

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

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FORM APPROVED
RECEIVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
NAME OF PROVIDER OR SUPPLIER BAPTIST MEMORIAL HOSP-Memphis SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 6019 WALNUT GROVE ROAD MEMPHIS, TN 38120	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is no met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to revised the comprehensive care plan to address oxygen, anticoagulants, bleeding precautions, removal of percutaneous endoscopy gastrostomy (PEG), diet changes, oxygen therapy, pain, nutrition, isolation, wound vacuums (vac), cardiac status, catheters, and/or falls for 6 of 10 (Residents #1, 2, 3, 6, 8 and 9) sampled residents.</p> <p>The findings included:</p> <p><i>Supp - PIC 11/11/11 PIC 11/11/11 PIC 11/11/11</i></p>	F 280	<p><u>Actions taken as follows:</u></p> <p><u>Revised Practice:</u></p> <ul style="list-style-type: none"> MDS Nurse will print Situation Background Assessment Recommendation (SBAR) Report from Electronic Documentation System (HED) daily to review for changes in condition. A fax machine has been installed in the MDS office so that all physician orders can be faxed to the MDS Nurse for review and assessment to be included in the care plan. <p><u>Education:</u></p> <ul style="list-style-type: none"> Nursing and ancillary staff have been educated to fax all physician orders to the MDS office for review. <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> A monitoring tool for assessing the accuracy of the MDS/Care Plan has been implemented. The frequency of monitoring will be 100% of resident care plans initially. When monitoring process demonstrates substantial improvement, 5 random MDS/Care Plans will be assessed weekly by the Director of Nursing and/or designee. <p><u>Attachment I</u></p> <ul style="list-style-type: none"> The findings will be reported to the appropriate department directors and the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time, the Performance Improvement Committee (PIC) will determine necessity 	<p>Completed 11/18/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/6/11 and continuing as directed by PIC</p>
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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Darlene M. Bell* TITLE: *Administrative* DATE: *11/18/11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <ol style="list-style-type: none"> Review of the facility's "INTERDISCIPLINARY PATIENT PLAN OF CARE and DAILY GOALS/PRIORITY LIST GUIDELINES" policy documented, "...2. All disciplines, involved in the patient's care, individualizes the plan for the patient by identifying problems or needs, desired outcomes, and interventions in the appropriate categories...5. The patient plan of care and goals are reviewed every day by 3 P.M. for appropriateness by an RN [registered nurse]...12...The daily goal (s)/priorities revision occurs based on individualized patient needs and changes in status..." Medical record review for Resident #1 documented an admission date of 10/26/11 with diagnoses of Encephalopathy, Congestive Heart Failure, Deep Vein Thrombosis Right Upper Extremity and Dementia. Review of the physician order dated 10/26/11 documented, "...11. Isolation: type Modified... 14. Respiratory Therapy Orders BNC [binasal cannula] L [liter] / [per] min [minute] ...3..." Review of the physician order dated 11/2/11 documented, "...Start heparin drip "A" Coumadin 5 mg [milligram] q [every] hs [hour of sleep] Pharmacy adjust Coumadin..." Review of the care plan dated 11/1/11 was not revised to address Coumadin therapy or bleeding precautions, Modified Isolation or oxygen therapy. <p>During an interview at the low hall nurses' station on 11/8/11 at 11:40 AM, Nurse #1 was asked to review Resident #1's medical record. Nurse #1 stated, "...No, there is no oxygen therapy on the care plan, yes he [Resident #1] is on oxygen... No, there is no anticoagulant therapy on the care plan, he is on heparin... No, there is no isolation on the care plan, yes he is in modified isolation..."</p> <ol style="list-style-type: none"> Medical record review for Resident #2 documented an admission date of 6/21/11 with diagnoses of Septicemia, Stage III Sacral Decubitus, Diabetes Mellitus, Mass of Ovary, Hypothyroidism, Hypertension and Coronary Artery Disease. Review of the physician's orders dated 6/21/11 documented, "...Isolation: type Modified contact..." Review of the clinical nutrition note dated 9/16/11 documented, 	F280	<p>for continued monitoring.</p> <ul style="list-style-type: none"> Resident #1 care plan was revised and updated to reflect the modified isolation, O2@ 2L BNC/min, anticoagulant medications and bleeding precautions. Resident #2 care plan was revised and updated to reflect modified contact isolation, wound vacuum dressing changes, discontinuation of PEG tube (9/15/11) and change to renal diet. 	<p>Completed 11/17/11</p> <p>Completed 11/17/11</p>
