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	12/18/2023

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 IN00421402, IN00421407, IN00422706 and IN00424361. Complaint IN00421402 - Federal/state deficiencies related to the allegations are cited at F550, F691 and F755. Complaint IN00421407 - Federal/state deficiencies related to the allegations are cited at F691. Complaint IN00422706 - No deficiencies related to the allegations are cited. Complaint IN00424361 - No deficiencies related to the allegations are cited. Survey dates: December 18, 19 and 20, 2023 Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 5 Medicaid: 74 Other: 15 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 22, 2023.	F 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick Burdsall	Executive Director	01/03/2024

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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility staff failed to answer a call light for 1 of 1 call light observed flashing on unit 3000. (Room 3012) Finding includes: During a random observation, on 12/18/23 at 9:59 a.m., the call light for Room 3012 was observed flashing white. The room was located close to the nursing station. QMA 5 was observed to straighten items at nursing station, then go to the end of the hall. A nurse was also visible in the hall passing medications. CNA 1 was then observed to come through the 3000 unit at 10:03 a.m., pass the nursing station, turn right, and move to the end of the hall. CNA 1 was then observed standing at the end of the hall with her back against the wall on her cell phone. The QMA was passing medication to the last room on the left. During an interview, on 12/18/23 at 10:06 a.m., when asked why she did not respond to the call light, CNA 1 indicated she was waiting for her nurse to help her transfer a resident. She had left the resident in the shower and went to get assistance to transfer the resident. On 12/18/23 at 10:07 a.m., a staff member entered the unit and went to answer the call light. None of the three (3) staff members currently working on the unit responded to the call light. During an interview, on 12/18/23 at 10:42 a.m., the Director of Nursing indicated her expectation was	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The resident in 3012 was not negatively affected by this deficient practice. **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. Residents from each unit were interviewed during angel care rounds to ensure call lights were being answered timely and any deficiencies were addressed and reported. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Staff were educated on facilities policy related to resident rights and responding to call lights. **How the corrective action(s) will be monitored to ensure the**	01/05/2024

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	for staff to answer the call lights. If they had a phone call they needed to take, staff were to inform the nurse and excuse themselves from the unit, however that was secondary to patient care. A facility in-service, dated 10/16, 10/18, 10/20 and 10/21/23, indicated "...Cellphones/Air pods...Cellphones and air pods are not allowed to be in use while the employee is working on the floor...." CNA 1 was signed-in for the in-service on 10/21/23. A facility policy, titled "Resident Rights," undated and received from the Director of Nursing on 12/18/23 at 1:28 p.m., indicated "...Staff will answer call needs promptly...." This Federal Tag relates to Complaint IN00421402. 3.1-3(t)		**deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON/Clinical Designee will conduct observations of staff to ensure that call lights are being answered timely. Three staff observations will be conducted 5 days per week x 90 days, and then once weekly x 3 months thereafter. The DON/Clinical Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months or ongoing until desired results achieved.	
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview and record review, the facility failed to check/change a colostomy bag prior to the bag bursting, failed to follow facility protocol when changing and cleaning the resident, and failed to provide a clean brief for 1 of 1 resident reviewed colostomy care. (Resident C)	F 0691	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** LPN 4 was educated on the proper	01/05/2024

