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<td>483.10(b)(11) NOTIFY OF CHANGES</td>
<td>F 157</td>
<td>P</td>
<td>157</td>
<td>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.</td>
<td>11/18/2010</td>
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<td>(INJURY/DECLINE/ROOM, ETC)</td>
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A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure the physician was notified of an elevated blood sugar.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Administrator

DATE: 11/18/2010

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 required to continued program participation.
3. On November 10, 2010 the Medical Director, Director of Nursing, and Administrator reviewed and discussed Policy and Procedures of Hyperglycemia as it relates to notification of Physician. An addendum was added to the policy to include notification of the physician if Blood Sugar is 400 or above and/or per physician’s order.

In-services with licensed nurses and CNAs were conducted by Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services on November 3 - 6, 2010 related to signs and symptoms of hypoglycemia and hyperglycemia. Physician notification of elevated blood sugars 400 and above, Policy and Procedures related to glucose monitoring.

November 10-12, 2010 licensed nursing staff in serviced on addendum to blood glucometer maintenance policy and procedures.

4. Audit of 100% of building on November 3, 2010 was performed. A daily audit of 100% of diabetic population will be audited daily for two weeks and will continue with 10 random checks per week for three months and/or until 100% compliance is achieved. Audits were to be completed by Director of Nursing and Nursing Supervisors.
Continued from page 1

(532) for 1 of 16 (Resident #10) sampled residents.

The findings included:

Medical record review for Resident #10 documented an admission date of 5/1/08 with a readmission date of 2/1/10 with diagnoses of Diabetes Mellitus, Pulmonary Fibrosis, Senile Dementia and Esophageal Reflux. Review of Resident #10's October 2010 medication administration record (MAR) documented, "10/26/10 4:00 PM, BS-532" with 8 units of Novolin R Insulin administered. The facility was unable to provide documentation the physician was notified of the elevated BS of 532.

During an interview in the family room on 11/3/10 at 2:25 PM, the Director of Nursing stated, "We don't have a policy per say for elevated BS. We go by doctor's decision what to do at that point in time. Above a certain amount call doctor and leave it to his discretion. Suppose to call for anything [BS] above 400."

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observations, it was determined 2 of 8 medication nurses (Nurse #1 and 5) failed to maintain residents' dignity by not pulling the privacy curtains during an invasive procedure or

All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.
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<tr>
<td>F 241</td>
<td>Continued From page 2: Entering a resident's room without knocking or gaining permission to enter. Two (2) of 5 Certified Nursing Assistants (CNAs #1 and 2) entering resident's rooms without knocking or gaining permission prior to entering the room during dining observations. The findings included: 1. Observations in Resident #13's room during medication administration on 11/1/10 at 4:20 PM, Nurse #1 entered the resident's room without knocking on the door or gaining permission to enter. Observations in room 10 on 11/1/10 at 3:50 PM, Nurse #1 left room 10 and entered room 6 to wash her hands without knocking on the door or gaining permission to enter. Observations in Resident #13's room during medication pass on 11/1/10 at 4:20 PM, Nurse #1 entered Resident #13's room without knocking on the door or gaining permission to enter. 2. Observations in Resident #13's room during medication pass on 11/2/10 at 8:15 AM, Nurse #6 entered Resident #13's room to administer medications via Resident #13's Percutaneous Endoscopy (PEG) tube. Nurse #6 did not close the door or pull the privacy curtain to maintain Resident #13’s privacy. 3. Observations on the 100 hall on 11/2/10 at 7:25 AM, CNA #2 entered room #9 with a meal tray without knocking or gaining permission to enter. 4. Observations on the 100 hall on 11/2/10 at...</td>
<td>Licensed practical nurse #5 was immediately in-serviced by the Assistant Director of Nursing on November 2, 2010 related to providing privacy to residents during medication administration. 2. Proper entering of a Resident’s room and offering privacy to residents during medication administration was audited with all licensed nurses during medication pass evaluation/audit on November 3, 2010 to November 6, 2010. Evaluations conducted by Director of Nursing, Assistant Director of Nursing, and Regional Director of Clinical Services, and/or Nursing Supervisors. 3. All employees of Grace Health Care of Franklin including all departments of Nursing, Dietary, Environmental Services, Maintenance, Activities, Social Work, Marketing, Therapy and Office staff were in-serviced November 3, 2010 through November 6, 2010 related to dignity, respect, and privacy issues, including proper entering of residents room and providing privacy for residents during medication administration. In-services were conducted by Regional Director of Clinical Services and Director of Nursing, and Assistant Director of Nursing.</td>
<td>11/03/2010</td>
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<td>F241</td>
<td>4. Observations of entrance and privacy of resident's to be monitored randomly by Social Services and/or Manager on Duty twice a day for seven days, then one time a day for seven days, then three times a week for two months and/or 100% compliant. All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.</td>
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Administrator 11/18/2010
continued from page 3

7:30 AM, CNA #1 entered room #7 with a meal tray without knocking or gaining permission to enter.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the current fall intervention in place for 1 of 16 (Resident #1) sampled residents.

The findings included:

Medical record review for Resident #1

Resident #1 was assessed on November 3, 2010 by Director of Nursing and Physician for any change in status. No adverse outcomes were noted.

The care plan for resident #1 was immediately updated by the Minimum Data Set Coordinator to reflect the resident's need for the bed alarm to be in place when up in chair. Alarm was discontinued on November 10, 2010 per physician's order. Care plan updated and interventions revised on November 10, 2010 by Minimum Data Set Coordinator.