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F 280	<p>Continued From page 2</p> <p>"...PEG tube removed 9/15. Renal (acute) diet resumed..." Review of the clinical nutrition note dated 10/3/11 documented, "...ET [enterstomal therapy] following for wound care, noted wound vac placed on 9/30/11..." Review of the Minimum Data Sets (MDS) dated 7/2/11 and 9/18/11 documented "... Section O Special Treatments, Procedures, and Programs... M. Isolation or quarantine for active infectious disease..." Review of Resident #2's care plan dated 7/5/11 and review dated 11/1/11 did not address the modified contract isolation, the wound vac or the PEG tube removal and change to a Renal diet.</p> <p>Observations outside and inside Resident #2's door on 11/7/11 at 9:55 AM, 2:25 PM and 4:30 PM and on 11/8/11 at 7:25 AM, 9:30 AM and 11:50 AM, revealed a modified contact isolation sign posted on R3sidnet #2's door and Resident #2 with a wound vac in place.</p> <p>During an interview in the MDS office on 11/8/11 at 3:15 PM, Nurse #1 was asked about the isolation, wound vac, PEG tube removal and change to Renal diet. Nurse #1 confirmed the care plan had not been updated and revised to reflect the current status of Resident #2.</p> <p>4. Medical record review for Resident #3 documented an admission date of 10/27/11 with diagnoses of Head and Neck Cancer, Respiratory Failure, Atrial Fibrillation and Vancomycin Resistant Enterococcus. Review of the medication profile report dated 11/8/11 documented, "...WARFARIN TAB [tablet] 3 MG [milligram] ORAL Q [every] day..." Review of the care plan dated 10/27/11 did not address anticoagulant therapy (warfarin) or cardiac problems (diagnosis of Atrial Fibrillation).</p> <p>5. Medical record review for Resident #6 documented an admission date of 10/27/11 with diagnoses of Osteopenia, Hypertension, Right Flank Pain, Left Lower Back Pain, Deconditioned Flank and T [thoracic] 7 Healing Compression Fracture. Review of a physician order dated 11/1/11 documented, "...Insert foley..." Review of the care plan dated 11/3/11 was not revised to address the use of a Foley catheter.</p>	F 280	<ul style="list-style-type: none"> Resident #3 care plan was revised and updated to reflect anticoagulation therapy, bleeding precautions, diagnosis of Atrial Fibrillation, Magnesium level fluctuations and IV Magnesium bolus. Resident #6 care plan was revised and updated to reflect a foley catheter inserted 11/1/11 for diagnosis of strict I&O and then discontinued on 11/8/11 	<p>Completed 11/17/11</p> <p>Completed 11/17/11</p>
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F 280	<p>Continued From page 3</p> <p>During an interview at the high hall nurses' station on 11/8/11 at 11:35 AM, Nurse #1 was asked to review Resident #6's medical record. Nurse #1 stated, "...No, I don't see a care plan for the Foley catheter...Yes, she [Resident #6] has a catheter..."</p> <p>6. Medical record review for Resident #8 documented an admission date of 10/25/11 with diagnoses of Infected Nonhealing Wounds of the Left Lower Extremity, Diabetes Mellitus, Hypertension, Anemia, Critical Ischemia of the Left Lower Extremity, Hypercoagulable Syndrome and Deconditioning. Review of a physician's order dated 10/25/11 documented, "...wound care...wound vac with pulse lavage..." Review of a physician's order dated 10/27/11 documented, "...Warfarin 7.5 mg [milligrams] PO [by mouth] daily..." Review of the care plan dated 11/7/11 failed to address wound care and anticoagulant therapy.