F 157
SS=D
483.10(b)(11) NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to ensure the family was notified when there was

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

The same POC was faxed 12/6/13
Continued From page 1

a change in status for 1 of 22 (Resident #116) residents included in the stage 2 sample.

The findings included:

Review of the facility's change of condition policy documented, "...6. Notify the resident's legal representative and/or interested family member of the change... Attempt at frequent interval, until notified of change and interventions..."

Medical record review for Resident #116 documented an admission date of 8/02/13 with diagnoses of Alzheimer's Disease, Hypertension, Diabetes Mellitus, Dementia, Depressive Disorder and Hyperlipidemia. Review of telephone orders dated 11/2/13 documented, "...start Isolation Precautions..."

During a family interview in Resident #116's room on 11/12/13 at 12:21 PM, the family member stated "...I came to visit and he was in isolation and we did know why or anything about it... no one notified me or my son... we did not what he was isolation for... the weekend nurse did not notify us of anything..."

During an interview in the Director of Nursing's office (DON) on 11/13/13 at 3:30 PM, the DON confirmed that the responsible party (RP) had not been notified by the nurse when Resident #116 was placed in isolation. The DON stated, "...the family is to be notified if there is any change in the resident's condition... we use the "...Communication Form and Progress Note" that should be followed when there is a change of condition or incident... notifying the family is part of that form... the form was not competed and the family had not be notified..."
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLINIC IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>446327</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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<tr>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tr>
<td>117 N MAIN STREET</td>
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<td>RIDGELEY, TN 38080</td>
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**NAME OF PROVIDER OR SUPPLIER**

**THE BRIDGE AT RIDGELEY**

**ID TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | **ID TAG** | **PROVIDERS PLAN OF CORRECTION** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | **COMPLETION DATE** |
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<tbody>
<tr>
<td>F 244</td>
<td>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</td>
<td>F 244</td>
<td>Monitoring measures:</td>
<td></td>
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<tr>
<td>SS=D</td>
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<td>Resident's Physician Orders will be reviewed daily per Clinical Team during morning clinical meeting to ensure that family is notified when there is a change in a resident's status. If any notifications are found to have not been completed, Medical Records Nurse/Unit Manager will notify the family of any status changes.</td>
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<td>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</td>
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<td>DON/ADON will complete medical record review on 10% of active medical records monthly to assure compliance.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Findings of medical records review will be reported per DON/ADON monthly to QA Committee Team.</td>
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<td>Based on policy review, review of resident council meeting minutes and interview, it was determined the facility failed to follow up on the resident council's concerns for 2 of 3 (September and October 2013) months of resident council meeting minutes reviewed.</td>
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<td>The findings included:</td>
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<td>Review of the facility's rules and regulations dated 2/13 documented, &quot;...Grievances We welcome you to share concerns about your care in the facility at any time. You may also suggest changes in the policies and services of the Facility. You will not be harassed or discriminated against for making a complaint or suggesting a change in a policy or service...&quot;</td>
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<td>Review of the facility's elder council meeting minutes revealed the following:</td>
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<td></td>
<td>a. 9/10/13 - &quot;...COMPLAINT / CONCERN...Cleanliness of the rooms/floors...&quot;</td>
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<td>b. 10/7/13 - &quot;...Report on Previous Concerns / Complaints / Grievances / Follow-up: none...&quot;</td>
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<td>The facility was unable to provide any documentation the facility followed up on the resident council concerns.</td>
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<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<td>F 244</td>
<td>Continued From page 3</td>
<td>F 244</td>
<td>Systemic measures: Resident Council meeting minutes will be reviewed monthly following the monthly meeting per Activity Director/Social Services Director.</td>
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<td>During an interview in the Director of Nursing's (DON) office on 11/15/13 at 8:20 AM, the DON was asked if there was any follow up with concerns voiced from residents in the resident council. The DON stated, &quot;Yes, we follow up...&quot; The DON was then asked if there is any documentation of the follow up. The DON confirmed there is no documentation.</td>
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<td>During an interview in the hall beside the therapy department on 11/15/13 at 9:10 AM, the Administrator was asked about follow up to grievances from the resident council and documentation of the follow up and resolutions. The Administrator stated, &quot;...we don't usually document little things like that [concerns of cleanliness]...&quot; The Administrator was then asked if anyone ever follows up with the group to let them know the resolution of their concern? The Administrator stated, &quot;...we are gonna put that in place as soon as the new Activity Director gets here...&quot;</td>
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<tr>
<td>F 253</td>
<td>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</td>
<td>F 253</td>
<td>HOUSEKEEPING &amp; MAINTENANCE SERVICES</td>
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<tr>
<td>SS=E</td>
<td>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure 15 of 51 (Rooms 201, 203, 204, 205, 206, 207, 208, 210, 212, 213, 214, 215, 216, 217 and 218) resident rooms were maintained in a clean,</td>
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Residents affected: Hall corridor (200) was deep cleaned on 11/15/13 per Plant Operation Manager and Maintenance.
Resident rooms 201, 203, 204, 205, 206, 207, 208, 210, 212, 213, 214, 215, 216, 217, 218 will be deep cleaned per Plant Operation Supervisor/Designee by 12/15/13.
Continued From page 4

safe and sanitary manner.

The findings included:

1. Review of the facility's "Floor Care" policy documented, "...Floors shall be maintained in a clean, safe and sanitary manner..."

Review of the facility's "Five Step Daily Resident Room Cleaning" policy documented, "...Resident's rooms are properly cleaned and sanitized on a scheduled daily basis to prevent the spread of infection and bacteria..."

