**Statement of Deficiencies and Plan of Correction**

**F 000 INITIAL COMMENTS**

Complaint investigations #30565 and #30724 were completed at The Bridge of Rockwood on November 16, 2012. No deficiencies were cited related to complaint investigation #30724. Deficiencies were cited related to complaint investigation #30565 under 42 CFR Part 483, Requirements for Long Term Care Facilities. 483.13(c)(1)(ii)-(iii), (c)(2) - (4)

**F 225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS**

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

**Disclaimer:**

The Bridge at Rockwood does not believe and does not admit that any deficiencies existed either before, during, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any other administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligations or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

[Signature]

**Title**

Administrator

**Date**

11/30/12

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 disclosureable 60 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 disclosureable 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 results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on review of facility policy and interview, the facility failed to investigate misappropriation of property for one resident (#3) of five residents reviewed.

The findings included:

Resident #1 was admitted to the facility on February 12, 2008, and readmitted on October 25, 2008, with diagnoses including Alzheimer's Disease, Anxiety, and Fractured Arm.

Medical record review of a Physician's telephone order dated September 11, 2012, revealed "...Oxycodone (narcotic pain medication) 15 mg (milligram) d/c (discontinue) due to non use..."

Interview with the Corporate Consultant on November 14, 2012, at 11a.m., in the conference room confirmed on September 18, 2012, the facility discovered the narcotic, the control sheet for the narcotic, and the narcotic bubble pack was missing, and had not been returned to the pharmacy. Continued interview confirmed the bubble pack was located at a later time in a paper shredder box.

The facility will investigate/report any allegations/individuals as per the federal guidelines.

Residents affected:
A thorough investigation was completed on Resident #1 by the Administrator and Clinical Nurse Consultant and statements re-obtained from staff members on 11/29/12.

Residents potentially affected:
Residents have the potential to be affected by this cited practice. Audit of abuse investigations were completed by 11/28/12 by the Administrator and Clinical Nurse Consultant with no other residents affected by deficient practice.

Systemic measures:
The Social Services Director will educate/train the management team on the importance of thorough investigation with any allegation of abuse along with the abuse investigative process per the abuse policy and procedure by 12/3/12. Staff was in-service on the Abuse policy and procedure, as well as reporting on 11/15/12, by the Chief Nursing Executive, Admissions Director, and Administrator.

Administrator will review all abuse investigations for completion and keep original investigation documentation locked up in the administrator's office.

Monitoring measures:
The Administrator and DON will observe for compliance with all investigations of any allegations of abuse and for supporting evidence/documentation to support completion of thorough investigation. Any concerns identified will be addressed immediately and discussed in monthly QA.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 225</td>
<td>Interview with the Corporate Consultant on November 14, 2012, at 1:42 p.m., in the conference room, confirmed the facility was unable to locate a facility investigation or witness statements for the missing Oxydine.</td>
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<td>C/O #30565</td>
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