**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID TAG**

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Prefix</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>F 315</td>
<td>This plan of correction is submitted as required under state and federal law. The submission of this plan of correction does not constitute an admission on the part of Grace Healthcare of Whites Creek to the accuracy of the surveyor's findings or conclusions drawn there from. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</td>
<td>05/12/2010</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

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

Based on policy review, medical record review, observation and staff interview, it was determined the facility failed to provide appropriate treatment and services by allowing Foley catheter bags and tubing to lay on the floor for 8 of 9 (Residents #5, 12, 14, 15 and 16) sampled residents with Foley catheters.

The findings included:

1. Review of the facility’s catheter care policy documented, “Catheter Care, Urinary... 11 ... Be sure the catheter tubing and drainage bag are kept off the floor...”

2. Medical record review for Resident #5 documented an admission date of 4/17/09 and a readmission date of 10/9/09 with diagnoses of Urinary Tract Infection (UTI), Renal Failure, Sepsis, Diabetes Mellitus, and Dehydration.

Observations in Resident #5’s room on 6/10/10 at 10:20 AM revealed Resident #5 lying in the bed.

**Administrator**

5/28/10

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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 also DNR 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction areducible 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.
**NAME OR PROVIDER OR SUPPLIER:**

Grace Healthcare of Whites Creek

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

3425 Knight Drive
Whites Creek, TN 37186

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<tr>
<td>F 315</td>
<td>Continued From page 1 with the Foley catheter bag and tubing were lying on top of the fall mat. Observations in Resident #5's room on 5/10/10 at 3:15 PM and at 6:15 PM, revealed Resident #5's Foley catheter tubing and bag were laying on the floor. During an interview in the hall beside room 208, on 5/12/10 at 9:06 AM, Nurse #8 was asked if Foley catheters should be on the floor. Nurse #8 stated, &quot;No ma'am.&quot; Nurse #8 was then asked if the catheter tubing should be on the floor. Nurse #8 stated, &quot;No Ma'm.&quot; Nurse #8 was then asked where the catheter should be if the resident is a fall risk and in a low bed. Nurse #8 stated, &quot;...the bag will probably be touching the floor due to the low bed but the tubing should not be...&quot; 3. Medical record review for Resident #12 documented an admission date of 2/6/08 with diagnoses of Cognitive Impairment, Urinary Incontinence, Dysphagia and Pressure Ulcers. Observations in Resident #12's room on 5/10/10 at 11:17 AM, revealed Resident #12 in bed with the Foley catheter bag and tubing laying on the floor. During an interview in the dining room on 6/12/10 at 1:00 PM, Nurse #3 stated, &quot;The resident [#12] is in a Tru-Low bed, which is only six inches off the floor. It is hard to keep the catheter bag off the floor, but the catheter tubing should have been on the bed.&quot; 4. Medical record review for Resident #14 documented an admission date of 10/13/06 with diagnoses of Depression, Insulin Dependent Glucose</td>
<td>F 315</td>
<td>Resident #12 was assessed and monitored for adverse effects by the Director of Nursing for Foley bag and tubing on the floor on 5/12/10. MD notified on 5/13/10 by the Director of Nursing. No new orders. Resident #12 was reassessed by the Director of Nursing for the appropriateness of low bed on 5/14/10. Based on reassessment of Resident #12's clinical status, the resident's low bed was discontinued on 5/15/10. Resident #12 is now in a regular hospital bed, with indwelling Foley catheter bag secured on bed frame off the floor, and tubing positioned, as per facility's urinary catheter care policy.</td>
<td>5/21/10</td>
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CMS-2587 (02-00) Previous Versions Obsolete
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<td>F 315</td>
<td>Continued From page 2</td>
<td>Diabetes, Peripheral Neuropathy, Constipation, and Diabetic Retinopathy. Observations in Resident #14's room on 5/11/10 at 5:25 PM, revealed Resident #14 lying in the bed with the Foley catheter bag lying on top of the fall mat. During an interview in the 100 hall beside the medication cart between room 108 and 108 on 5/12/10 at 10:50 AM, Certified Nurse Tech (CNT) #1 was interviewed in regards to the placement of Foley catheter bags for residents in the bed. CNT #1 stated, &quot;...Foley bag...can lay on the mat.&quot;</td>
<td>F 3:15</td>
<td>Resident #16 was assessed and monitored for adverse effects by Director of Nursing for Foley catheter bag and tubing on floor on 5/12/10. MD made aware no new orders. The indwelling urinary catheter bag secured on bed frame, off the floor, and catheter tubing positioned as per facility's urinary catheter care policy on 5/12/10.</td>
<td>5/21/10</td>
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5. Medical record review for Resident #15 documented an admission date of 4/9/10 with diagnoses of Acute Leukemia, Blindness One Eye, Rheumatoid Arthritis, Hypertension, Debality, Central Nervous System Disorder, Morbid Obesity, Palliative Care, and Drug Abuse in Remission. Review of physician's orders dated 5/1/10 documented order for "FOLEY CATH #15/10CC [cubic centimeter] BULB."