2. Observations in rooms 201, 203, 204, 205, 206, 208, 210, 212, 213, 214, 215, 216 and 217 on 11/14/13 starting at 3:30 PM, revealed there was a build up of dirt at the door frames and dried paint droplets on the floor.

3. Observations in room 204 on 11/12/13 beginning at 11:45 AM, revealed the bathroom sink faucet was corroded around the base of the faucet and the bathroom floor was dirty and stained.

4. Observations in room 206 on 11/12/13 at 11:50 AM, revealed the bathroom floor was dirty and stained around the wall and trash was on the floor.

Observations in room 206 on 11/13/13 at 8:05 AM, revealed the bathroom floor was dirty with pieces of chipped paint on the floor and pieces of paper towels on the floor and pieces of wood covering the door were broken off and missing.

5. Observations in room 207 on 11/13/13 at 8:10 AM, revealed the bathroom floor was dirty, dirt on...
the floor along the wall, white specks on the floor, dirty paper towels and pieces of torn paper towels on the floor.

6. Observations in room 212 on 11/12/13 at 12:05 PM and 3:30 PM, revealed the bathroom was dirty and the floor was stained and the bathroom walls had white spots like they were patched and not painted.

Observations in room 212 on 11/13/13 at 8:25 AM, revealed there were small paint chips or white flecks of trash and food crumbs on the floor in the bathroom.

7. Observations in room 214 on 11/12/13 at 12:05 PM, revealed the bathroom floor was dirty and there were chipped paint pieces on the floor, there were dark stains around the sink faucet, around the wall on the floor and around the commode and there were dirty paper towels on the floor.

Observations in room 214 on 11/14/13 at 8:45 AM, revealed the bathroom floor was dirty with small pieces of paper and trash on the floor.

8. Observations in room 217 on 11/12/13 at 11:00 AM, revealed the bathroom floor covering was torn in the doorway and cracked along the wall, there was dirt and grime around the wall on the floor, the toilet tissue holder was rusted and the finish of the wooden door to the bathroom had chipped cut places.

9. Observations in room 218 on 11/12/13 at 12:10 PM, revealed the bathroom faucet had stains on the metal.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:
445327

(The Bridge at Ridgely)

X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ________________________________

(X3) DATE SURVEY COMPLETED
11/15/2013

STREET ADDRESS, CITY, STATE, ZIP CODE
117 N MAIN STREET
RIDGELEY, TN 38080

NAME OF PROVIDER OR SUPPLIER

(X4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(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 253	Continued From page 6

10. Observations in room 218 on 11/14/13 at 3:30 PM, revealed a black line of dirt where the wall joins the floor along the width of the room.

11. During an interview on the 200 hall on 11/14/13 at 11:25 AM, the Administrator was informed of the findings noted above and made the following response "That is not acceptable... I don't know what it [referring to the paint specks on the floor] is... we did paint it a little while back..." The Administrator was then asked if the floors are stripped and waxed. The Administrator stated, "We just mop the floors, we don't use wax... yes, there has been some neglect... the black around the commode looks like grime..."

F 257	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS

The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure the air temperature of the common areas was maintained at a comfortable level on 3 of 4 (11/12/13, 11/13/13 and 11/14/13) days of the survey.

The findings included:

1. Review of the facility's "Building Standards" policy documented, "Temperatures in residents' rooms and common areas will be according to..."

F 257	COMFORTABLE & SAFE TEMPERATURE LEVELS

The facility will provide comfortable and safe temperature levels.

Residents affected:
On 11/14/13 heating unit was cleaned and inspected with temporary repairs performed per Maintenance Supervisor.

Heating unit was repaired per HVAC Technician on 11/18/13.

Residents potentially affected:
All residents on 200 hall and in common areas were affected.

Heating unit was repaired per HVAC Technician on 11/18/13

Systemic measures:
During daily environmental rounds per Department Heads will check for uncomfortable temperatures. Findings will be reported to Administrator/Plant Operation Manager during morning Department Head meeting.

Staff will be educated by 12/15/13 per Staff Development Coordinator/Plant Operation Manager to report uncomfortable temperatures to supervisor/Maintenance/Administrator.

Plant Operation Manager will inspect HVAC unit(s) quarterly to ensure condition and proper functioning.

Monitoring measures:
During daily environmental rounds per Department Heads will check for uncomfortable temperatures. Findings will be reported to Administrator/Plant Operation Manager during morning Department Head meeting.

12/15/13
Continued From page 7 state / federal requirements...

2. Observations in the 200 hall on 11/12/13 at 12:05 PM, revealed Resident #16 propelling self down the hall stating, "...I am going to the other side of the hall it may be warmer over there..."

Observations in the common hall beside the nurses' station and the 200 hall on 11/12/13 at 12:30 PM, revealed the air temperature to be 64 degrees Fahrenheit (F) and staff working in fleece jackets.

3. Observations in the common hall beside the nurses' station and the 200 hall on 11/13/13 at 8:30 AM, revealed the air temperature to be 60 degrees F and staff working in fleece jackets.

Observations at the nurses' station on 11/13/13 at 8:35 AM, revealed the maintenance man increasing the thermostat from 70 degrees F to 72 degrees F. The maintenance man stated, "...only maintenance can change thermostats, usually kept around 72 degrees [F]..."

4. Observations in the common hall beside the nurses' station and the 200 hall on 11/14/13 at 10:00 AM, revealed the air temperature to be 66 degrees F and staff working in fleece jackets.

During an interview in the hall beside the 200 hall shower on 11/14/13 at 11:25 AM, the Administrator was asked what the temperature should be in the hall where residents are located. The Administrator stated, "...we try to keep the temperature 70 to 71 degrees..."