</p> <p>7. Medical record review of Resident #9 documented an admission date of 10/21/11 with diagnoses of Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Hypertension and Arthritis. Review of a physician's order dated 10/31/11 documented, "...Nasal O2 [oxygen] 3L/M..." Review of the "Medication Profile Report" dated 11/8/11 documented, "...ENOXAPARIN [anticoagulant] SYRG [syringe] 40 MG/0.4 ML [milliliter] ... SUBCUT [subcutaneous] Q [every] DAY ... ACETEMINOPHEN TAB 500 MG 1,000MG ORAL Q8H [hours] PRN [as needed] PAIN..." Review of the MDS dated 11/2/11 documented, "...Section J Health Conditions... Number of Falls Since Admission or Prior Assessment...1...No injury..." Review of the care plan dated 10/21/11 was not revised to reflect the resident's current problems of pain, anticoagulant therapy, cardiac problems, need for O2 and fall/safety risks.</p> <p>During an interview in the DON's office on 11/8/11 at 3:50 PM, the DON confirmed that the care plan had not been updated to reflect Resident #9's current status.</p>	F 280	<ul style="list-style-type: none"> Resident #8 care plan was revised and updated to reflect wound care regimen, anticoagulation therapy, and bleeding precautions. Resident #9 care plan was revised and updated to reflect O2 BNC, anticoagulation therapy, bleeding precautions, pain, cardiac diagnosis, and fall and safety risk. 	<p>Completed 11/17/11</p> <p>Completed 11/17/11</p>
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F 283 SS=D	<p>483.20(I)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is no met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure each resident discharged from the facility had a recapitulation of the resident's stay for 1 of 1 (Resident #10) discharged residents reviewed.</p> <p>The findings included:</p> <p>Medical record review for Resident #10 documented an admission date of 9/22/11 and a discharge date of 11/2/11 with diagnoses of Cryptococcosis, Encephalopathy, Acute Kidney Failure, Dysphagia, and Failure to Thrive. The facility was unable to provide documentation of a discharge summary with a recapitulation of the resident's stay.</p> <p>During an interview in the conference room on 11/8/11 at 5:10 PM, the Administrator was asked if there was a discharge summary with a recapitulation. The Administrator stated, "...No. We don't do a discharge summary..."</p>	F 283	<p><u>Action taken as follows:</u></p> <p><u>Immediate Action:</u></p> <ul style="list-style-type: none"> At discharge a recapitulation summary has been included on all discharged residents. A note is attached to each discharged residents MDS summarizing progress toward goals or status of goals and resident disposition. The note is in the medical record at discharge. <p><u>Revised Practice:</u></p> <ul style="list-style-type: none"> MDS Nurse completes a recapitulation summary with the discharge MDS and sends to medical records for inclusion in the legal record. <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> Discharge records will be monitored at 100% of the residents initially. When the process demonstrates substantial improvement, 5 random discharge MDS records will be assessed weekly by the Director of Nursing and/or designee for the inclusion of the recapitulation summary. The findings will be reported to the appropriate department directors and the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time the Performance Improvement Committee (PIC) will determine the necessity for continued monitoring. 	<p>Completed 11/8/11</p> <p>Completed 11/8/11</p> <p>Completed 11/18/11</p> <p>Completion Date 12/6/11 and continuing as directed by PIC</p>
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to follow physician's orders for family education for 1 of 10 (Resident #1) sampled resident and failed to</p>	F 309	<p><u>Action Taken are as follows:</u></p> <p><u>Education:</u></p> <ul style="list-style-type: none"> The Director of Nursing will educate all nursing staff on education guidelines for patient/family self medication. Attachment II The Director of Nursing will educate all staff to document daily GI assessment in the electronic documentation system (HED) to include the last bowel movement (BM) 	<p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p>