An audit of 100% of alarms in building was conducted to ensure proper placement and importance of placement and following Physician orders. The audit was conducted by the MDS coordinator and assistant director of nursing on November 3, 2010.
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<td>F280</td>
<td>3. Minimum Data Set Coordinator in-serviced on the evening of November 3, 2010 by Director of Nursing about the care planning process. November 3-November 6, 2010 all licensed staff and CNAs were in-serviced by Director of Nursing, Assistant Director of Nursing, and/or Nurse Supervisor's related to making sure all alarms ordered are properly placed and Physician orders are being followed. 4. Completed admission, quarterly, significant change and annual assessments will be reviewed by the At Risk committee weekly to ensure that their care plans are addressing needs of the resident appropriately. The At Risk committee is comprised of the Administrator, Director of Nursing, Minimum Data Set Coordinator, Dietary Manager, Medical Records, and Social Services. 100% of completed quarterly, significant change and annual care plans will be reviewed weekly for four weeks beginning November 19, 2010 then 25 completed care plans monthly for three months and / or 100% compliance. All results of the above will be reported by the Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.</td>
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**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF FRANKLIN

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

1297 WEST MAIN
FRANKLIN, TN 37064

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<td>F 280</td>
<td>Continued From page 4 documented an admission date of 9/28/09 and readmission date of 6/14/10 with diagnoses of Peripheral Vascular Disease, Hypertension, Hypothyroidism, Osteoporosis, Dementia, Transient Ischemic Attack, Depression, Anxiety, Emphysema, Chronic Obstructive Pulmonary Disease, Macular Degeneration and Fracture of the Left Proximal Femur. Review of a physician’s order dated 6/8/10 and 10/29/10 documented, “...Tab alarm when up in chair to alert staff of unassisted ambulation...” Review of the comprehensive care plan dated 6/28/10 and revised on 9/24/10 did not include the use of a tab alarm when up in chair. Observations in Resident #1’s room on 11/3/10 at 9:15 AM, revealed Resident #1 sitting in a wheelchair with no tab alarm on the chair as ordered. During an interview in the family room on 11/3/10 at 10:30 AM, the Director of Nursing (DON) was asked about the fall interventions on the care plan for Resident #1. The surveyor informed the DON that the tab alarm was not included in Resident #1’s care plan. The DON stated, “...Okay...”</td>
<td>F 280</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>11/18/2010</td>
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**F 309 SS=D**

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

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**1. Resident #1 was assessed on November 3, 2010 by Director of Nursing and Physician for change in status. No adverse outcome noted. Alarms discontinued on November 10, 2010 per physician’s order. Care plan updated and interventions revised on November 10, 2010 by Minimum Data Set Coordinator.**
**F 309** Continued From page 5

Based on medical record review, observations and interviews, it was determined the facility failed to follow physician's orders for bed or chair alarms, heels were not floated, a bed cradle was not used or supplements of milk shakes and ice cream were not on a break tray for 4 of 16 (Residents #1, 4, 9 and 10) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 9/28/09 and readmission date of 6/14/10 with diagnoses of Peripheral Vascular Disease, Hypertension, Hypothyroidism, Osteoporosis, Dementia, Transient Ischemic Attack, Depression, Anxiety, Emphysema, Chronic Obstructive Pulmonary Disease, Macular Degeneration and Fracture of the Left Proximal Femur. Review of the physician's order dated 6/6/10 and 10/29/10 documented "...Tab alarm when up in chair to alert staff of unassisted ambulation..."

Observations in Resident #1's room on 11/3/10 at 9:15 AM revealed, Resident #1 seated in a wheelchair with no tab alarm on the chair as ordered.

During an interview in Resident #1's room on 11/3/10 at 9:15 AM, Certified Nursing Assistant (CNA #2) was asked about Resident #1's tab alarm. CNA #2 stated, "...No, I haven't seen it..."

2. Medical record review for Resident #4 documented an admission date of 5/1/10 and a readmission date of 12/2/09 with diagnoses of Lumbar Spinal Stenosis, Dementia, Frequent Falls, Diabetes, Hypertension, Degenerative Joint

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**F 309**

Resident #4 was assessed on November 3, 2010 by Director of Nursing and Physician for any change in status. No adverse outcomes noted. Discontinue order received for ice wrap November 10, 2010. Care plan updated and interventions revised on November 10, 2010 by Minimum Data Set Coordinator.

Resident #9 was assessed on November 3, 2010 by Director of Nursing and Physician for any change in status. No adverse outcomes noted. On November 3, 2010 the Care Plan was reviewed and updated, as appropriate by Minimum Data Set Coordinator.

Resident #10 was assessed on November 3, 2010 by Director of Nursing and Dietary Manager. On November 11, 2010 the Physician assessed resident for any change in status. No adverse outcome noted. On November 3, 2010 the Care Plan was reviewed and updated, as appropriate by Minimum Data Set Coordinator.