During an interview in the hall beside the nurses station on 11/14/13 at 8:20 AM, the Director of
| F 257 | Continued From page 8  
Nursing was asked why her staff works in fleece jackets. The DON stated, "...it's always cold in here..."

| F 258 | MAINTENANCE OF COMFORTABLE SOUND LEVELS  
483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS  
The facility must provide for the maintenance of comfortable sound levels.

This REQUIREMENT is not met as evidenced by: 
Based on observation and interview, it was determined the facility failed to ensure the environment was maintained with comfortable sound levels in 1 of 51 (Room 114) rooms.

The findings included:
Observations in Resident #116's room on 11/13/13 at 12:20 PM, a loud knocking noise was heard from heating unit.
During an interview in Resident #116's room on 11/13/13 at 12:20 PM, Resident #116's wife stated, "When the fan comes on the unit makes a loud noise..."
During an interview at the nurse's station on 11/13/13 at 1:00 PM the Director of Nursing (DON) confirmed there was a loud noise in Resident #116's room. The DON stated "...it sounds like it is coming from the unit we will look at that..."

| F 278 | ASSESSMENT  
483.20(g) - (j) ASSESSMENT  
ACCURACY/COORDINATION/CERTIFIED  
F 278 |
Continued From page 9
The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess residents with weight loss for 1 of 3 (Resident #121) sampled residents reviewed of the 22 residents included in the stage 2 review.

The findings included:
<table>
<thead>
<tr>
<th>F 278</th>
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</table>
|       | Medical record review for Resident #121 documented an admission date of 7/19/13 and a discharge date of 8/29/13 with diagnoses of Back Disorder, Spinal Stenosis, Soft Tissue Disorder, Hypocalcemia, Depressive Disorder, Anxiety, Insomnia, Aftercare for Post-Operative Anterior and Posterior Lumbar Radical Disectomy, Bone Graft, Spondylosis, Spondylolisthesis, Chronic Obstructive Pulmonary Disorder and Acid Reflux. The Physician's orders dated 8/1/13 documented, "...Ice cream twice daily @ [at] 2pm & [and] 8pm... wt. [weight] loss..."

The interdisciplinary progress notes documented the following:

|       | a. 7/26/13 - "...Resident reviewed c [with] NAR Nutritional Assessment Record... Wt currently 110.0 [down symbol] 2.8% [percent] from admit wt on 7/19/13. Will cont [continue] wky [weekly] wts [weights] until stable x [times] 4 wks [weeks]..."
|-------|--------------------------------------------------|
|       | b. 8/1/13 - "...Resident reviewed @ NAR. Wt currently 105.9 [down symbol] 3.7% x 1 wk. New order for ice cream twice daily @ 2pm & 8pm. Will cont wky wts..."
|       | c. 8/8/13 - "...Resident reviewed @ NAR wt currently 105.2 [down symbol] 0.7% x 1 wk. Stable x 1 wk cont. wky wts..."
|       | d. 8/16/13 - "...Resident reviewed with NAR. Wt currently 104.2 [down symbol] 1.0% x 1 wk. Stable x 2 wks cont wky wts..."
|       | e. 8/22/13 - "...Resident reviewed @ NAR. Wt currently 105.4 [increased symbol] 1.2% x 1 wk. Stable x 3 wks. Cont wky wts..."

The nutritional progress notes documented the following:

|       | a. 8/1/13 - "...Res. [Resident] had wt [decrease symbol]. ice cream BID [two times a day]..."
| (X4) ID PREFIX TAG | F 278 | Continued From page 11 added...
| b. 8/5/13 - "...A 14 Day Review... wt... [decreased symbol] 3.1% x 1 wk. [decreased symbol] 6% x admit. Will have RD [Registered Dietician] to review..." |
| c. 8/21/13 - "...30 Day Review... wt (admit) 113.0 [decreased symbol] 7% x admit wt..." |

Resident #121’s admission weight on 7/19/13 was 113 pounds. Resident #121’s weight at 15 days after admission on 8/4/13 and 30 days after admission was 105 pounds which was 8 pounds less which reflected a 7.1% weight loss.

The 30 day Minimum Data Set (MDS) dated 8/17/13 documented weight loss as "0", reflecting Resident #121 had no weight loss of 5% or more in the last month. According to Resident #121’s weight records, the resident had a weight loss of 7.1% during that time.

During an interview in the conference room on 11/14/13 at 5:03 PM, Nurse #1 was asked about the weight loss section of the MDS. Nurse #1 stated, "I don't do that section... [Named the Certified Dietary Manager (CDM)] does it...".

