STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA
IDENTIFICATION NUMBER:

445146

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
01/31/2012

NAME OF PROVIDER OR SUPPLIER

GRACE HEALTHCARE OF FRANKLIN

STREET ADDRESS, CITY, STATE, ZIP CODE

1287 WEST MAIN
FRANKLIN, TN 37064

(X4) ID
PREFIX
TAG

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

F 160: 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH

SS= D

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident’s funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident’s estate.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to ensure a resident’s personal funds were conveyed to the individual or probate jurisdiction administering the resident’s estate within 30 days of the death of the resident for 2 of 3 Random Residents (RR #1 and 2).

The findings included:

1. Record review of the facility’s “Patient Refund Form” documented RR #1 died on 11/8/11. Review of a copy of the refund check documented an issue date of 1/24/12 which was 78 days after RR #1’s death.

During an interview in the business office on 1/31/12 at 11:05 AM, the Business Office Manager (BOM) confirmed RR #1 died on 11/8/11 and that RR #1’s personal funds were not conveyed until 1/24/12.

2. Record review of the facility’s “Patient Refund Form” documented RR #2 died on 12/11/11. Review of a copy of the refund check documented an issue date of 1/24/12 which was acceptable for 1/31/12.

(X5) PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 160

1. The refund for RR #1 was refunded to the State Recovery Unit on 01/24/12 by the business office manager. The refund for RR #2 was refunded to the estate of RR #2 on 01/24/12 by the business office manager.

2. A 100% audit was completed on all deceased residents funds for the previous 2 years on 02/08/12 by the business office manager. Any refunds noted were refunded by Grace Healthcare of Franklin on 02/09/12.

3. The business office manager was inserviced on 02/01/12 by the administrator regarding refunding all deceased residents funds within 30 days of death.

4. The business office manager will audit deceased residents funds weekly times 4 weeks, then monthly times 2 months and/or until 100% compliance. The results will be reported by the business office manager to the Quality Assurance Performance Improvement Committee comprised of Medical Director, Administrator, Director of Nursing, Assistance Director of Nursing, MDS Coordinator, Dietary Manager, Environmental Director, Activities, Social Services and Maintenance Supervisor.

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

Judy White, Administrator

TITLE

02/15/12

DATE

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 dischargeable 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 dischargeable 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 form was faxed 2/15/12.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F160</td>
<td>Continued From page 1</td>
<td>54 days after RR #2’s death.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>During an interview in the business office on 1/31/12 at 11:05 AM, the BOM confirmed RR #2 died on 12/11/11 and that RR #2’s personal funds were not conveyed until 1/24/12.</td>
<td></td>
</tr>
<tr>
<td>F309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING</td>
<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>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on medical record review and interview, it was determined the facility failed to follow physicians’ orders of care when a resident failed to have a bowel movement (3M) after 2 to 3 days for 5 of 16 (Residents #4, 5, 6, 10 and 16) sampled residents.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The findings included:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Medical record review for Resident #4 documented an admission date of 11/25/09 with a readmission date of 2/15/11 with diagnoses of Anemia, Hyperlipidemia, Coronary Artery Disease, Cerebrovascular Accident, Pressure Ulcer, Psychosis and Anxiety. Review of the physician’s orders dated 12/1/11 documented, &quot;...MILK OF MAGNESIA [MOM] SUSP [suspension] THIRTY (30) CC [cubic centimeters] AFTER SECOND DAY OF NO BM... FLEETS</td>
<td></td>
</tr>
</tbody>
</table>
F 309: Continued From page 2

ENEMA OR SUPPOSITORY IF NO RESULTS
BY THIRD DAY..." Review of the "BM Detail
option 2 Roster" dated 12/1/11 through 12/31/11
had no BM documented for Resident #4 on
12/12/11, 12/13/11, and 12/14/11. Review of the
medication administration record (MAR) dated
12/1/11 through 12/31/11 had no laxative,
suppository or enema documented as being
given as ordered.

During an interview in the nursing administration
office on 1/31/12 at 12:35 PM, the Assistant
Director of Nursing (ADON) confirmed that no BM
was documented for Resident #4 after 12/11/11
until 12/15/11 and no laxative, suppository or
enema administration was documented on
12/14/11.