On November 3, 2010 through November 6, 2010 all licensed nursing staff were in services related to writing Physician order, Receiving Physician order, and processing physician orders including proper notification of departments. The In-service given by Director of Nursing, Assistant Director of Nursing, Nursing Supervisors, and/or Regional Director of Clinical Services.
| F 309 continued from page 6 | 2. On November 16-18, 2010 100% audits on physician's orders and treatment sheets were completed to ensure appropriate treatments are being followed. Treatment sheets will be relocated into medication administration chart for each hall to ensure all nursing staff follows prescribed orders. Audits completed by Director of Nursing, Assistant Director of Nursing and Treatment Nurse. Audits completed by Director of Nursing, Assistant Director of Nursing and Treatment Nurse. 100% Audit of building was done on all residents related to Dietary supplements by the Dietary Manager on November 10, 2010. | 3. Beginning November 3, 2010 through November 6, 2010 all licensed staff and CNAs were in-serviced by Director of Nursing, Assistant Director of Nursing, and/or Nurse Supervisor's related to making sure all alarms that are ordered are properly placed and Physician orders are being followed. | Minimum Data Set Coordinator in-serviced on November 3, 2010 by Director of Nursing regarding Care Plan process. New process put in place November 3, 2010 for Physician orders related to writing Physician order, Receiving Physician order, and processing Physician orders including proper notification of Departments. All licensed staff was in-serviced November 3, 2010 through November 6, 2010. |
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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**NAME OF PROVIDER OR SUPPLIER**  
**GRACE HEALTHCARE OF FRANKLIN**

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
**1287 WEST MAIN**  
**FRANKLIN, TN 37064**

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<th>(X3) COMPLETION DATE</th>
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| F 309              | Continued From page 7  
not floated as ordered. Resident #4's left hand was not elevated nor did she have an ace wrap on her left hand as ordered.  
During an interview at the Nurses' station on 11/3/10 at 1:30 PM, the Director of Nursing (DON) stated, "We don't do ace wrap... should have been addressed... should have been discontinued [chair and bed alarm] from the MD [Medical Doctor]... my nurses fault."  
3. Medical record review for Resident #9 documented an admission date of 12/1/08 with a readmission date of 12/12/09 with diagnoses of Osteoarthritis, Joint Pain, Asthma, Neurogenic Bladder and Diabetes Mellitus. Review of a physician's order dated 10/7/10 documented, "...FLOAT HEELS IN BED... CRADLE TO KEEP COVERS OFF OF R [right] FOOT."  
Observations in Resident #6's room on 11/2/10 at 5:45 AM, 7:30 AM and on 11/3/10 at 7:20 AM, 10:00 AM, 10:25 AM, 12:45 PM and 1:55 PM, revealed Resident #6 lying in bed without her heels being floated nor was there a cradle in place to keep the covers of the right foot as ordered.  
During an interview in Resident #9's room on 11/3/10 at 10:25 AM, the DON verified that Resident #9's heels were not floating and there was no cradle in place.  
4. Medical record review for Resident #10 documented an admission date of 5/1/08 with a readmission date of 2/15/10 with diagnoses of Diabetes Mellitus, Pulmonary Fibrosis, Senile Dementia and Esophageal Reflux. Review of a physician's order dated 10/7/10 documented, 4. Dietary Manager or cook will conduct 100% audit daily for seven days observing two meals per day for correctness of supplements. Then, audit will be performed randomly three times a week for four weeks. Then, random checks will be conducted on a monthly basis to include all three meals, observing at least two per week until 100% compliant.

An audit of 100% of alarms in building was conducted to ensure proper placement and importance of placement, and following Physician orders. The audit was conducted by the Director of Nursing and Nurse Supervisors on November 3, 2010.

Completed admission, quarterly, significant change and annual assessments will be reviewed by the At Risk committee weekly to ensure that their care plans are addressing needs of the resident appropriately. The At Risk committee is comprised of the Administrator, Director of Nursing, Minimum Data Set Coordinator, Dietary Manager, Medical Records and Social Services.

100% of completed quarterly, significant change and annual care plans will be reviewed weekly for four weeks beginning November 19, 2010, then 25 completed care plans monthly for 3 months and / or 100% compliance.

---

**Signature:**  
**Administrator**  
**11/18/2010**
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

GRACE HEALTHCARE OF FRANKLIN

NAME OF PROVIDER OR SUPPLIER

445146

STREET ADDRESS, CITY, STATE, ZIP CODE
1287 WEST MAIN
FRANKLIN, TN 37064

B. WING

11/03/2010

(printed)

Department of Health and Human Services
Centers for Medicare & Medicaid Services

(4X) ID

PREFIX TAG

F 309

"...MIGHTY SHAKE ON ALL TRAYS... NSA [no sugar added] ICE CREAM TO ALL TRAYS..."

Observations in Resident #10's room on 11/2/10 at 7:40 AM, revealed Resident #10 did not have a mighty shake or NSA ice cream on her breakfast tray as ordered.

F 315

483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on policy review, review of the "CNA [Certified Nursing Assistant] Candidate Handbook", observations, and interviews, it was determined the facility failed to ensure that pericare was performed according to training standards for nurse assistants, ensure the catheter bag and tubing were kept above the bladder level or ensure the catheter bag and tubing was not touching the floor for 2 of 2 (Residents #8 and 9) sampled residents with Foley catheters.

The findings included:

1. Review of the facility's "Urinary Catheters"

(XX) ID

PREFIX TAG

F 309

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

11/18/2010

F 315

1. Resident #6 was assessed by Director of Nursing and Physician on November 3, 2010 for any change in status, UA completed. No adverse outcome noted.

Resident #9 was assessed on November 3, 2010 by Director of Nursing and Physician for any change in status, UA completed. No adverse outcomes noted.

2. No other residents were affected, as these residents were the only residents with catheters in the building.

3. In-services were completed on November 3, 2010 through November 6, 2010 with all licensed nurses and CNAs related to proper catheter care and perineum care including male and female care, proper placement of catheter bag below bladder and not touching the floor, and demonstrations by each staff member. In-services were conducted by Director of Nursing, Assistant Director of Nursing, Nursing Supervision and/or Regional Director of Clinical Services.
F 315 | Continued From page 9

Medical record review for Resident #6 documented an admission date of 3/19/10 with diagnoses of Parkinson's Disease, Hypertension, Neurogenic Bladder, Organic Mental Syndromes with Agitation, Dementing Illness with Associated Behavioral Symptoms, Depression and Depressive Disorder.