During an interview in the conference room on 11/14/13 at 5:13 PM, the CDM was asked about the weight loss section of the MDS reflecting no weight loss when Resident #121’s weight record reflected the resident had a 7.1% weight loss during the last month. The CDM stated, "...no, no, no... it's not right... she was losing weight... she was actually sent out... she had a great big mess... she was eating 100% and still losing weight... that is wrong... that was just my mistake...".
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<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>Statement</th>
<th>Provider's Plan of Correction</th>
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<tr>
<td>F 279</td>
<td>SS=d</td>
<td>Continued from page 12</td>
<td>DEVELOP COMPREHENSIVE CARE PLANS</td>
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<td>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>F 279 DEVELOP COMPREHENSIVE CARE PLANS</td>
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<td>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</td>
<td>The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</td>
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<td>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</td>
<td>Residents affected: A referral was made to therapy on 11/13/13 per DON for evaluation of resident #83 due to contractures.</td>
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<td>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</td>
<td>Therapist attempted to evaluate resident on 11/15/13, but evaluation could not be completed due to resident's inability to tolerate evaluation due to pain, although pain management was being utilized.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure that range of motion interventions were on the care plan for 1 of 11 (Resident #85) sampled residents included in the stage 2 review.</td>
<td>Resident's responsible party and MD notified of resident's inability to tolerate therapy and ROM due to discomfort. Resident's responsible party requested resident not receive ROM due to discomfort and the need for resident to be kept comfortable and receiving hospice services for end of life care. MD notified of request for no ROM due to comfort measures per Restorative Nurse, and therapist agreed resident should not receive ROM due to inability to tolerate on 11/15/13.</td>
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<td>The findings included: Review of the facility's &quot;RANGE OF MOTION EXERCISES...&quot; policy documented, &quot;...Range of motion exercises will be done as ordered by the</td>
<td>Resident care plan was revised to reflect resident's status to not receive ROM to keep comfortable per DON on 11/15/13.</td>
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<td>Residents potentially affected: Nursing staff will be educated by 12/15/13 regarding process for ROM exercises, recognition of and reporting contractures, as well as process for revising resident care plan to accurately reflect the resident's status per Staff Development Coordinator/Restorative Nurse.</td>
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Residents will be assessed for contractures per Restorative Nurse/Charge Nurse by 12/15/13.

12/15/13
Continued From page 13

physician or indicated on the Care Plan...

Medical record review for Resident #85 documented an admission date of 2/5/13 with of Dementia with Lewy Bodies, Fracture Neck of Femur, Pneumonia, Paranoid State, Acute Kidney Failure, Alzheimer’s Disease, Paralysis Agitans, Senile Delusions, Psychosis, Osteoporosis, Confusions and Parkinson’s.

Review of the annual MDS dated 9/20/13 documented in Section G0400 documented a functional limitation in ROM for the upper extremity on one side. The care plan dated 9/24/13 documented a self care deficit for limited ROM with no interventions to provide range of motion. The nursing summary dated 11/11/13 documented, "...Restorative... range of motion..."

Observations in Resident #85's room on 11/13/13 at 3:00 PM, revealed Resident #85 with right and left hands contracted with no splints in place.

Observations in Resident #85's room on 11/13/13 at 3:15 PM, revealed Resident #85 with contractures noted to both hands.

Observations in Resident #85's room on 11/14/13 at 8:10 AM, revealed Resident #85 being fed breakfast meal by a certified nursing assistant (CNA).

During an interview at the nurses’ station on 11/15/13 at 9:25 AM, CNA #1 was asked how she washed Resident #85's hands. CNA #1 stated, "...try to move [Resident #85] fingers... try to do range of motion on [Resident #85] hands... do range of motion on arms and legs, too... do that for all my residents... suppose to..."
Continued From page 14

During an interview at the nurses' station on 11/15/13 at 5:10 PM, the Director of Nursing (DON) was asked whether she expected the range of motion provided with activities of daily living to be on the care plan. The DON stated, "Yes."

F 280

SS=E

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family, or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on policy review, review of incident reports, medical record review, observation and interview, it was determined the facility failed to revise care plans to include fall prevention and/or palliative care interventions for 4 of 22 (Residents #55, 91, 116 and 117) sampled residents.
**F 280** Continued from page 15

The findings included:

1. Review of facility’s care plan policy documented, "...The resident's care plan provides guidance to all staff caring for the resident and communicates changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provides individualization and coordination of resident care... The Interdisciplinary Care Plan is reviewed; revised and updated quarterly and more frequently if warranted by a change in the resident's condition... The resident care plan is initiated at the time of admission..."

2. Medical record review for Resident #55 documented an admission date of 4/17/12 with diagnoses of Acute Myocardial Infarction, Dysphagia, Muscle Disuse Atrophy, Atrial Fibrillation, Dementia with Behavior, Failure to Thrive, History of Fall, Anxiety Depressive Disorder and Frontal Lobe Deficit.

Review of Resident #55's monthly weight records documented the following weights:

a. 10/9/13 - 68 pounds.

b. 10/22/13 - 66 pounds.

c. 11/4/13 - 58 pounds.

Review of the physician orders dated 11/9/13 documented "Palliative care and d/c/discontinue] weights." The care plan was not revised to include palliative care.

Observations in Resident #55's room on 11/12/13 at 5:00 PM, revealed Resident #55 was very thin, lying on her side, in a low bed. The resident...
The care plan updated on 10/18/13 included the problem of the resident at risk for falls and documented interventions after the 7/18/13 and 9/18/13 falls but was not revised to include new interventions after the 9/23/13 and 11/1/13 falls.

Observations in Resident #91’s room on 11/13/13 at 3:30 PM, revealed Resident #91 lying in bed on a bolster mattress, there were no mats found on the floor.

Observations in Resident #91’s room on 11/14/13 at 8:15 AM, revealed Resident #91 lying in bed on a bolster mattress with a mat on the floor at the bedside.
F 280. Continued From page 17

During an interview at the nurses' station on 11/13/13 at 4:15 PM Licensed Practical Nurse (LPN) #1 stated, "The care plan is supposed to have the dates of falls and interventions... charge nurses complete [named the facility's communication and progress note form] and update the care plan... if it [intervention] is on the care plan it should be in use..." LPN #1 verified there was no documentation of interventions after the 11/11/13 fall and the care plan had not been revised after the 9/23/13 and 11/11/13 falls to include the interventions implemented.

4. Medical record review for Resident #116 documented an admission date of 8/23/13 with diagnoses of Alzheimer's Disease, Hypertension, Dementia, Depressive Disorder, Hyperlipidemia and Diabetes Mellitus.