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F 309	<p>Continued From page 5</p> <p>document interventions for lack of bowel movement for 2 of 10 (Resident's #2 and 10) sampled residents.</p> <p>1. Medical record review for Resident #1 documented an admission date of 10/26/11 with diagnoses of Encephalopathy, Congestive Heart Failure, Deep Vein Thrombosis Right Upper Extremity and Dementia. Review of the physician orders dated 11/7/11 documented, "...OK [okay] for family to give pt [patient] his meds [medications] crushed separately in peanut butter if he won't take for staff. Educate family..." Review of the "Patient Education" section dated 11/7/11 contained no documentation that the family was educated on how to give Residents #1's medications as order by the physician.</p> <p>During an interview at the low hall nurses' station on 11/8/11 at 11:40 AM, Nurse #1 stated, "...No, there is no documentation the family was educated, it [education] would be in the patient education section..."</p> <p>During an interview in the conference room on 11/8/11 at 3:35 PM, Nurse #3 stated, "...There is no documentation where the family was educated..."</p> <p>2. Medical record review for Resident #2 documented an admission date of 6/21/11 with diagnosis of Septicemia, Stage III Sacral Decubitus, Diabetes Mellitus, Mass of Ovary, Hypothyroidism, Hypertension and Coronary Artery Disease. Review of the "Flowsheet I & O [intake and output] Summary" date 9/1/11 to 11/7/11 documented no bowel movements (BM) on 9/21/11, 9/22/11 and 9/23/11. Review of the medication administration record documented no laxative given for no BM in 3 days.</p> <p>During an interview in the Director of Nursing's (DON) office on 11/8/11 at 3:00 PM, the DON was asked about a BM protocol/policy or standing orders for lack of BM. The DON stated they do not have a BM protocol/policy or standing orders for lack of BM. The DON was asked what are expectations for no BM and administering laxatives. The DON stated, "...three days is standards..."</p>	F 309	<ul style="list-style-type: none"> CNA's will be educated by the Director of Nursing to documents the number of BM's under the I&O tab in HED. <p><u>Revised Practice:</u></p> <ul style="list-style-type: none"> MDS Coordinator and/or MDS Nurse will review all physician orders for care plan inclusion as well as for proper education of patient/family education. <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> Resident records will be monitored for patient/family education and GI Assessment and I&O documentation at 100% of the residents initially. Attachment III When the process demonstrates substantial improvement, 5 random discharge MDS records will be assessed weekly by the Director of Nursing and/or designee for the inclusion of GI Assessment and I&O documentation in HED. The findings will be reported to the appropriate department directors and the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time the Performance Improvement Committee (PIC) will determine the necessity for continued monitoring. 	<p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/6/11 and continuing as directed by PIC</p>
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F 309	<p>Continued From page 6</p> <p>3. Medical record review for Resident #10 documented on admission date of 9/22/11 with Cryptococcosis, Encephalopathy, Acute Kidney Failure, Dysphagia, and Failure to Thrive. Review of the "Flowsheet I & O Summary" dated 9/23/11 to 11/2/11 documented no BM from 10/7/11 to 10/12/11 or from 10/22/11 to 10/23/11. Review of the medication administration record documented no laxative given for no BM in 3 days.</p> <p>During an interview in the conference room on 11/8/11 at 3:25 PM, Nurse #3 confirmed there was no documentation of BM from 10/7/11 to 10/12/11, on 10/21/11, 10/22/11 and 10/23/11 and no documentation that any laxative had been given for lack of a BM.</p>			
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES – RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure staff administered medications per Percutaneous Endoscopy Gastrostomy (PEG) tube per gravity for 1 of 1 (Resident #3) sampled residents observed receiving medications via PEG tube.</p> <p>The findings included:</p> <p>Review of the facility's "ADMINISTRATION OF MEDICATION VIA ENTERAL TUBES" policy documented, "... 14. Remove syringe from enteral tube. Remove plunger from syringe and reattach syringe to the enteral tube... 15. Pour liquefied medicine into syringe allowing the solution to flow into the stomach..."</p>	F 322	<p><u>Actions taken are as follows:</u></p> <p><u>Policy and Procedure Review:</u></p> <ul style="list-style-type: none"> The Director of Nursing reviewed with all nursing staff the Policy for Administration of Medications via Enteral Tubes. Attachment IV All nursing staff reviewed the competency for administration of medications via enteral tubes. Attachment V <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> 100% of all nurses will complete competency review of medications via enteral tubes. The Director of Nursing and/or designee will randomly monitor medication administration via enteral tubes for proper technique. The findings will be reviewed with the appropriate nurse and actions taken as needed. Overall monitoring findings will be reported to the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time the Performance Improvement Committee will determine 	<p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/6/11 and continuing as directed by PIC</p>