Observations in Resident #6's room on 11/11/10 at 3:25 PM and 11/2/10 at 3:25 PM, revealed Resident #6 up in the wheelchair with the Foley catheter bag laying on the floor.

Observations in Resident #6's room on 11/2/10 at 6:20 AM and on 11/3/10 at 10:00 AM, revealed Resident #6 in the bed with the Foley catheter bag laying on the floor.

During an interview in Resident #6's room on 11/3/10 at 10:05 AM, when asked if the Foley catheter bag was suppose to be laying on the floor. Nurse #10 stated, "No."

2. Review of the facility's "Urinary Catheters" policy documented, "...Maintain unobstructed urine flow by keeping the collection bag below the level of the bladder... Keep the collection bag off the floor..."

Review of the "CNA Candidate Handbook" October 2009 version, documented, "skill #20-Perineal Care for a Female... 11 Separating the labia, while physically separating the labia, 12 Using water and soapy washcloths, cleans one side of labia from top to bottom using a clean portion of a washcloth with each stroke. 13"

4. On November 6, 2010 audits began with three perineum care observations per shift daily for two weeks, then three observations per day per shift for two weeks, then three observations three times a week for two month and / or 100% compliance. The audits are to be completed by Director of Nursing, Assistant Director of Nursing, and Nursing Supervisors.

All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.
Continued From page 10
Cleans other side of labia from top to bottom using a clean portion of a washcloth with each stroke."

Medical record review for Resident #9 documented an admission date of 12/1/08 with a readmission date of 12/12/09 with diagnoses of Osteoarthrosis, Joint Pain, Asthma, Neurogenic Bladder and Diabetes Mellitus. Review of a physician's order dated 10/7/10 documented, "...FOLEY CATHETER CARE Q [every] SHIFT..."

Observations in Resident #9's room on 11/1/10 at 2:20 PM and 3:45 PM, on 11/2/10 at 7:30 AM, 8:00 AM, 11:30 AM and 12:30 PM and on 11/3/10 at 10:00 AM, revealed Resident #9's catheter tubing was laying on the floor.

Observations in Resident #9's room on 11/2/10 at 4:15 PM, revealed Resident #9 seated in a wheelchair with her catheter bag in her lap. The catheter bag was below the level of Resident #9's bladder.

Observations in Resident #9's room on 11/3/10 at 1:55 PM, revealed CNA #4 performed pericare and catheter care on Resident #9. CNA #4 washed down the right side of the perineum, down the left side of the perineum using different washcloths and then washed down the middle without separating the labia.

During an interview on the 100 hall on 11/3/10 at 2:20 PM, CNA #4 stated, "I should have spread it [labia] open to complete pericare."

Based on the comprehensive assessment of a
Continued From page 11

Resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observations and interviews, it was determined the facility failed to ensure staff diluted crushed medications with warm water/liquid and administered medications per gravity via Percutaneous Endoscopic Gastrostomy (PEG) tube for 2 of 2 residents (Resident #13 and Random Resident (RR) #4) observed during medication administration with a PEG tube.

The findings included:

1. Review of the facility's "Administering Medications through an Enteral Tube" documented, "...Dilute medications and flush tube with room temperature or warm liquids. (Note: cold liquids may induce abdominal cramping)... Administer medication by gravity flow. Pour diluted medication into the barrel of the syringe while holding the tube slightly above the level of insertion. Open the clamp and deliver medication slowly..."

2. Observations outside Resident #13's room on 11/2/10 at 8:15 AM, revealed Nurse #5 mixed the crushed medications for Resident #13 with ice water. Nurse #5 entered Resident #13's room, flushed Resident #13's PEG tube with ice water...
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| F 322 | All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.  

F 332 | 1. Resident #6 was assessed on November 3, 2010, by Director of Nursing and Physician for any change in status. No adverse outcomes were noted.  
Resident #9 was assessed on November 3, 2010, by Director of Nursing and Physician for any change in status and no adverse outcomes were noted.  
Resident #13 was assessed on November 3, 2010, by Director of Nursing and Physician for any change in status and no adverse outcomes were noted.  
Random resident #1 was assessed on November 11, 2010, by Director of Nursing and physician for any change in status and no adverse outcomes were noted.  
Random resident #2 was assessed on November 11, 2010, by Director of Nursing and physician for any change in status and no adverse outcomes were noted.  
1. Resident #6 was assessed on November 3, 2010, by Director of Nursing and Physician for any change in status.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
GRACE HEALTHCARE OF FRANKLIN

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1287 WEST MAIN
FRANKLIN, TN 37064

**ID PREFIX TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** | **ID PREFIX TAG** | **PROVIDER'S PLAN OF CORRECTION** | **COMPLETION DATE**
--- | --- | --- | --- | ---
F 332 | Continued From page 13
Novolog... Onset (in hours, unless noted)... 15 min [minutes], TYPICAL DOSING /
COMMENTS... 5-10 minutes before meals...

a. Medical record review for Resident #6 documented an admission date of 3/19/10 with
diagnoses of Parkinson's Disease, Hypertension, Organic Mental Syndrome with Dementia and
with Agitation, Diabetes Mellitus Type II and Depression. Review of a physician's order dated
9/27/10 documented, "Novolin R 100 U [unit] / [per] 1 ML [milliliter] VIAL SSI [sliding scale
insulin]... BS [blood sugar] 241 to 300 = [amount of insulin to be administered] 4 UNITS..."

