NAME OF PROVIDER OR SUPPLIER

GRACE HEALTHCARE OF WHITES CREEK

STREET ADDRESS, CITY, STATE, ZIP CODE

WHITES CREEK, TN 37189

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(NAME)

GRACE HEALTHCARE OF WHITES CREEK

DATE SURVEY COMPLETED

10/23/2012

Provider/Supplier/Clinic Identification Number

445281

((X1)) PROVIDER/SUPPLIER/Clinic Identification Number

((X2)) MULTIPLE CONSTRUCTION

A Building

B Wing

((X3)) DATE SURVEY COMPLETED

F 225 483.13(c)(1)(i)-(ii), (c)(2) - (4)

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.

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.

Provider's Plan of Correction

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

((X4)) PREFIX TAG

SSD

((Y4)) ID TAG

F 225

((X5)) COMPLETION DATE

11/13/2012

This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.

The allegation of abuse for Resident # 32 was reported on December 2, 2011 by the Director of Nursing. The medical record of resident # 32 was reviewed on October 30, 2012 by the Director of Nursing.

The allegation of abuse for Resident # 44 was reported on December 28, 2011 by the Director of Nursing. The medical record of resident # 44 was reviewed on October 30, 2012 by the Director of Nursing.

No new orders or negative outcomes were identified.

The Administrator and the Director of Nursing were in-service by the Regional Director of Clinical Services regarding reporting incidence of alleged abuse per the URIS guidelines on October 26, 2012.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE

ADMINISTRATOR

TITLE

COMMENTS

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 patient. (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 data those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
**F 225 Continued From page 1**

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

- Based on policy review, review of allegations of abuse investigations, and interview, it was determined the facility failed to report allegations of abuse to the state survey agency within 5 days of the allegations for 2 of 3 (Residents #22 and 44) incidents of alleged abuse reviewed in the stage 2 review.

The findings included:

1. Review of the facility's "Abuse Prevention Policy and Procedure" policy documented, 
   "...REPORTING / INVESTIGATION/RESPONSE POLICY Any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect, whether physical, verbal, mental, or sexual, involuntary, is to be thoroughly reported, investigated, and documented in a uniform manner..."

2. Review of the facility's investigation of an allegation of abuse to Resident #22 documented the date of the occurrence was 11/24/11 and was not reported to the state agency until 12/2/11.

3. Review of the facility's investigation of an allegation of abuse to Resident #44 documented the date of occurrence was 12/17/11 and was not reported to the state agency until 12/28/11.

4. During an interview at the front nurses' station on 10/23/12 at 12:38 PM, the Director of Nursing (DON) was asked within what time frame did the facility report allegations of abuse. The DON stated, "...I report it in seven days after my
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**: GRACE HEALTHCARE OF WHITES CREEK

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 3425 KNIGHT DRIVE, WHITES CREEK, TN 37189

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ICSI 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>DATE COMPLETION</th>
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<tbody>
<tr>
<td>F 225</td>
<td>Continued From page 2 investigation...</td>
<td>F 225</td>
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<td>The facility failed to report these two alleged allegations of abuse within 5 working days to the state survey agency as per regulations.</td>
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<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>F 309</td>
<td>Resident #91 was assessed by the Director of Nursing on 10/25/12. Resident #91 was assessed by the Physician on November 3, 2012. No new orders were received.</td>
<td>11/13/2012</td>
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<td>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.</td>
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<td>There were no negative outcomes identified</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to follow physician's orders for administering medications when a resident failed to have a bowel movement (BM) and failed to assess the heart rate before administering a medication for 4 of 26 (Residents #91, 108, 116, and 131) sampled residents included in in the stage 2 review.</td>
<td></td>
<td>Resident #131 was assessed by the Director of Nursing on 10/25/12. Resident #131 was assessed by the Physician on November 3, 2012. No new orders were received.</td>
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<td>The findings included: 1. Medical record review for Resident #91 documented an admission date of 9/6/10 with diagnoses of Senile Dementia with Behaviors, Senile Delusions, Psychosis, Hypertension, Heart Disease, Osteoarthritis, Hyperlipidemia, Chronic Kidney Disease, and Constipation. Review of a physician's order dated 10/2/12 documented: &quot;...MILK OF MAGNESIA [MOM]... TAKE 30ML</td>
<td></td>
<td>There were no negative outcomes identified</td>
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**DATE SURVEY COMPLETED**: 10/23/2012

**Facility ID**: TN1927

**Event ID**: 9MP11

**Previous Versions Obsolete**: CMS-3567(02-99)

If continuation sheet Page: 3 of 12
F 309 Continued from page 3
[milliliters] BY MOUTH AS NEEDED FOR NO BOWEL MOVEMENT IN 3 DAYS...