Review of the communication form and progress note dated 10/24/13 documented "...Resident had a fall... slid out of his chair... therapy to evaluate for new chair..." Review of the care plan dated 8/3/13 did not reflect the intervention for fall on 10/24/13.

Observations in Resident #116's room on 11/12/13 at 11:00 AM, revealed Resident #116 was in isolation, lying in a low bed with a bed alarm attached to bed and resident.

During an interview in the conference room on 11/13/13 at 4:30 PM, LPN #1 was asked who was responsible for updating the care plan with new interventions after a fall. LPN #1 stated, "The charge nurse is to update the care plan after a fall... this fall is not updated... it is not on the care plan... there is no interventions on the care
<table>
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<tr>
<th>F 280</th>
<th>Continued From page 18 plan...</th>
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<tr>
<td></td>
<td>During an interview in the conference room on 11/13/13 at 4:47 PM, the Director of Nursing (DON) stated, &quot;There is no new interventions on the care plan for the fall on 10/24/13...&quot;</td>
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<td>5. Medical record review for Resident #117 documented an admission date of 5/24/13 with diagnoses of Convulsions, Dysphagia, Hypertension, Diabetes, Chronic Hepatitis C, Coronary Artery Disease, Cerebral Aneurysm, Paranoid and Schizophrenia. Review of the communication form and progress notes documented the following:</td>
</tr>
<tr>
<td></td>
<td>a. 11/4/13 - fall with no injury.</td>
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<td></td>
<td>b. 11/7/13 - a fall with a skin tear to his nose with intervention of pressure alarm in wheelchair.</td>
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<tr>
<td></td>
<td>c. 11/10/13 - a fall with no injury.</td>
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<tr>
<td></td>
<td>The care plan was not updated to include all interventions in place for falls.</td>
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<tr>
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<td>Observations in Resident #117's room on 11/13/13 at 3:15 PM, revealed Resident #117 lying on top of the covers on the bed, with an alarm on the wheelchair and an alarm on the bed.</td>
</tr>
<tr>
<td></td>
<td>During an interview in the conference room on 11/10/13 at 4:30 PM LPN #1 stated, &quot;...care plan was not updated...&quot; LPN #1 was asked if she saw an intervention on the communication form and progress notes? LPN #1 stated, &quot;No ma'am. I do not.&quot;</td>
</tr>
<tr>
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<td>During an interview in the conference room on 11/10/13 at 4:50 PM, the DON stated, &quot;...there is not one [intervention] on the care plan...&quot;</td>
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<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR</td>
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| F 309 | }
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<th>F 309</th>
<th>Continued From page 19</th>
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<tr>
<td>SS=D</td>
<td>HIGHEST WELL BEING</td>
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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

- Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure a treatment ordered by the physician was provided for 1 of 22 (Resident #85) sampled residents included in the stage 2 review.

The findings included:

- Review of the facility's "DAILY REVIEW OF PHYSICIAN ORDERS" policy documented, "...It is the standard of this facility that physician orders are reviewed daily to ensure delivery of applicable care... Daily physician order copies will be reviewed daily by night shift and nursing administration during the Clinical Meeting... the MARS [medication administration records] /TARS [treatment administration records]... will be reviewed to ensure updates/changes have occurred..."

- Medical record review for Resident #85 documented an admission date of 2/6/13 with of Dementia with Lewy Bodies, Fracture Neck of Femur, Pneumonia, Paranoid State, Alzheimer's Disease, Paralysis Agitans, Acute Kidney Failure, Senile Delusions, Psychosis, Osteoporosis,
F 309  Continued From page 20

During an interview at the nurses' station on 11/14/13 at 10:00 AM, Nurse #6 was asked to look at the physician's order dated 11/5/13 and to verify that this was the current treatment. Nurse #6 looked at the orders and stated, "Yes." Nurse #6 was asked to verify the treatment on the treatment sheet. Nurse #6 looked at the treatment sheet and stated, "No documentation... not on here..."

During an interview at the nurses' station on 11/14/13 at 10:16 AM, the Director of Nursing (DON) was asked if she would expect a new treatment order to be put on the treatment sheet..." The DON stated, "Yes, I would."

F 323  SS-D  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.
### Summary of Deficiencies

**Provider:** The Bridge at Ridgely

**Address:** 117 N Main Street, Ridgely, TN 38080

**Identification Number:** 445327

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Prefix</th>
<th>Provider's Plan of Correction</th>
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</table>
| F 323  |        | Shower room was inspected on 11/15/13 per DON and Administrator. Wooden cabinet was secured at that time as well as nail clippers, wooden painted orange sticks, bottles of lotion, shaving cream and deodorant were removed per DON.

**Residents potentially affected:**
- Common shower rooms were inspected on 11/15/13 to ensure no potentially hazardous items were unsecured per DON and Restorative Nurse.

**Staff will be re-educated on 12/15/13 per Staff Development Coordinator/DON regarding policy and procedure to keep residents free from accidental hazards.

**Systemic measures:**
- Common shower rooms will be inspected daily to ensure no potentially hazardous items are unsecured per Charge Nurse/Unit Manager.

**Staff will be educated upon hire and annually per Staff Development Coordinator/Unit Manager regarding policy and procedure to keep resident free from accidental hazards.

**Monitoring measures:**
- DON/ADON will inspect common shower rooms weekly for one month then monthly to ensure compliance.

**DON/ADON will report findings to QA Committee Team during monthly meeting.**

---

**Finding:** Shower room was inspected on 11/15/13 per DON and Administrator. Wooden cabinet was secured at that time as well as nail clippers, wooden painted orange sticks, bottles of lotion, shaving cream and deodorant were removed per DON.

