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

45th 4/13/13

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445143	A. BUILDING ____ B. WING ____	02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #30941 and #30991 were completed on February 27, 2013. No deficiencies were cited related to the complaint investigation #30941 and #30991, under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	**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 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 contentions and defenses in any type of civil 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.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Jarfi

TITLE: Administrator

(X6) DATE: 3/21/13

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.

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 272	Continued From page 1 areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess the use of a side rail for one (#194) resident out of thrity-eight residents reviewed. The findings included: Resident #194 was admitted to the facility on February 14, 2013, with diagnoses including End Stage Renal Disease Stage IV, Hypertension, Lupus, and Convulsions. Observation on February 26, 2013, at 8:28 a.m., revealed the resident in bed with two half rails at the upper end of the bed in the raised position. Medical record review of the Side Rail Evaluation revealed the form was not completed. Medical record review of the Informed Consent for Side Rails revealed a blank for the date and "...use of 1/4 partial upper side rail..." Interview on February 27, 2013, at 8:40 a.m., at the 300 nursing station, with Licensed Practical Nurse #3 revealed the Side Rail Evaluation was	F 272	**F272 Comprehensive Assessments** The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. **Residents affected:** Resident #194 side rail evaluation and consent was completed by the unit manager with correct side rail length, dates and signatures. **Residents potentially affected:** All Residents that use side rails have the potential to be affected by this cited practice. A 100% audit of residents that use side rails will be completed to ensure side rail evaluation and consent are accurate and complete by the DON/designee. **Systemic measures:** The SDC/designee will educate licensed staff on completing the side rail evaluation, documenting the accurate length and location of the side rail with the completed consent. The SDC/designee completed a use of bed rail competency on licensed nurses. The ADON/designee will bring residents charts on admission/re-admissions to clinical meeting throughout the work week to review side rail evaluation and consents for accuracy and completion. The SDC/designee will be notified by the DON/designee if the side rail evaluation or consent wasn't completed. The DON/designee will immediately complete the side rail evaluation and consent during the clinical meeting. The SDC/designee will re-educate the licensed staff involved and provide a written competency. **Monitoring measures:** The DON/designee will report to the administrator any licensed nurse that needed re-educated on side rail assessment and consents. The administrator will be given a copy of the competency of the nurse. Any concerns with side rails will be addressed in monthly QA x 2 months and upon occurrence thereafter.	4/12/13

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

PRINTED: 03/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 272	Continued From page 2 the 300 nursing station, with Licensed Practical Nurse #3 revealed the Side Rail Evaluation was to be completed when the resident was admitted on February 14, 2013. Further interview confirmed the Side Rail Evaluation had not been completed.	F 272	**F281 Services Provided Meet Professional Standards** The services provided or arranged by the facility must meet professional standards of quality.	4/12/13
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and staff interview, the facility failed to obtain a blood pressure and pulse per physician order for one (#27) resident of thirty-eight residents reviewed. The findings included: Resident #27 was admitted to the facility on January 20, 2012, with diagnoses including Peripheral Vascular Disease, Diabetes Mellitus, Hypertension, Cerebral Arthrosclerosis, Dementia with Behavioral Disturbances, Vascular dementia with Delusions, Congestive Heart Failure, Pulmonary Edema, Cardiomegaly, Cellulitis, Atrial Fibrillation, Chronic Kidney Disease, and Chronic Anemia. Medical record review of the February 2013 Physician Recapitulation Orders revealed "Digoxin (heart regulation medication) ½ (half) of the 125 mcg (microgram) tablet every day (at 9:00 a.m.). Hold if pulse is less than 60." Further	F 281	**Residents affected:** Resident #27 B/P and pulse were reviewed with the MD for the month of February, with no new orders. Administrator educated licensed staff to document B/P and pulse when ordered by physician. **Residents potentially affected:** All residents with orders for B/P and pulse have the potential to be affected by this cited practice. Residents with B/P and pulse parameters per physician orders were reviewed for documentation on the MAR. **Systemic measures:** The SDC or designee will educate the licensed staff on documenting pulse and blood pressure as indicated by the physician's order with written post-test. The DON or designee will review the physician orders throughout the work week during clinical meeting for any residents with ordered parameters. The DON or designee will audit MARs twice a week for one month, then once a week for one month, then monthly during change over for documentation of physician ordered B/P and pulse. The DON or designee will immediately notify physician for concerns identified during the audit. The SDC or designee will coach and mentor the licensed nurse responsible for failing to document B/P and pulse. **Monitoring measures:** The DON or designee will report B/P and pulse documentation concerns identified during the audit to the Administrator weekly for two months. The Administrator will report any B/P and pulse documentation issues to the QA meeting monthly for two months, and then upon occurrence thereafter.	