Review of the "BM Detail Roster" dated 8/22/12 through 10/22/12 revealed Resident #91 had no documented BM on 8/22/12, 8/23/12, 8/24/12, 8/25/12, 8/26/12, and 8/27/12 for a total of 5 consecutive days with no BM.

Review of the August 2012 Medication Administration Record (MAR) revealed there was no laxatives documented as being administered when Resident #91 failed to have a BM within 3 days as per the physician's orders.

During an interview at the back hall nurses station on 10/23/12 at 4:30 PM, Nurse #3 was asked what intervention were implemented for no bowel movement after 3 days for Resident #91. Nurse #3 reviewed the MAR and stated, "It doesn't look like she had anything."

2. Medical record review for Resident #108 documented an admission date of 7/1/11 and a readmission date of 8/10/11 with diagnoses of Hemiplegia, Arthrosclerosis, Diabetes Mellitus Type I, Cerebrovascular Accident with Dyphagia, Deep Vein Thrombosis, Hyperlipidemia, Joint Contracture, Morbid Obesity, Hypertension, Osteoprosis, Peripheral Vascular Disease, Anxiety, Constipation, and Dementia. Review of a physician's order dated 10/2/12 documented, "...METOPROLOL 25MG [milligrams] TABLET TAKE 1 TABLET BY MOUTH DAILY... HOLD FOR HR [heart rate] BELOW 60 SBP [systolic blood pressure] BELOW 110..."

Review of the August 2012 MAR revealed no

The licensed nursing staff was inserviced regarding following physician orders and the facility bowel protocol on October 29, 2012 by the Director of Nursing.

All resident's medical records will be audited for following physician orders and bowel protocol compliance for 5 times a week x 4 weeks then 3 times a week for 4 weeks and weekly for 4 weeks and/or 100% compliance is achieved.

The results of the above audits will be reported by the Director of Nursing monthly at the Quality Assurance Performance Improvement Committee comprised of the Medical Director, Administrator, Director of Nursing, Unit Managers, Medical Records Director, Minimum Data Set Coordinator, Rehab Director, Activities Director, Environmental Service, Dietary Manager, and Maintenance Director.
F 309 Continued From page 4

documentation that Resident #108’s heart rate was assessed prior to administering the Metoprolol on 8/7/12, 8/24/12, or 8/31/12.

Review of the September 2012 MAR revealed no documentation that Resident #108’s heart rate was assessed prior to administering the Metoprolol on 9/14/12.

Review of the October 2012 MAR revealed no documentation that Resident #108’s heart rate was assessed prior to administering the Metoprolol on 10/4/12, 10/6/12, or 10/7/12.

During an interview in the 400 hall on 10/23/12 at 9:43 AM, Nurse #4 was asked what was the heart rate for Resident #108 on 10/4/12 and 10/6/12. Nurse #4 reviewed the MAR and stated, "I see a blood pressure. I can't see the pulse... I can't say I see one [pulses] on the 6th..."

3. Medical record review for Resident #116 documented an admission date of 6/13/12 with a readmission date of 8/17/12 with diagnoses of Depressive Disorder, Neuropathy, Left Below the Knee Amputation, Hyperlipidemia, Diabetes Mellitus Type II, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Hypertension, History of Deep Vein Thrombosis, Constipation, and Personality Disorder. Review of a physician’s order dated 10/2/12 documented, "...METOPROLOL... 50 MG TAKE 1 TABLET BY MOUTH DAILY [check mark] AP [APICAL PULSE] HOLD DOSE < [less than] 60...30 ml MOM if no BM in 3 days needed..."

Review of the October 2012 MAR revealed no documentation that Resident #110’s heart rate

F 309

Resident #108 was assessed on October 15, 2012 by the Director of Nursing. Resident #108 was assessed by the physician on November 3, 2012.

No new orders were given and no negative outcomes were identified.

Resident #116 was assessed on October 25, 2012 by the Director of Nursing. Resident #116 was assessed by the physician on November 3, 2012.

No new orders were given and no negative outcomes were identified.

Nurse #4 was in-serviced on following the physician orders and blood pressure medication compliance related to apical pulse.

A chart audit of all residents receiving blood pressure medications that requires an apical pulse was completed from October 26, 2012 to November 2, 2012 by the Director of Nursing and Unit Managers.

No other residents were affected by this practice.

The licensed nursing staff were in-serviced on following physician orders related to blood pressure medications which require assessing apical pulses prior to administering medications by the Director of Nursing on October 19, 2012.
F 309 Continued From page 5

was assessed prior to administering the Metoprolol on 10/4/12, 10/5/12, 10/6/12, 10/7/12, 10/8/12, and 10/17/12.