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	Finding includes: During an interview, on 12/18/23 at 10:08 a.m., Resident C was resting in bed with the television on. Resident C allowed observation of her colostomy bag. The bag was observed to be intact, distended, and full of feces. There was a brown dried substance noted on the resident's skin at the lower end of the colostomy bag. Resident C indicated sometimes they (facility staff) changed the bag. The record for Resident C was reviewed on 12/18/23 at 10:36 a.m. Diagnoses included, but were not limited to, type 2 diabetes, anemia, and chronic obstructive pulmonary disease (COPD). A physician's order indicated to change the ostomy bag as needed. During an observation, on 12/19/23 at 4:28 a.m., LPN 4 was observed sitting at the nursing station with her cell phone in hand. She was swiping and reading. The nurse put her phone away and left the nursing station. She went to check Resident B who was being cared for by the CNA, then went to check Resident C. On 12/19/23 at 4:31 a.m., Resident C was observed resting in bed. LPN 4 donned gloves and went to the left of Resident C and pulled back the blankets/sheets. Resident C had feces on her gown at waist height and feces at the top of her brief. Also visible was a colostomy bag which had been partially covered with the brief. LPN 4 then indicated the colostomy bag had busted. Feces was observed on the resident's abdomen. LPN 4 then went to the nightstand, removed a new colostomy bag and hygiene wipes, placed them at		protocol related to changing and cleaning of a resident with a colostomy bag. Resident C was not negatively affected by the deficient practice. **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 a colostomy, urostomy, and ileostomy will be interviewed to ensure they are receiving the proper care when changing and cleaning the area. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The Director of Nursing or designee will educate staff related to the proper protocol for colostomy care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The DON/Clinical Designee will conduct observations of staff changing and cleaning a resident	

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	the foot of the bed, removed her gloves and discarded them in the trash. She indicated she needed to go and get scissors. As she exited the room, she indicated she was going to perform hand hygiene outside the room. At 4:33 a.m., LPN 4 reentered the room, performed hand hygiene using alcohol-based hand sanitizer (ABHR), donned gloves, and cleaned the scissors with alcohol pads. She then cut a hole in the back of the colostomy bag where the wafer (portion which fits over the ostomy and secures the bag in place) was located. She approached the resident's left side, pulled back the brief and indicated, "gosh it's really busted here." Feces was observed under the bag on the resident's skin and on the inside of the front of the brief. She removed and discarded the bag. Using the hygiene wipes she cleaned the feces from the skin; each time using one hand to pull the wipes and the other hand to hold the wipe's container down while pull the wipe out. She repeated the process four times. While LPN 4 was cleaning the feces from the resident's skin, Resident C asked what made the nurse come and look at the colostomy bag. The nurse indicated "this gal wanted to visit you and see, good thing she came." The nurse discarded the soiled wipes into the trash, removed her gloves, went to the restroom, and performed hand hygiene with soap and water. LPN 4 donned new gloves and applied the self-adhesive wafer/bag to the area. The nurse then removed the soiled gown and place a new gown on the resident. LPN 4 indicated she would have the CNA come in and change the resident's soiled brief. LPN 4 removed one glove and discarded it, picked up the soiled gown and scissors, and put the wipes away in the nightstand drawer. During an interview, on 12/19/23 at 4:56 a.m., LPN 4 indicated she could change the brief, but she did		with a colostomy. Three observations will be conducted 3 days per week x 90 days, and then once weekly x 3 months thereafter. The DON/Clinical Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months or ongoing until desired results achieved.	

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	not get her "stuff" done and she would have the CNA change the brief. A facility in-service, dated 10/16, 10/18, 10/20 and 10/21/23, indicated "...Cellphones/Air pods...Cellphones and air pods are not allowed to be in use while the employee is working on the floor...." A facility policy, titled "Routine Resident Care," undated and received from the Director of Nursing on 12/19/23 at 8:32 a.m., indicated "...Licensed Staff will include the following services based upon their scope of practice, but not limited to...bowel and bladder management...Toileting, providing care in incontinence...." A facility policy, titled "Colostomy Appliance Bag Change," undated and received from the Director of Nursing on 12/19/23 at 8:32 a.m., indicated "...Observe Standard Precautions...Cleanse surrounding skin area and stoma with mild soap and water...." This Federal tag relates to Complaint IN00421402 and Complaint IN00421407. 3.1-47(a)(3)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to provide medications/treatments per the physician's order and failed to document in the Medication and Treatment Record the reason for the omission of the medications/treatments for 2 of 3 residents reviewed for medication administration. (Resident B and C) Findings include: 1. During an interview, on 12/18/23 at 9:27 a.m., Resident B indicated she did not receive her anticoagulant injection daily. During an interview, on 12/20/23 at 12:48 p.m.,	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B and C were not affected by this alleged deficient practice. **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;**	01/05/2024

