F 000 INITIAL COMMENTS

Complaint investigations were initiated on 9/26/11 beginning at 8:30 AM and continued through 9/27/11 for TN00028369, TN00028226 and TN00028714.

Complaint # TN00028369 had a deficiency cited at F309.

Complaint # TN00028226 had a deficiency cited at F314.

Complaint # TN00028714 had a deficiency cited at F323.

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

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:

Intake: TN00028369

Based on policy, medical record review and interview, it was determined the facility failed to follow physician's orders for bowel movement (BM) protocol for 4 of 13 (Residents # 2, 5, 11 and 12) sampled residents.

The findings included:

For Douglass Dairy, Rebecca Traylor, MD Interim DOC 10-7-11

Disclaimer:
The Bridge at Ridgely 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 administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible exceptions and defenses in any type of civil or 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.
F 309 Continued From page 1

1. Review of the facility's "BM PROTOCOL" documented, "...Interventions-If no BM in 2 days, give MOM [Milk of Magnesia] 30ml [milliliters] PO [by mouth]-If no BM in 3 days, give Dulcolax 10mg [milligram] suppository PR [per rectum] or, Dulcolax 10mg Tablets PO-if no results from Dulcolax, within 8 hours give Fleets enema PR- If no results from Fleets within one hour Notify MD [Medical Doctor]..."

2. Medical record review for Resident #2 documented an admission date of 6/23/11 with diagnoses of Alzheimer's Disease, Depressive Disorder, Anxiety, Essential Hypertension and Kidney Malignancy. Review of the July 2011 "BM PROTOCOL" documented no BM on 7/1/11, 7/2/11, 7/3/11, 7/4/11, 7/5/11, 7/6/11 and 7/7/11 for a total of 6 days without a BM. MOM was given on 7/4/11. The BM protocol was not followed.

During an interview in the conference room on 9/27/11 at 1:30 PM, the Director of Nursing (DON) confirmed the BM protocol was not followed.

3. Medical record review for Resident #5 documented an admission date of 7/19/11 with diagnoses of Essential Hypertension, Dementia with Behavioral Disturbances, Orthostatic Hypotension, Alzheimer's Disease and Constipation. Review of the July 2011 "BM PROTOCOL" documented no BM on 7/24/11, 7/25/11, 7/26/11, 7/27/11 and 7/28/11. MOM was given on 7/26/11 and 7/28/11. The BM protocol was not followed.

Review of the August 2011 "BM PROTOCOL":

F 309 Provide Care/Services for Highest well being

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.

Residents affected:
Resident #2 has been discharge from the facility. Resident #5, #11, and #12 bowel regimen, ADL flow sheets and medications were reviewed. Resident's medications reviewed with MD with no new orders.

Residents potentially affected:
All Residents bowel flow sheets and ADL flow sheets were compared and reviewed to ensure BM's were documented/recorded (per protocol) and appropriate interventions were implemented. Education on bowel protocol and facility tracking sheets was initiated for direct care staff and the dietary department.

Systemic changes:
DON/designee will review BM (flow sheets) throughout the week in the clinical setting to ensure episodes of acute/chronic constipation are addressed with a dietary supplement or pharmaceutical intervention. The charge nurse/designee will notify the physician if resident has no BM on the 4th day. SDC/designee will in-service direct care staff and dietary department on bowel protocol and tracking flow sheets.

Monitoring measures:
DON/designee will track and review bowel flow sheet in the clinical setting throughout the week to ensure appropriate interventions are implemented. Any concerns will be addressed immediately and reported in monthly QA x 3 months.
F 309  Continued From page 2

documented no BM on 8/1/11, 8/2/11, 8/8/11, 8/9/11, 8/16/11 and 8/17/11. No medication was given. The BM protocol was not followed.

Review of the September 2011 "BM PROTOCOL" documented no BM on 9/10/11, 9/11/11, 9/12/11, 9/14/11, 9/15/11, 9/21/11 and 9/22/11. MOM was given 9/12/11. The BM protocol was not followed.

During an interview in the conference room on 9/27/11 at 1:45 PM, the DON confirmed the BM protocol was not followed.

4. Medical record review for Resident #11 documented an admission date of 8/28/11 with diagnoses of Dementia with Delusional Disorder, Malignant Neoplasm of the Lung, Brain, Bone and Spinal Cord, Depression and Anxiety.

Review of the June and July 2011 "BM PROTOCOL" documented no BM on 6/28/11, 6/29/11, 6/30/11 and 7/1/11. No medication was given. The BM protocol was not followed.