Observations in Resident #6's room on 11/1/10 at 3:36 PM, Nurse #1 administered 4 units of
Novolin R insulin to Resident #6. As of 5:00 PM, Resident #6 had not received his dinner tray. The
administration of the insulin more than 30 minutes before Resident #6 received his meal tray,
resulted in medication error #1.

Medical record review for Resident #13 documented an admission date of 5/1/2009 with
diagnoses of Parkinson's Disease, Hypertension, Diabetes, Cervical Spondylosis with Myelopathy,
Dysphagia, Gastrostomy and Anxiety. Review of a physician's order dated 9/27/10 documented,
"Novolog Mix 70/30 VIAL TWENTY-SIX (26) UNITS SQ [subcutaneous] Q [every] PM."

Observations in Resident #13's room on 11/1/10 at 4:20 PM, Nurse #1 administered 26 units of
Novolog Mix 70/30 insulin to Resident #13. As of 5:00 PM, Resident #13 had not received his
dinner tray. The administration of the insulin more than 10 minutes before Resident #13 received his
meal, resulted in medication error #2.

**DATE SURVEY COMPLETED**
11/03/2010
F 332  Continued From page 14

During an interview in Resident #13's room on 11/1/10 at 5:00 PM, Resident #13 was asked if he had eaten anything since he was given insulin at 4:20 PM. Resident #13 stated "No."

During an interview on the 100 hall on 11/2/10 at 4:48 PM, Nurse #7 was asked if Resident #13 had not been fed since he had received his insulin. Nurse #1 confirmed that Resident #13 had not received his dinner.

b. Medical record review for Random Resident (RR) #2 documented an admission date of 1/6/09 with diagnosis of Muscle Weakness, Acute Pancreatitis, Osteoporosis, Diabetes Mellitus Type II, Hypertension and Psychotic Depression. Review of a physician's order dated 9/29/10 documented, "Novolin R 4 units before lunch... change sliding scale...150 - 200 1 unit..."

Observations in RR #2's room on 11/2/10 at 11:28 AM, Nurse #7 administered 5 units of Novolin R Insulin to RR #2. RR #2 did not receive her lunch tray until 12:47 PM and was not fed her first bite of food until 12:55 PM. The administration of insulin 1 hour and 27 minutes before lunch was served resulted in medication error #3.

During an interview on the 100 hall on 11/3/10 at 12:20 PM, Nurse #7 was asked why RR #2 had not been fed for over 1 hour after her insulin had been administered on 11/2/10. Nurse #7 stated, "The insulin is given according to the doctor's specific time and I might need to call him to adjust this."

2. Review of the facility's "Administering..."
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<tbody>
<tr>
<td>F 332</td>
<td></td>
<td>Continued From page 15 Medications through a Metered Dose documented, &quot;...Allow at least one (1) minute between inhalations of the same medication...&quot;</td>
<td>F 332</td>
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<tr>
<td>a. Medical record review for RR #1 documented an admission date of 1/31/09 with diagnoses of Pneumonia, Diabetes Mellitus, Hypertension, Atrial Flutter, Degenerative Joint Disease and Parkinson's Disease. Review of a physician's order dated 9/28/09 documented, &quot;Symbicort 160-4.5 MCG [micrograms] INH [inhaler] TWO (2) PUFFS BID [twice a day].&quot;</td>
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<td>Observations in RR #1's room on 11/1/10 at 4:00 PM and on 11/2/10 at 4:00 PM, Nurse #2 administered 2 puffs of Symbicort inhaler to RR #1. Nurse #2 did not wait one minute between the puffs. Failure to wait one minute between puffs resulted in medication errors #4 and #5.</td>
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<td>During an interview on the back hall on 11/2/10 at 4:50 PM, Nurse #2 confirmed that she did not wait one minute between the puffs.</td>
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<td>b. Medical record review for RR #3 documented an admission date of 5/1/10 and a readmission date of 2/12/10 with diagnoses of Insulin Dependent Diabetes Mellitus, Coronary Artery Disease, Asthma, Anxiety, Hypothyroidism, Chronic Obstructive Pulmonary Disease and Depression. Review of a physician's order dated 9/23/10 documented, &quot;Flovent HFA 44 MCG INH TWO (2) PUFFS BID <em>RINSE MOUTH AFTER USE</em>&quot;.</td>
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<td>Observations in RR #3's room on 11/3/10 at 9:45 AM, Nurse #7 administered 2 puffs of Flovent inhaler to RR #3. Nurse #7 did not wait one minute between the puffs. Failure to wait one minute between the puffs.</td>
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Continued From page 16

minute between the puffs resulted in medication error #6.

During an interview on 100 hall on 11/3/10 at 12:20 PM, Nurse #7 was asked about not waiting one minute between the puffs. Nurse #7 stated, "I thought it was 30 seconds between puffs."

3. Review of the facility's "Administering Medications" policy..." documented, "...6. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication."

a. Medical record review for Resident #13 documented an admission date of 5/1/09 with a diagnosis of Parkinson's Disease, Hypertension, Diabetes, Cervical Spondylosis with Myelopathy, Dysphagia, Gastrostomy and Anxiety. Review of a physician's order dated 09/27/10 documented, "CARBIDOPA-LEVO 25-250 TAB ONE AND ONE-HALF (1 & [and] 1/2) tablets PO / PT @ [at] 7AM AND 7PM."