2. Medical record review for Resident #5
documented an admission date of 4/11/11 with
diagnoses of Gastroesophageal Reflux Disease,
Depression, Constipation, Chronic Obstructive
Pulmonary Disease, Insomnia, Anxiety,
Osteoporosis, Bowel Obstruction and Dysthmic
Disorder. Review of the "PHYSICIAN'S
ORDERS" dated 11/2/11 documented "...MILK
OF MAGNESIA SUSP THIRTY CC AFTER
SECOND DAY OF NO BM AND FLEETS ENEMA
OR SUPPOSITORY IF NO RESULTS BY THIRD
DAY..." Review of the "BM Detail option 2 Roster"
dated 11/1/11 through 11/30/11 had no BM
documented on 11/9/11, 11/10/11, 11/11/11,
11/13/11, 11/14/11, 11/15/11 and 11/16/11.
Review of the MAR dated 11/1/11 through
11/30/11, had no medication documented as
being given for no BM's.

During an interview in the nursing administration
F 309

1. An assessment of resident # 4 was completed
by director of nursing on 01/30/12. The
medical director was notified by the assistant
director of nursing on 01/31/12 with no new
orders. The family was notified by the
assistant director of nursing on 2/10/12.
There were no adverse outcomes.

An assessment of resident # 5 was completed
by the assistant director of nursing on
01/31/12. The medical director was notified by the assistant
director of nursing on 01/31/12 with no new order. The family was notified by the
assistant director of nursing on 2/10/12.
There were no adverse outcomes.

An assessment of resident # 6 was completed
by the assistant director of nursing on
01/31/12. The medical director was notified by the assistant
director of nursing on 01/31/12 with no new orders. The family was notified by the assistant
director of nursing on 2/10/12.
There were no adverse outcomes.

An assessment of resident # 10 was completed
by the assistant director of nursing on
01/31/12. The medical director was notified by the assistant
director of nursing on 01/31/12 with no new orders. The family was notified by the assistant
director of nursing on 2/10/12.
There were no adverse outcomes.

Resident # 16 no longer resides in facility and
the medical record was reviewed by the director
of nursing and the assistant director of nursing
on 01/31/12. There were no adverse outcomes.
F 309  Continued From page 3

office on 1/31/12 at 12:30 PM, the ADON was asked what she would expect if a resident did not have a BM in 2 days. The ADON stated, "I would expect them [nurses] to follow the doctor's orders."

3. Medical record review for Resident #6 documented an admission date of 1/26/11 with a readmission date of 1/12/12 with diagnoses of Diabetes Mellitus, Prerenal Acute Renal Failure, Iron Deficiency Anemia, Hypertension, a History of Transient Ischemic Attack, Dysphagia, Depression and Cerebrovascular Accident. Review of the physician's orders dated 12/7/11 documented, "...MILK OF MAGNESIA SUSP THIRTY (30) CC AFTER SECOND DAY OF NO BM...FLEETS ENEMA OR SUPPOSITORY IF NO RESULTS BY THIRD DAY..." Review of the "BM Detail option 2 Roster" dated 12/1/11 through 12/21/11 had no BM documented on 12/14/11, 12/15/11, 12/16/11 and 12/17/11. Review of the MAR dated 12/1/11 through 12/31/11 had no laxative, suppository or enema documented as being given during the month of December 2011.

During an interview in the nursing administration office on 1/31/12 at 12:35 PM, the ADON confirmed that no BM was documented for Resident #6 after 12/13/11 until 12/17/11, and no laxative, suppository or enema administration was documented during this time. The ADON stated, "...it looks like they [nurses] didn't follow the protocol..."

4. Medical record review for Resident #10 documented an admission date of 3/12/09 with diagnoses of Atrial Fibrillation, Hypertension,
F 309 Continued From page 4

Dementia, Hyperlipidemia and Gastroesophageal Reflux Disease. Review of the physician's orders dated 1/11/12 documented, "...MILK OF MAGNESIA SUSP THIRTY (30) CC AFTER SECOND DAY OF NO BM...FLEETS ENEMA OR SUPPOSITORY IF NO RESULTS BY THIRD DAY..." Review of the "BM Detail option 2 Roster" dated 1/1/12 through 1/30/12 had no BM documented from 1/25/12 until 1/30/12. Review of the current MAR had no laxative, suppository, or enema documented as being administered on 1/28/12 or 1/29/12 as ordered.

During an interview in the hallway on 1/30/12 at 4:30 PM, Nurse #2 was asked about Resident #10 not having a BM from 1/25/12 to 1/30/12. Nurse #2 stated, "...if the CNAs [Certified Nursing Assistants] don't write it [BM] down..."

5. Medical record review for Resident #16 documented an admission date of 11/8/11 with diagnoses of Cerebrovascular Accident, Lewy Body Dementia, Hypertension and Hyperlipidemia. Review of the physician's orders dated 11/8/11 documented, "...MILK OF MAGNESIA SUSP THIRTY (30) CC AFTER SECOND DAY OF NO BM...FLEETS ENEMA OR SUPPOSITORY IF NO RESULTS BY THIRD DAY..." Review of the "BM Detail option 2 Roster" dated 11/1/11 through 11/30/11 had no BM documented from 11/8/11 until 11/15/11. Review of the MAR dated 11/8/11 through 11/30/11 had no laxative, suppository, or enema documented as being administered during the month of November 2011.