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 281	Continued From page 3 orally daily (at 9:00 a.m.). Hold if B/P (blood pressure) less than 110/60), and Metoprolol Succinate ER (Extended Release) 25 mg (milligrams) ½ tablet (half = 12.5 mg) by mouth (at 9:00 a.m.). Hold for systolic B/P less than 110 or HR (heart rate) less than 60. Medical record review of the February Medication Administration Record (MAR) revealed no documentation of a blood pressure on February 9 and 19, 2013. Further review revealed no documentation of a pulse/heart rate on February 9, 11, 12 and 19, 2013. Interview with the Assistant Director of Nursing (ADON), on February 27, 2013, at 11:30 a.m., in the conference room confirmed the facility had failed to document the blood pressures and pulse/heart rate as ordered by the physician. Interview with the Administrator and ADON, in the administrator's office, on February 27, 2013, at 1:45 p.m. confirmed the facility had failed to follow the Physician Prders to monitor blood pressure and pulse/heart rate.	F 281	**F309 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 #194 was admitted to the hospital on 2/26. **Residents potentially affected:** Residents on dialysis and fluid restrictions have the potential to be affected by this cited practice. Residents on dialysis and fluid restrictions were reviewed for documentation. The SDC/designee educated licensed nurses on assessing the thrill and bruit and accurate recording of fluid restrictions. **Systemic measures:** The SDC/designee educated licensed nurses on documenting fluid restrictions on intake and output records and assessing for the thrill and bruit on dialysis residents. A competency on care of dialysis resident was administered to licensed nurses. The DON/designee will review post dialysis log and intake/output record for residents on fluid restrictions throughout the week during clinical meeting for accurate documentation. The SDC or designee will coach and mentor the licensed nurse responsible for failure to document or assess. **Monitoring measures:** The DON/designee will report any intake recording and dialysis documentation concerns to the Administrator weekly for two months. The Administrator will report any concerns related to this practice to QA monthly for two months and upon occurrence thereafter.	4/12/13
F 309 SS=D	483.25 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	F 309		

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 309	Continued From page 4 by: Based on medical record review, review of facility policy, and interview, the facility failed to assess a shunt for thrill and bruit related to dialysis treatment and failed to accurately monitor fluid intake and output for one (#194) resident of thirty-eight residents reviewed. The findings included: Resident #194 was admitted to the facility on February 14, 2013, with diagnoses including End Stage Renal Disease Stage IV, Hypertension, Lupus, and Convulsions. Medical record review of the February 14, 2013, Admission Physician Orders revealed the resident received Dialysis on Tuesday, Thursday and Saturday, and a Renal Diet with 1500 ml/24hr (1500 milliliter per 24 hours) (fluid restriction). Medical record review of the Care Plan dated February 25, 2013, revealed the "potential for complications related to hemodialysis for diagnosis of end stage renal failure...monitor shunt site by palpating for thrill & (and) for bruit every shift...at risk for fluid volume deficit related to edema, fluid restriction, ESRD (End Stage Renal Disease) dialysis...provide/monitor intake of diet/fluids...Fluid restriction 1500 ml/24hr..." Medical record review of the Nurses Notes, Medication Administration Record (MAR), and dialysis documentation, dated February 15 - 25, 2013, revealed no documentation of monitoring of the shunt by thrills or bruit every shift.	F 309		

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 309	Continued From page 5 Medical record review of the Intake & Output Record dated February 15 - 25, 2013, revealed an intake range of 60 to 600 milliliters. Review of the Certified Nurse Aide Fluid Intake documentation dated February 15 to 25, 2013, revealed an intake range of 240 to 1620 milliliters. Review of facility policy, Fluid Restriction, dated December 20, 2010, revealed "...Purpose: 1. To assure that the amount of fluids given do not exceed the amount ordered by the physician...Procedure... 4. Document strict I&O (intake and output) each shift..." Interview with the Assistant Director of Nursing (ADON), and the Chief Nursing Executive on February 27, 2013, at 9:35 a.m., and 11:15 a.m., in the conference room, confirmed the facility had failed to assess the thrills and bruit every shift. Interview with Licensed Practical Nurse #3 on February 27, 2013, at 8:45 a.m., at the 300 nursing station, confirmed the Intake & Output Record was the document used for the intake and output for the 24 hour period. Interview with the Chief Nursing Executive on February 27, 2013, at 11:15 a.m., in the conference room, confirmed the facility had failed to accurately document strict intake and output.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	**F431 Drug Records, Label/Store Drugs & Biologicals** Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. **Residents affected:** The expired drug was immediately disposed of upon discovery. **Residents potentially affected:** All residents could be potentially affected by this cited practice. All medication carts were checked for any other expired medications on 2/26. Licensed nurses were educated on expiration dates. **Systemic measures:** Central supply clerk or designee will check expiration dates on over-the-counter medications while stocking the medication rooms. Medications within one month of expiration will be moved to the front of the shelf for usage and removed if not used before the end of that month. The pharmacy consultant will audit med carts monthly for expired drugs and storage during pharmaceutical visit and report findings to the DON/designee during the exit report. The SDC/designee will educate licensed nurses on discarding and storage of over the counter medications. **Monitoring measures:** Central Supply/designee will conduct a medication storage audit weekly for 4 weeks, then monthly for two months. The pharmacy consultant will conduct monthly cart audits and report concerns to the DON/designee related to expired over-the-counter medications. Concerns will be addressed immediately and reported to the Administrator for monthly QA for three months and upon occurrence thereafter.	4/12/13