Observations in Resident #13's room on 11/2/10 at 8:15 AM. Nurse #6 administered Carbidopa-Levodopa 25-250 one tablet per Percutaneous Endoscopy Tube (PEG). Failure to administer 1 & 1/2 tablets resulted in medication error #7.

During an interview on 100 hall on 11/3/10 at 12:40 PM, Nurse #5 was asked about the Carbidopa-Levodopa 25-250 should have been 1 & 1/2 tablets instead of one tablet. Nurse #5 stated, "OK, I'm sorry."

b. Medical record review for Resident #9
Continued From page 17
documented an admission date of 12/1/08 and a
readmission date of 12/12/09 with diagnoses of
Osteoarthritis, Joint Pain, Asthma, Neurogenic
Bladder, Diabetes Mellitus and Depressive
Disorder. Review of physician's order dated
9/27/10 documented, "METFORMIN HCL
[hydrochloride] 500 MG TABLET ONE (1) PO
BID..." The medication administration record
documented the Metformin was to be
administered at 7AM and 5PM.

Observation in Resident #9's room on 11/3/10 at
9:50 AM, Nurse #9 administered Metformin 500
mg one tablet. Failure to administer the Metformin
within one hour of scheduled time of 7 AM,
resulted in medication error #8.

During an interview on the 100 hall on 11/3/10 at
12:43 PM, Nurse #9 was asked about the time
the Metformin was given. Nurse #9 stated, "I saw
that it was due at 7:00 AM, but it was already too
late. It had to be given."

F 332

483.25(m)(2) RESIDENTS FREE OF
SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any
significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on review of "MED-PASS COMMON
INSULINS" provided by the American Society of
Consultant Pharmacist, medical record review,
observations and interviews, it was determined 2
of 8 nurses (Nurses #1 and #7) administering
medications failed to ensure that residents were
free of significant medication errors.

F 333

1. Resident # 6 was assessed on
November 3, 2010, by Director of Nurs-
ing and Physician for any change in sta-
tus. No adverse outcomes were noted.

Resident #13, on November 3, 2010,
was assessed by Director of Nursing
and Physician for any change in status.
No adverse outcome noted.

Random resident # 2 was assessed on
November 11, 2010, by Director of
Nursing and physician for any change
in status and no adverse outcomes were
noted.
2. All licensed nursing staff was in-serviced with Med Pass evaluations/audits November 3, 2010 -- November 6, 2010 related to proper medication administration. Med Pass Evaluations/Audit were observed by Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and/or Nursing supervisors.

3. All licensed nursing staff was in-serviced November 3, 2010 -- November 6, 2010 related to proper medication administration, including proper insulin administration as it is related to time of administration and receiving a snack/meal.

On November 10, 2010 Director of Nursing, Administrator and Medical Director met and added new addendum to glucose monitoring policy stating every diabetic being treated with oral or injectable diabetic medications will receive a diabetic snack with medication delivery.

4. Random medication pass evaluations/audit will continue and be evaluated by Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisors to evaluate Med pass one per day per shift for four weeks, then two evaluations/audit per shift per week.
**Grace Healthcare of Franklin**

**Summary Statement of Deficiencies**

**(4) ID**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or lsc identifying information)</th>
</tr>
</thead>
</table>
| F 333         | Continued From page 19

"Novolog Mix 70/30 VIAL TWENTY-SIX (26) UNITS SQ [subcutaneous] Q [every] PM."

Observations in Resident #13's room on 11/1/10 at 4:20 PM, Nurse #7 administered 26 units of Novolog Mix 70/30 insulin to Resident #13. As of 5:00 PM, Resident #13 had not received his dinner tray. The administration of the insulin more than 10 minutes before Resident #13 received his meal, resulted in a significant medication error.

During an interview in Resident #13's room on 11/1/10 at 5:00 PM, Resident #13 was asked if he had eaten anything since he was given insulin at 4:20 PM. Resident #13 stated "No."

During an interview on the 100 hall on 11/2/10 at 4:46 PM, Nurse #7 was asked if Resident #13 had not been fed since he had received his insulin. Nurse #1 confirmed that Resident #13 had not received his dinner.

c. Medical record review for Random Resident (RR) #2 documented an admission date of 1/6/09 with diagnosis of Muscle Weakness, Acute Pancreatitis, Osteoporosis, Diabetes Mellitus Type II, Hypertension and Psychotic Depression. Review of a physician's order dated 9/28/10 documented, "Novolin R 4 units before lunch... change sliding scale...150 - 200 1unit...".

Observations in RR #2's room on 11/2/10 at 11:28 AM, Nurse #7 administered 5 units of Novolin R insulin to RR #2. RR #2 did not receive her lunch tray until 12:47 PM and was not fed her first bite of food until 12:55 PM. The administration of insulin 1 hour and 27 minutes before lunch was served resulted in a significant medication error.

**Provider's Plan of Correction**

**(4) ID**

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<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
</table>
| F 333         | times two months, and/or 100% compliant.

All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.
Continued From page 20

During an interview on the 100 hall on 11/3/10 at 12:20 PM, Nurse #7 was asked why RR #2 had not been fed for over 1 hour after her Insulin had been administered on 11/2/10. Nurse #7 stated, "The insulin is given according to the doctor's specific time and I might need to call him to adjust this."

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure proper kitchen sanitation practices by not wearing hair nets, presence of dust on the ice machine vent and failed to store food properly when an open box of greens was stored on top of a ham and turkey on 2 of 3 (11/1/10 and 11/2/10) days of the survey.