Review of the "BM Detail Roster" dated 8/23/12 through 10/22/12 revealed Resident #116 had no documented BM on 9/4/12, 9/5/12, 9/6/12, and 9/7/12 for a total of 4 consecutive days with no BM. There was no documented BM for Resident #116 on 9/26/12, 9/27/12, 9/28/12, and 9/29/12 for a total of 4 consecutive days with no BM. There was no documented BM for Resident #116 on 10/10/12, 10/11/12, 10/12/12, and 10/13/12 for a total of 4 consecutive days with no BM.

Review of the September 2012 MARs had no laxatives documented as being administered when Resident #116 failed to have a BM, every 3 days as per the physician's orders.

During an interview on the 400 hall on 10/23/12 at 8:15 AM, Nurse #3 was asked what was the heart rate for Resident #116 on 10/4/12, 10/5/12, 10/6/12, 10/7/12, and 10/17/12 prior to the administration of the Metoprolol. Nurse #3 reviewed the MAR and stated, "...There is no pulse on that one [10/5/12 and 10/6/12]. can't read that one either [10/17/12]."

During an interview at the back hall nurses' station on 10/23/12 at 6:15 PM, Nurse #2, was asked if Resident #116 received a laxative as ordered for no bowel movements after three days on 9/4/12 through 9/7/12, 9/25/12 through 9/29/12, and 10/10/12 through 10/13/12. Nurse #2 stated, "...According to this MAR [September 2012 and October 2012], nothing was given [for constipation]... This [MAR] is the only place it..."
**F 309** Continued From page 6 would be documented besides the nurses notes..."

4. Medical record review for Resident #131 documented an admission date of 4/18/11 and a readmission date of 4/25/11 with diagnoses of Hypertension, Hypothyroidism, Dementia with Behavior Disturbance, Cardiomegaly, B-Complex Deficiency, Depression, and Constipation. Review of a physician’s order dated 10/6/12 documented, "...MILK OF MAGNESIA... TAKE 30ML BY MOUTH AS NEEDED IF NO BOWEL MOVEMENT IN 3 DAYS..."

Review of the "BM Detail Roster" dated 8/22/12 through 10/22/12 revealed Resident #131 had no documented BM on 8/31/12, 9/1/12, 9/2/12, and 9/3/12 for a total of 4 consecutive days with no BM.

Review of the August 2012 MAR had no laxatives documented as being administered when Resident #131 failed to have a BM, every 3 days as per the physician’s orders.

During an interview at the March 2012 interview the Resident #131 failed to have a BM, every 3 days as per the physician’s orders.

**F 311** 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLs

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (b)(1) of this section.
Continued From page 7

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 resident received appropriate rehabilitative services for 1 of 3 (Resident #55) sampled residents of the 53 residents included in the stage 2 review.

The findings included:

- Review of the facility’s "RESTORATIVE PROGRAMS" policy documented, 
  "...IMPLEMENTATION PLAN... Select one restorative program... set up the structure for that program and implement the structure and program on every unit... Put the following structure in place... CNA (Certified Nursing Assistant) care plan reference sheet / Kardex - this is where restorative programs for individual residents are written to serve as a point of reference... CNA assignment sheets - address restorative programs for individual residents on appropriate CNA assignment sheets... Narrative notes... CNAs - When resident has not responded as expected, refuses, shows signs of decline... Implement your plan... Start the flow sheet and add to the appropriate unit notebook or designated place... Write the frequency, the amount of assistance, equipment, involved extremities if applicable..."

Medical record review for Resident #55 documented an admission date of 12/11/09 with a readmission date of 8/31/10 with diagnoses of Convulsions, Hypertension, Hyperlipidemia, Esophageal Reflux Disease, Left Sided
### F 311 Continued From page 8


Review of the quarterly Minimum Data Set (MDS) dated 2/28/12 documented, "...Section O - Special Treatments and Programs... O0500... Restorative Nursing Programs... Number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days... A. Range of motion (passive) ...0... B. Range of motion (active) ...3..." Review of the quarterly MDS dated 8/28/12 documented, "...Section O - Special Treatments and Programs... O0500. Restorative Nursing Programs... Number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days... A. Range of motion (passive) ...3... B. Range of motion (active) ...3..."