Observations in Resident #16's room on 5/10/10 at 10:50 AM, revealed Resident #16 lying in bed with the Foley catheter bag laying on floor.

Observations in Resident #15's room on 5/11/10 at 4:15 PM, revealed Resident #15 lying in bed with the Foley catheter bag laying on the floor.

Observations in Resident #16's room on 5/12/10 at 7:40 AM, revealed Resident #16 lying in bed with the Foley catheter bag laying on the floor.

During an interview outside of room 110 on 5/12/10 at 8:45 AM, Nurse #3 stated, "It [Foley.
F 315 Continued from page 3 catheter bag should not be on the floor."

6. Medical record review for Resident #16 documented an admission date of 4/29/08 with readmission date of 9/29/09 with diagnoses of Paraplegia, Arthritis, Stage 4 Coccyx Wound Care, Congestive Heart Failure, Chronic Bedrest, Foley Catheter for Bladder Retention and Stage 4 Coccyx Wound.

Observations in Resident #16’s room on 5/1/10 at 4:00 PM revealed Resident #16 lying in bed with the Foley catheter bag and tubing laying on the floor.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined that the facility failed to ensure 5 of 6 medication nurses (Nurses #3, 5, 6, 7 and 8) administered medications without a medication error rate of less than 5 percent (%). A total of 10 errors were observed out of 47 opportunities for error, resulting in a medication error rate of 21.27%.

The findings include:

1. Review of the facility’s policy and procedure for eye drop administration documented, “...10. Wait at least five (5) minutes before applying additional medication to the eye.”
F 332 - Continued From page 4

Medical record review for Random Resident (RR) #3 documented an admission date of 5/8/09 with diagnoses of Hemiplegia, Diabetes, Hypertension, and Hyperlipidemia. A physician's order signed 5/3/10 documented, "AURAL 0.6% OPTH TH PLAN BALMIC SOLUTION INSTILL DROP (S) IN RIGHT EYE AS DIRECTED 4 TIMES DAILY. PRED FORTE 1% EYE DROPS PREDNISOLONE AC 1% EYE DR [DROPS] INSTILL 1 DROP IN BOTH EYES 4 TIMES DAILY."

Observations in RR #3's room on 5/11/10, beginning at 7:55 AM, revealed Nurse #5 administered Acular eye drops to the RR #3. At 7:57 AM, Nurse #5 administered the Prednisolone eye drops, waiting 2 minutes between the two different eye drops. The failure to wait 5 minutes between the two different eye drop medications resulted in medication error #1.

During an interview in the hallway outside RR #3's room on 5/11/10 at 8:08 AM, Nurse #5 stated, "Would wait 2 minutes [between eye drops]."

3. In-services were conducted for licensed staff from 5/12/10 to 5/21/10, by the Director of Nursing and/or her Nursing Unit Managers, on administering complete medication dosage, administering insulin as ordered - at prescribed time, based on insulin type and meal times; and administering medications as ordered by the physician.