The findings included:
1. Review of the facility's personal hygiene policy documented, "...3. Head Covering Worn a. Wear a clean hat or other hair restraint. Hair must be appropriately restrained per state regulations..."

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<td>F 333</td>
<td>Continued From page 20</td>
<td>F 333</td>
<td>During an interview on the 100 hall on 11/3/10 at 12:20 PM, Nurse #7 was asked why RR #2 had not been fed for over 1 hour after her Insulin had been administered on 11/2/10. Nurse #7 stated, &quot;The insulin is given according to the doctor's specific time and I might need to call him to adjust this.&quot;</td>
<td>F 371</td>
<td>F371</td>
<td>11/18/2010</td>
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| 463.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY | | | The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions | | | 1. Ice machine vent on wall was cleaned 11/3/10 by Maintenance Director. A tray was placed under the greens on 11/3/2010 by Dietary Manager.
Thawing meats will continue to be thawed on the bottom shelf. All vegetable products will be stored separately.

2. No residents were identified as being affected by these deficiency.

Audit 100% of the ice machines in the building ice machine vent cleanliness by Maintenance Director one time a week for three months, starting November 4, 2010.

Dietary Manager or Cook will audit hand washing and hair nets of dietary staff to begin on November 3, 2010 randomly observing five hand washings per day for two weeks, then random observations to be made two hand washings per day for two weeks, if 100% compliance is met, observations should continue with three observations per week for one month until compliant.
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<td>F 371</td>
<td>Continued From page 21</td>
<td>F 371</td>
<td>Audit to be started November 3, 2010 for appropriately stored food and temperature of freezer and refrigerator daily by the Dietary Manager or Cook.</td>
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<td></td>
<td>a. Observations during the initial kitchen tour on 11/1/10 at 10:25 AM revealed the following:</td>
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<td>3. In-Service was completed with Dietary staff on 11/3/10 in relation to hand washing and food sanitation practices by Dietary Manager.</td>
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<tr>
<td></td>
<td>a. Four dietary workers did not have hair completely covered while preparing lunch.</td>
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<td>In-Service was completed with Dietary staff on 11/3/10 in relation to hand washing and food sanitation practices by Dietary Manager.</td>
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<td>b. Two men delivering bread came back and forth though the kitchen while lunch was being</td>
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<td>4. All results of the above will be reported by Dietary Manager quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Environmental Services Supervisor, and Maintenance Director.</td>
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<td></td>
<td>prepared without a head cover.</td>
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<td></td>
<td>During an interview in the administrators office on 11/3/10 at 10:15 AM, the Food Service</td>
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<td>confirmed that the dietary staff were not wearing proper head covering.</td>
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<td>b. Observations during the initial kitchen tour on 11/1/10 at 10:25 AM, revealed a gray dust</td>
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<td>in the vent on the side of the ice machine.</td>
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<td>2. Review of the facility's personal hygiene policy documented, &quot;...2. Clean Hands and Fingernails...&quot;</td>
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<td>b. Hands must always be washed after smoking, using the restroom, or handling any unsanitary items...&quot;</td>
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<td>Observations on 11/1/10 at 4:50 PM, revealed the main cook was observed to put paper in the trash and touch the lid. The main cook proceeded to obtain the ladies and placed them into the food on the trayline without washing his hands.</td>
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<td>3. Observations on 11/2/10 at 5:55 PM, revealed a open box of greens in the cooler lying on top of a ham and turkey.</td>
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<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 431</td>
<td>11/18/2010</td>
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<td>FF=DM</td>
<td>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all</td>
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controlled drugs in sufficient detail to enable an 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 policy review and observation, it was determined the facility failed to ensure medication was not left unattended on top of the medication cart for 1 of 4 (100 hall) medication storage areas.

Licensed Practical Nurse #1 was in-service by Director of Nursing on November 10, 2010 that included policy and procedure on Medication Security.

2. No other resident was identified as being affected by this observation. Med Pass evaluation/audit began on November 3, 2010 and continued through November 6, 2010 with all licensed staff being educated and evaluated.

3. An in-service was conducted by Director of Nursing, Assistant Director of Nursing, and Nursing supervisors on November 3-November 6, 2010 for all licensed nurses on proper storage and security of medications.

4. Random medication pass evaluations/audit will continue and be evaluated by Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisors to evaluate med pass one per day per shift for four weeks, then two evaluations/audit per shift per week, times two months, and 100% compliant.

All results of the above will be reported by Director of Nursing quarterly to the Quality Assurance committee comprised of the Medical Director, Administrator, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietitian Manager, Environmental Services Supervisor, and Maintenance Director.
**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF FRANKLIN