Review of the care plan dated 5/28/12 and updated on 8/28/12 documented, "...Problem / Concern... Decrease in strength and endurance Bil [bilateral] lower ext [extremities]... Approaches... 1. Restorative for Thera [therapeutic] exercise to bil lower ext using 2# [pound] wts and perform 3 sets of 10 reps of each exercises 3x wkly [weekly]... Problem/Concern... Decrease in strength and endurance Right upper ext... Approaches... Restorative for exercise to right upper ext with 3# dumbbell 5 sets x 10 reps..."
During an interview in the conference room on 11/27/2012 at 7:40 PM, when asked about what he was doing, Resident #55 stated, "I was just exercising my arms and legs with the weights that were given to me." When asked if he had any specific needs or concerns, Resident #55 stated, "Nothing specific, just need help with mobility and strength." Nurse #6 stated, "He is doing well with his passive range of motion exercises, but needs assistance with active range of motion exercises." During the interview, Resident #55's strength on the bilateral lower extremities and right upper extremity was noted to be weak, and he had difficulty moving his left upper extremity. A therapist recommended increased active range of motion exercises for both lower extremities and passive range of motion exercises for the right upper extremity.

Review of the Restorative Care Plan dated 10/12/2012 through 12/31/2012 documented, "RESTORATIVE NURSING"

BLE 2B WEIGHTS 3X/WK.

Nurse #6 stated that Resident #55 is progressing well with his restorative care plan, and that he is able to move his left upper extremity with assistance. Resident #55 is noted to have increased strength in both lower extremities and is able to transfer from wheelchair to bed with minimal assistance. However, he is still unable to actively move his left upper extremity.

A physical therapist recommended the following goals for Resident #55:

- Increased active range of motion exercises for both lower extremities
- Passive range of motion exercises for the right upper extremity
- Increased assistive devices for transfers

Nurse #6 noted that Resident #55 is responsive to the interventions and is making progress. However, he continues to need assistance with mobility and strength.
**F 311** Continued From page 10

- able to do most... usually doesn't involve any equipment [weights],” Nurse #5 was asked what charting “Other” included on the “Restorative Roster”. Nurse #5 stated, “...I'm not sure...”

During an interview in the restorative office on 10/23/12 at 3:50 PM, Restorative Tech #1 was asked if weights were used with the exercises for Resident #55. Restorative Tech #1 stated, “No, no weights with him... just move his arms...”

During an interview in the lobby on 10/23/12 at 4:00 PM, Restorative Tech #2 was asked how she knew what type of care to provide for a resident. Restorative Tech #2 stated, “...from the Therapy Communication to Restorative sheet...” Restorative Tech #2 was asked if she used weights with the exercises for Resident #55. Restorative Tech #2 stated, “No...”

During an interview in the conference room on 10/23/12 at 4:10 PM, Nurse #5 was shown the care plan for the exercises of the right upper extremity. Nurse #5 was asked if this restorative nursing intervention should have been written as a physician’s order. Nurse #5 stated, “Yes...”

**F 364** 11/13/2012

- Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:

The Dietary Manager will ensure that the foods served from the steam tables are served at the correct temperatures and any request for additional food will be delivered directly from the steam table in the Dietary Kitchen.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CAREGIVER IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>445281</td>
<td></td>
<td>10/23/2012</td>
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**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF WHITES CREEK

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

3425 KNIGHT DRIVE
WHITES CREEK, TN 37189

**F 364 Continued From page 11**

Based on policy review, observation and interview, it was determined the facility failed to ensure that food was served at the proper temperature from 1 of 2 steam tables during dining observation.

The findings included:

- Review of the facility's "FOOD TEMPERATURE CHART" policy documented, "...NOON MEAL... Entrees, hot... Desired Temp [temperature] (F) [Fahrenheit]... 140-165... Starches...140-165... Vegetables...140-165..."

- Observations in the main dining room on 10/23/12 at 12:19 PM, revealed the following steam table temperatures:
  a. Barbecue chicken 90 degrees F.
  b. Scalloped potatoes 100 degrees F.
  c. Green Peas 90 degrees F.

- Observations in the main dining room on 10/23/12 at 12:22 PM, Nurse #6 served barbecue chicken and scalloped potatoes from the steam table to a resident.

- During an interview in the main dining room on 10/23/12 at 12:25 PM, the Dietary Manager (DM) was asked about the low temperatures of the food on the steam table. The DM stated, "...we don't need to serve the food from here [steam table]."

**F 364**

The Administrator in-serviced the Dietary Manager and staff regarding the temperatures food must be when they are served to residents on October 26, 2012.

The Dietary Manager completed a 100% audit of all food preparation to ensure that foods are served at appropriate temperatures at all times on October 26, 2012.

No other incidents were found.

Steam table food temperatures audits will be conducted daily at all meals for 2 weeks and once a week for 2 months and/or 100% compliance.

All results of the above will be reported by Director of Maintenance quarterly to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Unit Managers, Medical Records, Minimum Data Set Coordinator, Rehab Director, Social Services at the Director, Activities Director, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.

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**RECEIVED**

[Signature]