**Residents potentially affected:**
- Common shower rooms were inspected on 11/15/13 to ensure no potentially hazardous items were unsecured per DON and Restorative Nurse.

**Staff will be re-educated on 12/15/13 per Staff Development Coordinator/DON regarding policy and procedure to keep residents free from accidental hazards.

**Systemic measures:**
- Common shower rooms will be inspected daily to ensure no potentially hazardous items are unsecured per Charge Nurse/Unit Manager.

**Staff will be educated upon hire and annually per Staff Development Coordinator/Unit Manager regarding policy and procedure to keep resident free from accidental hazards.

**Monitoring measures:**
- DON/ADON will inspect common shower rooms weekly for one month then monthly to ensure compliance.

**DON/ADON will report findings to QA Committee Team during monthly meeting.**

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**Additional Remarks:** Medical record review of Resident #91 documented an admission date of 6/28/13 with diagnosis of old Cerebrovascular Accident, Weakness, difficulty Walking, Dysphagia, Hyperosmolality, Hyperpotassemia, Anemia, Thrombocytopenia, Dehydration, Aortic Aneurysm, Atrial Fibrillation, Thoracic Aortic Aneurysm, Coronary Artery Anomaly, Esophageal Reflux, Hyperlipidemia, Alzheimer's disease, Senile Depressive, Convulsions, Constipation and

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<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 323</td>
<td>Continued From page 22</td>
<td>Myelodysplastic Syndrome. The fall assessments dated 7/18/13 and 11/1/13 documented the resident at a high risk for falls.</td>
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<td>Review of incident reports for Resident #91 documented the resident had falls on 9/18/13, 9/23/13 and 11/1/13. The facility failed to implement a new intervention after a fall on 11/1/13.</td>
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<td>Observations in Resident #91's room on 11/13/13 at 3:30 PM, revealed Resident #91 lying in bed on a bolster mattress, there were no mats found on the floor.</td>
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<td>Observations in Resident #91's room on 11/14/13 at 8:15 AM, revealed Resident #91 lying in bed on a bolster mattress with a mat on the floor at the bedside.</td>
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<td>During an interview at the nurses' station on 11/13/13 at 4:15 PM Licensed Practical Nurse (LPN) #1 stated, &quot;The care plan is suppose to have the dates of falls and interventions... charge nurses complete [named the facility's communication and progress note form] and update the care plan... If it [intervention] is on the care plan it should be in use...&quot; LPN #1 verified there was no documentation of interventions after the 11/1/13 fall and the care plan had not been revised after the 9/23/13 and 11/1/13 falls to include the interventions implemented.</td>
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<td>2. Observations in the 200 hall common bath room on 11/12/13 at 12:00 PM revealed an unsecured wooden cabinet with 2 pairs of large nail clippers on the bottom shelf of the cabinet.</td>
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<td>During an interview in the Director of Nursing's</td>
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Continued From page 23

(DON) office on 11/15/13 at 8:20 AM, the DON was asked if it is acceptable for nail clippers to be left unsecured. The DON stated, "No, it is not."

3. Observations in the 200 hall common shower on 11/14/13 at 3:30 PM, revealed an unsecured wooden cabinet with 5 wooden pointed orange sticks, 3 (1.5) ounces bottles of lotion, 4 (1.5) ounces containers of shaving cream, 2 (4) ounce bottles of deodorant with labels that read "Keep Out of Reach of Children".

During an interview in the 200 hall common shower room on 11/14/13 at 4:10 PM, certified nursing assistant (CNA) #2 was asked if the bottles should be left unsecured and stated, "No ma'am, I will throw them away now..."

During an interview in the DON's office on 11/15/13 at 8:20 AM, the DON was asked if it is acceptable for orange sticks to be left unsecured in the common shower rooms. The DON stated, "No, it is not."

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the
F 431

Continued from page 24

appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were stored properly as evidenced by internal and external medications stored together, chemicals stored with food supplements and medication and loose pills in medication drawers in 2 of 5 (100 hall and 300 hall medication carts) medication storage areas.

The findings included:

1. Review of the facility's 'MEDICATION ADMINISTRATION-STORAGE OF MEDICATION" policy documented; "...Orally administered medications are kept separate from

On 11/14/13 on the 300 hall medication cart the suppositories were placed in a separate compartment from the batteries, hand sanitizer was placed in a separate compartment, the Sanicloth cleaner was placed in a separate compartment, lanolin was removed from the medication cart, the loose pills were removed from the medication cart and destroyed, and medication cart was cleaned per Charge Nurse.

Residents potentially affected:
Nursing staff will be re-educated by 12/15/13 regarding policy and procedure for storing food supplements away from medications, internal and external medication storage, and chemicals cannot be stored with food supplements, no loose pills in the medication cart and process for keeping medication cart clean per Staff Development Coordinator/DON.

Systemic measures:
Nursing staff will be educated upon hire and annually per Staff Development Coordinator/DON regarding policy and procedure for storage of medications, internal and external, food supplement storage and keeping medication carts clean, as well as loose pill recovery form the medication carts.

Unit manager/Staff Development Coordinator will inspect medication carts weekly to ensure medication carts are clean with no loose pills in drawers, no food supplements or topical medications are stored on carts, and that cleaning chemicals are stored separate from medications, and internal and external medications are properly stored in separate compartments.

Pharmacy Consultant will inspect medication carts during consultation visit monthly to ensure compliance. Findings will be reported to DON/ADON.