Review of the July 2011 "BM PROTOCOL" documented no BM on 7/7/11, 7/8/11, 7/9/11, 7/10/11, 7/11/11, 7/12/11, 7/13/11 and 7/14/11. MOM was given on 7/9/11 and 7/13/11. The BM protocol was not followed. No BM was documented on 7/19/11, 7/20/11, 7/21/11, and 7/22/11. MOM was given on 7/21/11.

Review of the September 2011 "BM PROTOCOL" documented no BM on 9/13/11, 9/14/11, 9/15/11, 9/16/11, 9/25/11 and 9/26/11. MOM was given on 9/16/11. The BM protocol was not followed.
**F 309** Continued From page 3

During an interview in the conference room on 9/27/11 at 1:40 PM, the interim DON confirmed the BM protocol was not followed.

5. Medical record review for Resident #12 documented an admission date of 5/7/11 with diagnoses of Cerebral Artery Occlusion, Atrial Fibrillation, Dehility and Hypothyroidism. Review of physician's orders dated 5/11 documented, "...BM PROTOCOL..." Review of Resident #12's "BM PROTOCOL" had no BMs documented for Resident #12 from 6/2/11 through (-) 6/5/11, from 6/9/11-6/11/11 and from 6/25/11-6/28/11. There were no interventions documented.

During an interview in the conference room on 9/27/11 at 1:40 PM, the DON confirmed the BM protocol was not followed.

**F 314**

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<th>463.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</th>
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Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This **REQUIREMENT** is not met as evidenced by:

Intake: TN00028226

Based on review of the "National Pressure Ulcer
### Summary Statement of Deficiencies

#### F 314 Continued From page 4

Advisory Panel (NAUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE,” policy review, medical record review, observation and interview, it was determined the facility failed to accurately identify and assess and follow interventions for pressure ulcers for 2 of 5 (Resident #3 and 9) sampled residents with pressure ulcers. The failure to identify and prevent skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #9.

The findings included:

1. Review of the “National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE” documented, “...3. Inspect skin regularly for signs of redness...Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat edema, or induration (hardness), especially in individuals with darkly pigmented skin...”

2. Review of the facility’s “Skin Care and Wound Management Program” policy documented, “...The Licensed Nurse is responsible in completing the weekly skin assessment to identify any new skin impairments and to document skin condition...”

Review of the facility’s “BATH POLICIES” policy documented, “...Report to the Charge Nurse any unusual conditions you notice while bathing the resident...”

3. Medical record review for Resident #9

#### F 314

**Systemic Changes:**

The treatment nurse/designee will report to the DON/designee new skin conditions and provide a weekly wound report that includes measurements and preventative measures that are currently in place. The treatment nurse/designee will review documentation for weekly skin rounds and report findings to the DON/designee weekly. The DON/Designee will address in clinical meeting new skin conditions to ensure appropriate interventions and recommendations are followed. The SDC/Designee will in-service direct care staff on skin protocol and preventative measures and licensed nurses will complete a skin management/prevention competency.

**Monitoring Measures:**

The Treatment nurse will conduct a skin care performance improvement audit weekly x 2 months then monthly thereafter. Any concerns will be addressed immediately and reported to the monthly QA x 3 months.
Continued From page 5
documented an admission date of 7/14/11 with diagnoses of Dysphagia, End Stage Renal Disease, Essential Hypertension, Diabetes and Depressive Disorder.
Review of the "Weekly Skin Rounds" documented the following:
  a. "...Date: 9/6/11 Skin Condition: pressure ulcer to buttocks [coccyx area circled on diagram]..."
  b. "...Date: 9/13/11 Skin Condition: [no skin assessment documented]...

Review of the "INDIVIDUAL SKIN REPORT" dated 9/26/11 documented, "DATE OF ONSET: 9/26/11...Facility Acquired: X...Check one...X Pressure...X Unstageable Pressure Ulcers due to slough and/or eschar...Date 9/26/11 Week # 1 Type Wound pressure...Stage unstageable Measurements (cm) [centimeter] L [length] 1.1 W [width] 1.1 D [depth] N/A [not applicable]...Wound Bed...[symbol for check mark] Slough Tissue...Periwound Wound margins reddened Secondary tissue reddened Surrounding tissue color/description pink...

Observations in Resident #9's room on 9/26/11 at 4:35 PM with Nurse #2 revealed Resident #9 lying in bed on her left side with her buttocks exposed. Observations revealed a large red area with a round dark area with white edges in the center of the red area on her right buttock.

Observations in Resident #9's room on 9/26/11 at 4:55 PM with Nurse #2 revealed Resident #9 lying on her right side with her buttocks exposed.
### F 314

Continued From page 6

Nurse #2 measured the dark area with white edges on the right buttock as L 1.1 cm W 1.1 cm.

During an interview in Resident #9's room on 9/26/11 at 4:35 PM, when asked when the ulcer on the right buttock started, Nurse #2 stated, "...This is the first time I've seen this [ulcer to right buttock]."