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	Resident B was observed in her bed doing an activity. She indicated she did not receive her anticoagulant injection yesterday. The record for Resident B was reviewed on 12/18/23 at 10:20 a.m., and again on 12/20/23 after the resident voiced concerns about her medication. Diagnoses included, but were not limited to, cutaneous abscess of the abdomen (a pocket of puss in the abdomen), type 2 diabetes, and obesity. The resident had a BIMS (Brief Interview for Mental Status) score of 14 on the quarterly assessment, dated 10/24/23, which indicated she was cognitively intact. A care plan, initiated on 4/13/23, indicated Resident B was on an anticoagulant/antiplatelet medication and to provide the medication per the medical provider's orders. A physician's order indicated to give Enoxaparin Sodium (an anticoagulant) 40 milligrams/0.4 milliliters (mg/ml) subcutaneously (injected into the fatty tissue just under the skin) every morning. The Medication Administration and Treatment Record (MAR/TAR) indicated there was no documentation of the administration of the Enoxaparin Sodium on 11/16/23 at 8:00 a.m., and on 12/19/23 at 8:00 a.m. Other omissions found in the MAR/TAR were: a. A physician's order for a daily wound assessment to the bilateral upper arms was missing documentation on 11/23, 11/25 and 11/26/23. b. A physician's order to measure colostomy		All residents have the potential to be affected. The DON/Designee will complete an audit of the MAR and TAR to ensure medication/treatments are administered as ordered by the provider. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The DON or designee will educate the licensed nurses and qualified medication aides on the facility policy related to Medication Administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The MAR/TAR audit will be conducted by the Director of Nursing or designee to ensure compliance with medication/treatment administration as ordered by the provider. The Director of Nursing will audit 3 residents, 5 days a week, for 6 months or ongoing until desired results are achieved. The DON/Designee will bring the results of the audits to the	

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	output every shift was missing documentation on the day shift 11/5, 11/6 and 11/15/23 and on the night shift 11/6/23. During an interview, on 12/20/23 at 11:33 a.m., the Director of Nursing (DON) was informed of the missing anticoagulant injection. The DON indicated she had a QMA on the unit yesterday (12/19/23). 2. The record for Resident C was reviewed on 12/18/23 at 10:36 a.m. Diagnoses included, but were not limited to type 2 diabetes, anemia, and chronic obstructive pulmonary disease (COPD). A care plan, initiated on 10/6/20, indicated Resident C used an antidepressant Trazodone for depression and insomnia and to give the antidepressant medications as ordered by the physician. A physician's order indicated to give Trazodone (an antidepressant) 50 mg at bedtime for depression. The Medication Administration and Treatment Record (MAR/TAR) indicated there was no documentation of the administration of the Trazodone on 11/25/23 at bedtime. A physician's order indicated to give Fluticasone Propionate Nasal Suspension (a nasal spray used for asthma and allergies) every morning and at bedtime. The MAR/TAR indicated there was no documentation of the administration of the Fluticasone Propionate on 11/26/23 at bedtime. A physician's order indicated to give Fluticasone-Salmeterol (an inhaler) 250-50 micrograms (mcg) every morning and at bedtime for COPD. The MAR/TAR indicated there was no documentation of the administration of the		monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months or ongoing until desired results are achieved.	

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	Fluticasone-Salmeterol on 11/26/23 at bedtime. A physician's order indicated to give guaifenesin extended release (used to help clear mucus) 600 mg every 12 hours. The MAR/TAR indicated there was no documentation of the administration of the guaifenesin on 11/26/23 at 9:00 p.m. A physician's order indicated to give two (2) sennosides-docusate (a medication for constipation) 8.6-50 mg every morning and every bedtime. The MAR/TAR indicated there was no documentation of the administration of the sennosides-docusate on 11/26/23 at bedtime. A facility policy, titled "Medication Administration," undated and received from the Director of Nursing on 12/18/23 at 1:28 p.m., indicated "(...Administer medication only as prescribed by provider...Medications will be charted when given....) This Federal Tag relates to Complaint IN00421402. 3.1-25(a)			