07/18/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00384803, IN00384811, IN00384821, IN00384598 and IN00385343. Complaint IN00384803 - Substantiated. Federal/State deficiencies related to the allegations are cited at F690 and F842. Complaint IN00384811 - Unsubstantiated due to lack of evidence. Complaint IN00384821 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00384598 - Unsubstantiated due to lack of evidence. Complaint IN00385343 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F880. Survey dates: July 14, 16 and 18, 2022. Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 5 Medicaid: 58 Other: 10 Total: 73	F 0000	The creation and submission of this Plan of Correction does not constitute and 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 on or after August 13, 2022.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 22, 2022.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or			

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	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to ensure the family of a resident was notified of a change in condition and hospitalization for 1 of 4 residents reviewed for notification of a change in condition and hospitalization. (Resident C) Finding includes: During an interview, on 7/18/2022 at 10:15 a.m., a family member indicated she was not informed Resident C had a positive Covid test on 6/18/2022. She indicated she was not informed of his change in condition, his positive Covid symptoms or his hospitalization on 6/20/2022. She was not aware of Resident C's change of condition until the resident informed the family of his condition and hospitalization during a facility visit on 6/23/2022. The record for Resident C was reviewed on 7/14/2022 at 1:30 p.m. Diagnoses included, but were not limited to, acute respiratory failure with	F 0580	**F-580** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident C, as listed in the 2567, has previously discharged from the facility on 6/26/2022. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficiency. Facility will audit documentation for resident representative	08/13/2022

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	hypoxia, type 2 diabetes mellitus, hypertensive heart disease, anemia and paroxysmal atrial fibrillation. The nursing notes indicated Resident C had a positive Covid test on 6/18/2022 and had Covid symptoms. The records indicated the resident was transferred to the hospital on 6/20/2022. There was no indication the family was informed of the residents change in condition and hospitalization. During an interview, on 7/18/2022 at 1:55 p.m., the Director of Nursing (DON) indicated he was not aware the staff had not notified the family. The resident's family should have been informed of a change in condition and hospitalization. The DON indicated he was not the DON at the facility on 6/18/2022. A facility policy, titled "Notification for Changes in Condition," dated as last reviewed 5/30/2019 and provided by the DON on 7/18/2022 at 3:00 p.m., indicated "...The purpose of this policy is to provide guidance for notification made to residents, resident representatives, and family for resident changes in condition...i. The DON designee will contact the provider, resident representative and/or the authorized family members e. Notification may be made via telephone or face- to- face...c. The nurse will record in the progress notes, the name of the person called, the time of each attempt to contact, and the telephone number(s) attempted...." This Federal tag relates to Complaint IN00385343 and IN00384821.		notifications for those residents who have experienced a change in condition in the past 30 days. Facility will contact resident representatives for residents lacking documentation of notification to verify if a notification occurred and discuss change in condition. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SDC/designee will conduct in-servicing for licensed nurses to review facility policy on notification of changes in conditions. IDT team will review changes in condition during IDT meetings and review notification for resident representative. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** • DNS/designee will review changes in condition for documentation of resident representative notification 5 times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months with goal/threshold of 95% compliance rate. DNS/designee	

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	3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)		will present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.	
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 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			

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	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 obtain orders for an indwelling Foley catheter for 1 of 3 residents reviewed for catheters (Resident H). Finding includes: During an observation, on 07/15/22 at 12:08 p.m., Resident H was observed to be laying in bed with a Foley catheter bag below his bladder to the resident's left. The Foley was draining tea colored urine to gravity and there was approximately 400 milliliters of tea colored urine in the drainage bag. At that time, the resident indicated staff did not provide him catheter care, his wife did the care. The record for Resident H was reviewed on 07/14/22 at 1:47 p.m. Diagnoses included, but were not limited to, Cauda Equina syndrome (extreme pressure and swelling of the nerves at the end of the spinal cord), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and Bell's Palsy (a condition which causes sudden weakness in the muscles on one side of the face). There was no order for catheter care found in the record. There was no order to measure and record urine output found in the record. There was no order to flush the catheter found in the record.	F 0690	**F-690** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** DNS immediately corrected catheter orders for Resident H, as listed in the 2567, when notified by surveyor that orders were not present. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with catheters have the potential to be affected by this deficiency. Facility will complete audit for all residents with catheters and ensure orders are in place and accurate according to facility policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SDC/designee will conduct in-servicing for licensed nurses to	08/13/2022