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER
BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
5580 ROANE STATE HWY
ROCKWOOD, TN 37854

(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 431	Continued From page 6 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 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 observation and interview, the facility failed to dispose of expired medications for one of eight medication carts inspected for medication storage. The findings included;	F 431		

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445143		02/27/2013

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 5580 ROANE STATE HWY, ROCKWOOD, TN 37854

(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 431	Continued From page 7 Observation on February 26, 2013, at 9:45 a.m., at the West Wing Hall A medication cart, revealed one bottle of Geri-Care liquid stool softener 100 mg (milligram)/(per) ml (milliliter) with a manufacturer's expiration date of January 2013 stamped on the label. Interview with Licensed Practical Nurse (LPN) #2 at the time of the observation confirmed the bottle of Geri-Care liquid stool softener had expired.	F 431	**F441 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. **Residents affected/potentially affected:** All residents have the potential to be affected by this cited practice. LPN #1 was immediately educated on hand washing policy. **Systemic measures:** SDC or designee will educate staff on facility hand washing policy. SDC or designee will conduct medication pass on 4 licensed nurses per month to ensure proper hand washing techniques for two months. The pharmacy will conduct medication pass on 6 licensed nurses quarterly for two quarters. Any concerns identified during the medication pass will be immediately corrected with the licensed nurse and education provided by the SDC/designee. **Monitoring measures:** The DON/designee will report concerns identified with hand washing during medication pass in the clinical meeting to the Administrator throughout the work week. Administrator will address any concerns during QA monthly for two months and upon occurrence thereafter.	4/12/13
F 441 SS=D	483.65 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, 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	F 441		

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445143	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2013
NAME OF PROVIDER OR SUPPLIER BRIDGE AT ROCKWOOD, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 ROANE STATE HWY ROCKWOOD, TN 37854	

(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 441	Continued From page 8 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, facility policy review, and interview, the facility failed to ensure the hands were disinfected between residents during medication administration. The findings included: Observation during medication administration on February 25, 2013, at 9:45 a.m., revealed Licensed Practical Nurse (LPN) #1 donned gloves, and administered eye drops to the resident. Continued observation revealed LPN #1 removed the gloves and proceeded to administer oral medications to the resident. Continued observation revealed LPN #1 exited the resident's room and charted on the Medication Administration Record without disinfecting the hands. Observation on February 25, 2013, at 10:10 a.m., revealed LPN #1 disinfected the glucometer and proceeded to set up medications from the medication cart for the next resident. Continued	F 441		

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

PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445143	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/27/2013
NAME OF PROVIDER OR SUPPLIER BRIDGE AT ROCKWOOD, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 6680 ROANE STATE HWY ROCKWOOD, TN 37854	

(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 441	Continued From page 9 observation revealed LPN #1 entered the resident's room and administered medications to the resident. Continued observation revealed LPN #1 donned gloves to look for a medicated patch on the resident's skin, touched the resident's clothing, removed the existing patch, and applied the new medicated patch to the resident's skin. Continued observation revealed LPN #1 exited the resident's room, removed the gloves, and discarded the gloves in the trash receptacle on the side of the medication cart. Continued observation revealed LPN #1 went back into the resident's room, moved items on the over-bed table, placed a hand on the resident's shoulder, and exited the room to the nurse's station to locate the sack lunch for another resident leaving for dialysis with Emergency Medical Services personnel. Review of facility policy, Handwashing, revealed, "...Appropriate Times for Staff to Wash Hands...Before and after caring for each resident and/or their units. This includes handling anything the resident has touched..." Review of facility policy, Medication Administration, revealed, "...Wash hands before beginning medication pass and after any direct contact with resident." Interview with LPN #1 on February 27, 2013, at 8:00 a.m., on the East Wing hallway, confirmed the hands had not been disinfected after the gloves had been removed.	F 441		