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

1287 WEST MAIN

FRANKLIN, TN 37064

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 431</td>
<td>Continued From page 23</td>
<td>F 431</td>
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<td>The findings included:</td>
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<td>Review of the facility's &quot;Storage of Medications&quot; policy documented, &quot;...Locked Compartments 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes,) containing drugs and biological shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.&quot;</td>
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<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F 441</td>
<td>11/18/2010</td>
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<td>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.</td>
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<tr>
<td></td>
<td>(a) Infection Control Program</td>
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<td>1. Residents occupying rooms 6, 8, 9, 11, 23, 25, 26, 30, 36, and 38 were assessed by Director of Nursing on November 11, 2010 with no adverse outcomes noted.</td>
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<td>The facility must establish an Infection Control Program under which it -</td>
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<td>Nurse #1 was in-serviced by Director of Nursing on November 9, 2010, related to proper disinfection of glucometer and proper disposable of contaminated glucometer strip and lancets.</td>
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<td>(1) investigates, controls, and prevents infections in the facility;</td>
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<td>2. All licensed nursing staff was in-serviced with Med Pass evaluations/audits November 3, 2010 – November 6, 2010 related to proper medication administration, which included proper disinfection procedures for the glucometer and proper disposal of glucometer strips and lancets. Med-Pass Evaluations/Audit were observed by Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and/or Nursing supervisors.</td>
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(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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 policy review, observations and interview, it was determined the facility failed to ensure 4 of 6 Certified Nursing Assistants (CNAs #1, 2, 3 and 5) and 6 of 8 nurses (Nurse #1, 2, 3, 5, 6 and 9) followed infection control practices to prevent the spread of infection by not using sanitary hand hygiene during dining or medication administration. One (1) of 8 nurses (Nurse #1) failed to disinfect the glucometer with a Sani-wipe. Nurse #1 disposed a lancet and glucometer strip contaminated with blood in the regular trash not in biohazard or sharps container as required.

The findings included:
1. Review of facility's "Handwashing" policy documented, "Purpose: To decrease the risk of transmission of infection by appropriate handwashing... A. Turn on water to a comfortable warm temperature... E. Turn off faucet with paper..."
F 441 Continued From page 25 towel and discard."

a. Observations on the 100 hall on 11/2/10 at 7:25 AM, CNA #1 wiped her hands with a wipe then placed the wipe into her pocket and continued to serve meal trays.

b. Observations on the 100 hall on 11/2/10 at 7:30 AM, CNA #2 went into room 9 prepared the resident's food and assisted the resident up in bed and left the room. CNA #2 left the room, went to the meal cart and continued to serve meal trays without washing her hands.

c. Observations on the 200 hall on 11/2/10 at 12:20 PM, CNA #3 entered Room 25, placed the meal tray on then table, then opened the straw and touched the straw with bare hand while placing the straw in the milk carton. CNA #3 entered Room 23, 26 and 30, placed the meal trays on the tables and assisted the residents with their food. CNA #3 washed her hands each time but turned the water off with her bare hands.

d. Observations in the 300 hall on 11/2/10 at 12:25 PM, revealed CNA #5 repositioned the resident in her wheelchair, washed her hands and turned off the water faucet with her bare hands.

e. Observations in room 66's bathroom on 11/1/10 at 3:50 PM and 4:20 PM, Nurse #1 washed her hands but turned the water off with her bare hands.

f. Observations in room 36's bathroom on 11/1/10 at 4:00 PM and on 11/2/10 at 4:00 PM, Nurse #2 washed her hands and turned the water off with her bare hands.

Proper glucometer disinfection and disposal of contaminants will be audited by med pass evaluations/audit. Random medication pass evaluations/audit will continue and be evaluated by Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisors to evaluate med pass one per day per shift for four weeks, then two evaluations/audit per shift per week, times two months, and/or 100% compliant. All results of the above will be reported by Director of Nursing monthly to the Quality Assurance committee comprised of the Medical Director, Administrator, Director of Nursing, Medical Records, Minimum Data Set Coordinator, Social Services, Activities, Dietary Manager, Environmental Services Supervisor, and Maintenance Director.
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<th>(X4) ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 441</td>
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<td>g. Observations outside room 25 on 11/1/10 at 4:40 PM, Nurse #3 was not observed to wash her hands before medication preparation or after administering medications.</td>
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<td>h. Observations in room 8's bathroom on 11/2/10 at 8:15 AM, Nurse #5 washed his hands but turned the water off with his bare hands.</td>
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<td>i. Observations in room 38 on 11/2/10 at 8:00 AM, Nurse #6 did not wash his hands before administer medications, Nurse #9 placed his bare finger over the tip of the syringe and shook the syringe, Nurse #8 then placed the contaminated syringe in the resident's Percutaneous Endoscopy Gastrostomy (PEG) tube and flushed the PEG tube with water.</td>
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<td>j. Observations in room 8's bathroom on 11/3/10 at 8:25 AM, Nurse #3 washed her hands but turned the water off with her bare hands. Observations in room 25's bathroom on 11/3/10 at 9:45 AM, Nurse #3 washed her hands but turned the water off with her bare hands. Observations in room 11's bathroom on 11/3/10 at 9:50 AM, Nurse #3 washed her hands but turned the water off with her bare hands.</td>
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<td>2. Review of facility's &quot;Maintaining Meter&quot; policy documented, &quot;...Purpose: The Blood Glucose Meter [glucometer] should be cleaned and disinfected between each resident use... 3. When using the wipes to clean and disinfect the meter; wipe the outside of the meter thoroughly... (2 minute dry Super Sani-wipes).&quot;</td>
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<td>Observations on the 100 hall on 11/1/10 at 3:50 PM, Nurse #1 cleaned the glucometer with an alcohol pad, not with a Super Sani-cloth as per</td>
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<td>F 441</td>
<td>Continued From page 27 policy. Observations on the 100 hall on 11/1/10 at 3:55 PM, Nurse #1 obtained a blood sugar and disposed the contaminated glucometer strip and lancet in the regular trash container on the 100 hall medication cart. The lancet should have been disposed in a sharps container. The glucometer strip contaminated with blood should have been disposed of in a biohazard container. Nurse #1 placed the glucometer on the medication cart without disinfecting the glucometer. During an interview on the 100 hall on 11/2/10 at 4:46 PM, Nurse #1 stated, &quot;I thought it was okay to clean the glucometer with alcohol.&quot;</td>
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