Findings will be reported weekly to the DON/ADON per the Unit Manager/Staff Development Coordinator.
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**F 431** Continued From page 25

*Externally used medications... Potentially harmful substances (such as... cleaning supplies... disinfectants) are... stored in a locked area separately from medications... Medication storage areas are kept clean, well lit and free of clutter..."

2. Observations on the 100 hall accompanied by Nurse #4 on 11/14/13 at 4:15 PM, revealed the pink/100 hall medication cart had 2 packs of Juven protein supplement, a bottle of wound cleanser, a container of Sani Cloths cleaners and a package of replacement gastrostomy tubes located in the bottom right drawer stored together and a container of Nystatin powder, a Proair inhaler and Flunonazole nose spray stored in the top left drawer compartment stored together. The second and third left drawers had multiple loose pills. The second drawer on the left had multiple topical medications stored with pill blister packs. The bottom left drawer had a sticky pink residue in bottom of drawer.

During an interview on the 100 hall on 11/14/13 at 4:15 PM, Nurse #4 was asked about topical medications being stored with oral medications. Nurse #4 stated, "I don't know why the treatment meds would be on this cart... We have a treatment cart..." Nurse #4 was asked who is responsible for keeping the carts cleaned and how often they are cleaned. Nurse #4 stated, "We [nurses] are... whenever it needs to be cleaned... It needs to be cleaned now..." Nurse #4 was asked about Juven and chemical cleansers being stored together. Nurse #4 stated, "They shouldn't be in there together..."

3. Observations on the 300 hall accompanied by Nurse #5 on 11/14/13 at 4:30 PM, revealed the Blue/300 hall medication cart had suppositories,
Continued From page 26

batteries and hand sanitizer stored together in the top right drawer. A container of Sanicloth cleaners and a can of Jevity were stored together in the bottom right drawer and there was a loose pill in the left second drawer.

During an interview on the 300 hall on 11/14/13 at 4:30 PM, Nurse #5 was asked of the medications should be stored with food (Jevity) or medication items. Nurse #5 stated, "They shouldn't be [stored] together..." Nurse #5 was asked if there should be loose pills in the cart. Nurse #5 stated, "No."

4. During an interview in the DON's office on 11/14/13 at 5:00 PM, the DON was informed of the findings observed on the 100 and 300 hall medication carts. The DON confirmed chemicals should not be stored with the food supplements, internal and external medications should not be stored together, loose pills should not be in the drawers and the medication carts should be clean.

483.55 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it-
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation,
F 441 Continued From page 27
should be applied to an individual resident; and 
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure effective infection control practices were maintained in the facility in 2 of 6 (200 hall common bathroom and 200 hall shower room) common / shower rooms and 1 of 5 (medication refrigerator freezer compartment) medication storages areas as evidenced by used patient care items left unattended and not secured in the shower rooms and the medication refrigerator freezer compartment was dirty and an applesauce container was in the biohazard refrigerator.

On 11/14/13 the applesauce container was removed from the biohazard refrigerator freezer compartment and discarded, and the refrigerator was cleaned per DON.

Residents potentially affected:
Staff will be re-educated by 12/15/13 infection control policy and procedures per Staff Development Coordinator.

Systemic measures:
Staff will be educated upon hire and annually per Staff Development Coordinator/DON regarding infection control policy and procedure.

Common showers and bathrooms will be inspected daily per Charge Nurse/Unit Manager to ensure infection control policy and procedures are being followed.

Common showers, common bathrooms, medication refrigerator, employee refrigerator, and biohazard refrigerator will be inspected weekly per Unit Manager/Staff Development Coordinator to ensure infection control policy and procedures are being followed.

Findings will be reported weekly to the DON/ADON per the Unit Manager/Staff Development Coordinator.

Monitoring measures:
DON/ADON will inspect common showers, common bathrooms, medication refrigerator, employee refrigerator, and biohazard refrigerator monthly to ensure compliance.

DON/ADON will report findings to QA Committee Team during monthly meeting.
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<th>PROVIDER’S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 28 freezer compartment.</td>
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The findings included:

1. Observations in the 200 hall common bath room on 11/14/13 at 11:30 AM, revealed an unsecured wooden cabinet with a used hair brush and a large pastry muffin in the cabinet.

2. Observations in the 200 hall common shower room on 11/14/13 at 3:30 PM, revealed an unsecured wooden cabinet that contained 3 used combs, a toothbrush and a used hairbrush.

During an interview in the 200 hall common shower/bathroom on 11/14/13 at 11:30 AM, the Administrator confirmed the findings noted above was not acceptable.

During an interview in the 200 hall common shower room on 11/14/13 at 4:10 PM, Certified Nursing Assistant (CNA) #2 was asked if the staff used the same combs, toothbrush and hair brush on different residents. The CNA #2 stated, "...I don't, I bring the residents things from their room and use them, but I am sure some [CNAs] do..."

3. Observations in the medication room accompanied by the Director of Nursing (DON) on 11/14/13 at 11:30 AM, revealed the medication refrigerator freezer compartment was dirty with red and yellow substances on the bottom. An applesauce container was noted in the biohazard refrigerator freezer compartment.