During an interview at the nurses station on 9/27/11 at 7:45 AM, when asked about the stage of the pressure ulcer found on 9/26/11, Nurse #2 stated, "...It is unstageable and there is slough around the edge."

During an interview in the conference room on 9/27/11 at 2:35 PM, when asked about daily skin assessment documentation by the Certified Nursing Assistant, the DON stated, "...any issue, take to nurse. If find something it's charted." The DON confirmed there is no daily documentation.

The failure to identify and prevent skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #9.

4. Medical record review for Resident #8 documented an admission date of 5/8/11 with a readmission date of 9/22/11 with diagnoses of Alzheimer's Dysphagia, Atrial Fibrillation, Adult Failure To Thrive and Gastrostomy. Review of a physician's order dated 9/24/11 documented, "... (1) Cleanse wounds on feet with Saf-Cleanse or (2) apply foam dressings to wound areas & [and] secure with gauze bandage (3) Off load wounds at all times, Change dressing..."
**NAME OF PROVIDER OR SUPPLIER**  
THE BRIDGE AT RIDGELEY

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

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<tr>
<th>(X4) ID</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 314</td>
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every 2 days..."

Observations in Resident #8's room on 9/26/11 at 12:45 PM, 2:15 PM, 3:45 PM and on 9/27/11 at 7:45 AM, revealed Resident #8 lying in bed and her heels were not floating/offloaded.

During an interview in Resident #8's room on 9/26/11 at 3:45 PM, Nurse #1 stated, "No they [referring to Resident heels] are not floating..."

**ID | TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

| F 323 | 483.25(n) 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.

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

This REQUIREMENT is not met as evidenced by:

Intakes: TN0028369

Based on review of the facility investigations, medical record review, observation and interview, it was determined the facility failed to put interventions in place to prevent falls and failed to follow interventions for falls on 3 of 7 (Resident #2, 5 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 9/23/11 with diagnoses of Alzheimer's Disease, Depressive
<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 323</td>
<td>Continued From page 8 Disorder, Anxiety, Essential Hypertension and Kidney Malignancy. Review of the facility's investigation report documented a fall on 6/30/11. Review of the care plan dated 6/23/11 documented, &quot;...At risk for fall related injury As evidenced by: [symbol for check mark] Previous Fall [symbol for check mark] Fall Risk factors present as determined by Fall Risk Screen Fall Risk Scores: Date: 6/23/11 Score: 14 ...&quot;</td>
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During an interview in the conference room on 9/27/11 at 1:30 PM, the interim Director of Nursing (DON) confirmed there was no new intervention on the care plan for the 6/30/11 fall.

2. Medical record review for Resident #5 documented an admission date of 7/19/11 with diagnoses of Essential Hypertension, Dementia with Behavioral Disturbances, Orthostatic Hypotension, Alzheimer's Disease and Constipation.

Review of the care plan dated 8/1/11 documented falls on 7/19/11, 7/23/11, 8/9/11, 8/28/11, 8/30/11, 9/5/11, 9/7/11 and 9/14/11. Review of the facility's investigative report documented a fall on 9/25/11.

Review of the care plan dated 8/1/11 documented, "...At risk for fall related injury As evidenced by: [symbol for check mark] Previous Fall [symbol for check mark] Fall Risk factors present as determined by Fall Risk Screen Fall Risk Scores: Date: 7/19/11 Score: 18 ...8/28/11 strips to floor ...9/5/11 pressure pad alarm in chair ..."

Observations in Resident #5's room on 9/26/11 at 2:30 PM revealed no strips on the floor.
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<th>F 323</th>
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<td>Observations in Resident #5's room on 9/27/11 at 7:25 AM revealed Resident #5 was seated in the wheelchair with the pressure pad in the chair. The alarm was on the over bed table still attached to the bed pad. There was no alarm attached to the pressure pad in the wheelchair.</td>
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<tr>
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<td>During an interview in Resident #5's room on 9/27/11 at 7:45 AM, Nurse #4 confirmed the alarm was not attached to the pressure pad in the Resident #5's wheelchair.</td>
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<td>During an interview in the conference room on 9/27/11 at 1:45 PM, the DON confirmed the intervention for the 9/25/11 fall had not been added to the care plan.</td>
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<td>Observations in Resident #11's room on 9/26/11 at 9:45 AM and 2:35 PM revealed no anti slip strips in front of the bed and no fall mat in the room.</td>
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<td>F 323</td>
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<tr>
<td></td>
<td>During an interview in Resident #11's room on 9/26/11 at 2:35 PM, Nurse #3 confirmed there were no anti slip strips on the floor and no mat in the room.</td>
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