During an interview at the nurses' station on 1/31/11 at 9:00 AM, the ADON confirmed that
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
GRACE HEALTHCARE OF FRANKLIN

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

F 309. Continued From page 5
there was no documentation of a BM from 11/8/11 through 11/15/11 for Resident #16 and no documentation that a laxative, suppository or enema had been administered to Resident #16.

6. During an interview at the nurses' station on 1/29/12, Nurse #3 was asked how the facility monitored residents' BMs and what was the facility's protocol to address a resident's lack of BMs. Nurse #3 stated, a no BM report was printed off every morning, and the nursing staff followed the physician's orders to administer MOM after the second day of no BM.

During an interview in the Administrator's office on 1/31/12 at 10:45 AM, the Regional Director of Clinical Services was asked what the facility's protocol for BMs was. The Regional Director of Clinical Services stated, "...we follow physician's orders..."

During an interview in the Administrator's office on 1/31/12 at 11:45 AM, the Administrator was asked what the staff should do if the resident did not have a BM after following the BM protocol. The Administrator stated, "...call the doctor..."

During an interview in the nursing administration office on 1/31/12 at 12:35 PM, the ADON was asked how the facility knew the nursing staff was following the physician's orders for treating a resident with no BMs. The ADON stated, "...it should be documented on the MAR if they [nurses] gave something..."

F 502 483.75((1)(1)) ADMINISTRATION

The facility must provide or obtain laboratory services to meet the needs of its residents. The
### F 502
Continued From page 6
facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure laboratory testing was done as ordered for 1 of 16 (Resident #9) sampled residents.

The findings included:

Medical record review for Resident #9 documented an admission date of 6/16/12 with diagnoses of Hypertension, Hypothyroidism, Esophageal Reflux and History of Fall. Review of the current physician’s order documented: “…CBC [Complete Blood Count] Q [every] 6 MONTHS -- DUE DEC [December] 2011 and BMP [Basic Metabolic Panel] Q MONTH…” There was no documentation the CBC and the BMP were obtained as ordered.

During an interview at the nurses’ station on 1/30/12 at 10:55 AM, Nurse #1 stated, “…no CBC has been drawn since 6/24/11… the nurse drew a CMP instead of the BMP…”

During an interview in the nursing administration office on 1/31/12 at 9:25 AM, the Assistant Director of Nursing stated, “…the CBC was missed in December [2011]... the nurse drew a CMP by mistake, should have drawn a BMP…”

### F 504
483.75(i)(2)(i) LAB SVCS ONLY WHEN
SS=D
ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory
F 504  Continued From page 7

services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined a blood sample was obtained without a physician's order for 1 of 16 (Resident #9) sampled residents.

The findings included:

Medical record review for Resident #9 documented an admission date of 6/16/11 with diagnoses of Hypertension, Hypothyroidism, History of Falls and Osteoporosis. Review of the physician's order for laboratory tests had no order documented for a Complete Metabolic Panel (CMP) to be obtained in December 2011. There were test results that reflected a CMP was obtained on 12/20/11.

During an interview at the nurses' station on 1/30/12 at 10:55 AM, Nurse #1 stated, "...a CMP was done instead of a BMP [Basic Metabolic Panel] the nurse must have checked the wrong box..."

During an interview in the nursing administration office on 1/31/12 at 9:25 AM, the Assistant Director of Nursing (ADON) stated, "...it was a mistake.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</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 504</td>
<td>Continued From page 7</td>
<td>services only when ordered by the attending physician.</td>
<td>F 504</td>
<td></td>
<td>1. Resident #9 was assessed by the nursing supervisor on 01/31/12. The physician was notified on 1/31/12 by the nursing supervisor with no new orders. The assistant director of nursing notified the family on 02/10/12. There were no adverse outcomes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. An audit of all labs drawn in last 30 days was completed by the nursing supervisor on 02/08/12 to insure that Physician orders were followed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. All licensed nurses will be instructed by the director of nursing starting on 02/03/12 and completed on 02/13/12 on following physician orders for labs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. The director of nursing and/or the assistant director of nursing will do a weekly audit for 4 weeks on 20 residents, then monthly for 2 months and/or until 100% compliance. The results will be reported by the director of nursing to the Quality Assurance Performance Improvement Committee comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Environmental Director, Dietary Manager, Social Services, Activities, and Maintenance Supervisor.</td>
<td>02/15/12</td>
</tr>
</tbody>
</table>