During an interview in the medication room on 11/14/13 at 11:30 AM, the DON was asked about the cleanliness of the medication refrigerator freezer. The DON stated, "We don’t use that."
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<th>ID PREFIX TAG</th>
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<th>COMPLIANCE DATE</th>
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| F 441        | Continued From page 29  
The DON was asked if medications were stored in the refrigerator section under the freezer and if the freezer should be clean. The DON stated, "Yes, medications are stored in there... It should be cleaned..." The DON was asked about the applesauce being in the biohazard freezer. The DON stated, "That should not be there." |
| F 463        | 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  
The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  
This REQUIREMENT is not met as evidenced by:  
Based on policy review, observation and interview, it was determined the facility failed to ensure the emergency call light was in working order in 1 of 6 (200 hall common bath) common shower rooms.  
The findings included:  
Review of the facility's "Building Standards" policy documented, "...The facility will be constructed, arranged and maintained to ensure the safety of the residents..."  
Observations in the 200 hall common bath / shower room on 11/12/13 at 12:00 PM, revealed that when the call light string was pulled there was no response from the staff. The light was noted not to be flashing in the shower room or above the door. |
| F 463        | RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  
The nurses' station will be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  
Residents affected:  
200 hall common bath replace immediately on 11/12/13 per Plant Operations Manager.  
Residents potentially affected:  
All residents on 200 hall were affected. Staff were re-educated regarding reporting of non-functioning call light systems and to immediately report findings to Plant Operation Manager/Designee per Administrator on 11/12/13.  
Systemic measures:  
All call lights will be inspected for proper functioning per Plant Operations Manager by 12/15/13. Any malfunctions will be corrected immediately.  
During daily environmental rounds call lights will be inspected for proper functioning per Department Managers. Findings will be reported to Administrator/Plant Operation Manager during daily Department Managers meeting. Any malfunctions will be corrected per Plant Operation Manager.  
All call lights and emergency light systems will be inspected monthly per Plant Operation Manager and monitored via TEL.S system. Any malfunctions will be corrected immediately. | 12/5/13 |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>445327</td>
<td>A. BUILDING</td>
<td>11/15/2013</td>
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<td></td>
<td>B. WING</td>
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**NAME OF PROVIDER OR SUPPLIER**

THE BRIDGE AT RIDGELY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

117 N MAIN STREET

RIDGELY, TN 38060

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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F 463             | Continued From page 30
During an interview in the hall beside the 200 hall common bath / shower room on 11/12/13 at
12:05 PM, Certified Nursing Assistant (CNA) #1 was asked if the call light was working. CNA #1
stated, "It's not working."

F 465
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure 3 of 6 (200 hall shower room, 200 hall bathroom, 300 shower room) showers and bathrooms and 1 of 3 (200 hall) halls was maintained in a clean and sanitary manner.
The findings included:

1. Review of the facility's "Environmental / Housekeeping / Floor Care" policy documented, "...Floor work-Ceramic Tile... Daily Care: All ceramic tile should be swept and mopped daily. This helps control odor and retains floor appearance..."

2. Observations in the 200 hall central shower room on 11/12/13 at 10:05 AM, revealed a black substance in the floor grout, the shower faucet dripping, shower walls had a brown-black substance on it and the shower wall next to the faucet had a rusty brown substance on it.

| F 463             | Monitoring measures:
During daily environmental rounds call lights will be inspected for proper functioning per Department Managers. Findings will be reported to Administrator/Plant Operation Manager during daily Department Managers meeting. Any malfunctions will be corrected per Plant Operation Manager.

Administrator will monitor TELS maintenance system to ensure compliance. Findings will be reported to Plant Operation Manager immediately and QA Committee Team during monthly meeting.

F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT

The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Residents affected:
Hall corridor (200) was deep cleaned on 11/13/13 per Plant Operation Manager and Maintenance.

Resident rooms 201, 203, 204, 205, 206, 207, 208, 210, 212, 213, 214, 215, 216, 217, 218 will be deep cleaned per Plant Operation Supervisor/Designee by 12/15/13.

200 hall common shower room, 200 hall common bathroom, 300 hall common shower room will be deep cleaned per Plant Operation Supervisor by 12/15/13

Residents potentially affected:
Administrator and Plant Operation Manager conducted room to room inspection on 11/13/13 and no further concerns observed.

Staff educated on 11/15/13 per Administrator regarding policy and procedure, and notification of soiled, stained flooring requiring maintenance.

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Observations in the 200 hall central shower room on 11/14/13 at 3:30 PM, revealed peeled wall covering over the shower, the shower was dripping with a steady stream and there was a black color in the tile grout and a black stain around the commode base.

3. Observations in the 200 hall central bathroom on 11/12/13 at 12:05 PM and on 11/14/13 at 3:35 PM, revealed dirty tile grout and black stained shower tiles, a dried brownish, yellow substance on the corner wall halfway down the length of the wall having the appearance of old glue, the shower curtain had a black substance on the front and back of the curtain.

During an interview during a walking tour with the Administrator on 11/14/13 beginning at 11:25 AM, the Administrator was asked if the 200 hall bathroom was clean. The Administrator stated, "...I don't know what that [the black in the tile grout and the black in the shower area] is... I think it is just grime... that's not acceptable..." The Administrator was asked what the brownish, yellow substance could be. The Administrator stated, "Looks like something was glued on there and pulled off ...

4. Observations of the 300 hall central shower rooms on 11/14/13 at 8:30 AM, revealed both of the shower rooms floors had a black substance in the grout.

During an interview during a walking tour with the Administrator on 11/14/13 beginning at 11:25 AM, the Administrator stated, "...I don't know what that [the black in the tile grout and the black in the shower area] is... I think it is just grime... that's not acceptable..."
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<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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5. Review of the facility's "Building Standards" policy documented, "...The physical environment will be maintained in a safe, clean and sanitary manner... Vents... Most vents should be cleaned daily..."

Observations in the 200 hall beside room 208 on 11/12/13 at 11:05 AM, 11/13/13 at 8:05 AM and 11/14/13 at 8:45 AM, revealed a black substance on the vent in the ceiling.

Observations in the 200 hall beside the shower and bath on 11/12/13 at 12:00 PM, revealed the floor in the hallway was dirty.