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	There was no order to indicate the catheter size or bulb size in the record. There was no documentation specific to catheter care found in the record. During an interview, on 07/16/22 at 6:00 a.m., the Director of Nursing indicated typically when a resident with a catheter admits to the facility, they input a batch (group of orders) for catheter care. The orders include providing catheter care, flushing the catheter, the size of the catheter and bulb size (the bulb was what anchors the catheter in the bladder) and to record the output of urine. The nurse who received the admission inputs the orders. The orders are reviewed by the Interdisciplinary Team when they do an admission review. It was a standard process. The Director of Nursing was unable to provide documentation of catheter care provided but indicated the CNA could do catheter care and it was part of perineal care (care which involved cleaning the private areas of a patient). The policy related to catheter care orders was requested. The Director of Nursing provided the policies he could find. A facility policy, titled "Indwelling Catheterization Male," dated as reviewed on 06/03/21 and provided by the Director of Nursing on 07/16/22 at 7:03 a.m., indicated "...Check for physician's order that includes the type, size...for catheter...." This Federal tag relates to Complaint IN00384803. 3.1-41(a)(2)		review facility policy on catheter orders and demonstrate proper catheter care. IDT team will review new admissions for the presence of a catheter and ensure orders are accurate per facility policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** DNS/designee will review orders for residents with catheters weekly for 4 weeks, and then monthly for 3 months with goal/threshold of 95% compliance rate. DNS/designee will review documentation for completion of catheter care for residents with catheters weekly for 4 weeks, and then monthly for 3 months with goal/threshold of 95% compliance rate. DNS/designee will present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.	
F 0842 SS=D	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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Bldg. 00	§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 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			

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	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. §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 document meal intakes for 1 of 3 residents reviewed for complete and accurate documentation. (Resident J). Finding includes: During an interview, on 07/15/22 at 4:52 p.m., a family member of Resident J indicated the resident was not provided three meals daily or staff would leave the meal tray at the bedside if the resident was asleep and not wake him.	F 0842	**F-842** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The time period reviewed by surveyor is outside the available window for the facility to correct the documentation for Resident J	08/13/2022

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	The record for Resident J was reviewed on 07/14/22 at 1:36 p.m. Diagnoses included, but were not limited to, hypertension, gout and cerebral infraction (stroke). A facility document, titled "Task: *Amount Eaten," provided by the Director of Nursing on 07/18/22 at 1:40 p.m., indicated the following omissions: There was no meal documentation for June 21, 22, 23, 25 and June 26 2022. There was no meal documentation the evening meal on July 2, 2022. There was no meal documentation for the morning or mid day meal on July 3, 2022. There was no meal documentation for the evening meal on July 04, 2022. There was no meal documentation for July 05 and July 06, 2022. There was no meal documentation for the evening meals on July 15 and 16, 2022. During an interview, on 07/18/22 at 3:01 p.m., Resident J indicated he was provided with three meals a day. A facility policy, titled "Clinical Documentation Standards," dated as reviewed on 02/07/22 and provided by the Executive Director on 07/18/22 at 3:15 p.m., indicated "...A complete record contains an accurate...representation of actual experience of the resident...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 IN00384803.		as listed in the 2567. Facility will review charting from the current window period for Resident J and correct any missing documentation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficiency. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SDC/designee will conduct in-servicing for nursing personnel regarding documentation of meal intakes and consumption. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** DNS/designee will conduct review of resident meal intake and consumption documentation for 12 residents weekly for 4 weeks, and then monthly for 3 months with goal/threshold of 95% compliance rate. DNS/designee will present results during monthly QAPI	

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	3.1-50(a)(1) 3.1-50(a)(2)		meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.	
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 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			

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	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. 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 develop and implement written policies and procedures for	F 0880	**F-880** **What corrective action(s) will**	08/13/2022

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	infection control, to contain the spread of infections which include, but are not limited to, the Covid-19 virus, when the facility failed to ensure staff preformed hand hygiene before entering and upon exiting resident rooms for 1 of 7 observed staff members. (Housekeeper 2) Finding includes: During a random observation of the 3000 hall, on 07/18/22 at 8:26 a.m., Housekeeper 2 was observed carrying plastic clothing hangers when she entered room 3013. She checked the wardrobe, exited the room and entered room 3014. She exited room 3014 and entered room 3015. She exited room 3015 and entered room 3016. She exited room 3016 and entered room 3017. She exited room 3017 and entered room 3018 and then exited room 3018. She was not observed to perform hand hygiene before entering the rooms or upon her exit of the rooms. During an interview, on 07/18/22 at 8:29 a.m., Housekeeper 2 indicated she did not perform hand hygiene when entering or exiting the rooms because she was just going in to get hangers from the rooms. During the exit conference, on 07/18/22, the Executive Director indicated staff should perform hand hygiene before entering and when exiting resident rooms. A facility policy, titled "Standard Precautions," dated as revised on 04/01/17 and provided by the Executive Director on 07/18/22 at 3:19 p.m., indicated "...When to perform Hand Hygiene...After contact with inanimate objects...in the...vicinity of the residents...." This Federal tag relates to Complaint IN00385343.		**be accomplished for those residents found to have been affected by the deficient practice:** ED met with housekeeping manager and staff member when notified of concern from surveyor. One-on-one education was completed by the ED on proper hand sanitizing when entering/exiting resident rooms. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficiency. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** IP/designee will conduct in-servicing and demonstration for facility staff on proper hand hygiene per facility policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** IP/designee will review 20 hand	

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	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-18(l)		hygiene moments weekly for 4 weeks, and then monthly for 3 months with goal/threshold of 95% compliance rate. Any instances of missed hand hygiene will result in immediate in-servicing with the staff member who was reviewed. IP/designee will complete 10 hand hygiene/washing check-offs for employees weekly for 4 weeks, and then monthly for 3 months with goal/threshold of 95% compliance rate. DNS/designee will present results during monthly QAPI meeting, overseen by Executive Director, to determine further actions, educational needs, and frequency of ongoing monitoring.	