4. The Director of Nursing and/or Unit Manager will conduct 2 medication pass observation audits with licensed nurses daily, times 4 weeks; then 2 times a week for 4 weeks; then weekly times 4 weeks and/or until 100% compliance. Results of audits will be reviewed by Quality Assurance Committee monthly. Members of the committee are: Administrator, Director of Nursing, Minimum Data Set Nurse, Social Services, Dietary Manager, Activity Director, Rehab Manager, and Medical Director.

5/21/10
**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF WHITES CREEK.

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

3428 KNIGHT DRIVE

WHITES CREEK, TN 37169

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<td>F 332</td>
<td>Continued From page 6 administered. The failure to administer the complete dose of Oyster Shell Calcium resulted in medication error #6.</td>
<td>F 332</td>
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During an interview in Resident #12's room on 5/11/10 at 5:00 PM, Nurse #3 verified, "Some [medication] residual [was] left in the cup."

4. Review of the facility’s insulin administration policy and procedure documented, “Characteristics and Types of Insulin 1. The three key characteristics of insulin are: a. Onset of action - how quickly the insulin reaches the bloodstream and begins to lower blood glucose; b. Peak effects - the time when the insulin is at its maximum effectiveness; c. Duration of effects - the length of time during which the insulin is effective. 2. The four types of insulin and their characteristics are: Rapid-acting Onset: 10- [to] 15 minutes, Peak: 0.5-3 hours, Duration: 3-6 hours."

Medical record review for RR #2 documented an admission date of 4/27/07 with diagnoses of Diabetes, Congestive Heart Failure and Hypothyroidism. A physician’s order dated 5/1/10 through 5/31/10 documented, "NOVOLIN 70/30 100U [units] / [per] ML [milliliter] INJECT 15 UNITS SQ [subcutaneous] AT 5PM."

Observations in RR #2's room on 5/11/10 at 5:25 PM, revealed Nurse #7 administered 15 units of Novolin 70/30 insulin SQ to RR #2. RR #2's supper tray was not served and the resident did not start eating until 6:55 PM, 30 minutes after the administration of the rapid-acting insulin. The administration of the fast-acting Novolin insulin and not providing food in a timely manner resulted in medication error #7.
5. Medical record review for RR #4 documented an admission date of 1/13/09 with diagnoses of Iron Deficient Anemia, Venous Thrombosis, Spinal Stenosis and Diverticulum of Colon. A physician's order signed 5/2/10 documented, "FLEXERIL 10MG 1/2 TABLET CYCLOBENZAPRIN 10 MG 1/2 TAB TAKE 1/2 TABLET (5MG) BY MOUTH EVERY MORNING. OMNIPRES 1 GTT [drop (L) left] EYE 2X [times] DAILY X 3 WEEKS. NEVONEC 1 GTT (L) EYE 3X DAILY X 3 WEEKS."

Observations in RR #4's room on 5/11/10 beginning at 9:08 AM, revealed Nurse #8 administered one drop of Omnipres into RR #4's left eye. Two minutes later, at 9:10 AM, Nurse #8 administered two drops of Nevonec ophthalmic drops into RR #4's left eye. Nurse #8 did not administer the 5 mg Flexeril as ordered. The administration of two drops of the Nevonec ophthalmic drops instead of one as ordered resulted in medication error #8. The administration of the second eye medication without waiting 5 minutes per facility policy resulted in medication error #9. The failure to administer the Flexeril as ordered resulted in medication error #10.

During an interview outside of RR #4's room on 5/12/10 at 9:35 AM, Nurse #8 was shown the empty medication packets for RR #4 and there was not a packet for the Flexeril. Nurse #8 verified she should have given the Flexeril.

During an interview in the back hall on 5/12/10 at 12:30 PM, Nurse #8 stated, "...mis-read the directions for the eye drops, 2 to 5 minutes for same medication but 5 minutes for different
Continued From page 8
meds. Just read it wrong. I asked the resident [RR #4] who is alert if she had received the Flexeril and RR #4 said "No" so I went back and gave it."