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F 322	Continued From page 7 Observations in Resident #3's room on 11/7/11 beginning at 11:50 AM, Nurse #5 administered Resident #3's medication per PEG tube. Nurse #5 pushed the water flushes and the medication in the PEG tube using the syringe. Nurse #5 did not let the water or medication flow in per gravity. During an interview on the high hall on 11/8/11 at 4:00 PM, Nurse #5 confirmed that she pushed the water and medication in the PEG tube instead of administering per gravity.		the necessity for continue monitoring.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is no met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to identify a fall and implement new interventions to prevent future falls for 1 of 2 (Resident #9) sampled residents with a history of falls. The findings included: Review of the facility's "INTERDISCIPLINARY PATIENT PLAN OF CARE and DAILY GOALS/PRIORITY LIST GUIDELINES" policy documented, "...2. All discipline, involved in the patient's care, individualized the plan for the patient by identifying problems or needs, desired outcomes, and interventions in the appropriate categories... 5. The patient plan of care and goals are reviewed every day by 3:00 PM for appropriateness by an RN [registered nurse]... 12... The daily goal (s)/priorities revision occurs based on individualized patient needs and changes in status..." Medical record review of Resident #9 documented an admission date of 10/21/11 with diagnoses of Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Hypertension and Arthritis. Review of the Minimum Data Set dated 11/2/11 documented, "...Section J Health Conditions..."	F 323	<p><u>Actions taken are as follows:</u></p> <p><u>Practice change:</u></p> <ul style="list-style-type: none"> Implemented Post Fall Analysis Tool being piloted on another unit. Attachment VI Post Fall Analysis Tool can be utilized as a guide for any discipline witnessing a resident fall event. MDS Nurse will review Post Fall Analysis tool for information to include on resident care plan. <p><u>Policy and Procedure Review:</u></p> <ul style="list-style-type: none"> Fall Assessment and Management (Adult) Policy will be reviewed in staff meetings. Attachment VI <p><u>Education:</u></p> <ul style="list-style-type: none"> Education provided to all nursing on fall documentation in HED Post Fall Monitoring and in the use of the Post Fall Analysis Tool. Director of Skilled Nursing Facility Rehabilitation reviewed fall documentation guidelines with staff. <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> The Director of Nursing and the Director of Skilled Nursing Facility Rehabilitation Department will review all fall events for compliance with documentation. Fall event monitoring findings will be reported to the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time the Performance 	<p>Completed 11/16/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 11/18/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/6/11 and continuing as directed by</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2011
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NAME OF PROVIDER OR SUPPLIER BAPTIST MEMORIAL HOSP-MEMPHIS SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 6019 WALNUT GROVE ROAD MEMPHIS, TN 38120
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F 323	<p>Number of Falls Since Admission or Prior Continued From page 8</p> <p>Assessment... 1... No injury..."Review of the care plan, physical therapy notes and nurses' notes failed to document the resident's fall.</p> <p>During a interview in the conference room on 11/8/11 at 4:40 PM, Nurse #6 was asked about documentation in Resident's #9's medical record addressing the fall. Nurse #6 stated, "...we don't expect interventions to change or documentation in the care plan for every fall..." The Director of Nursing (DON) stated, "...The facility's internal occurrence reporting log documented a fall on 10/28/11 when, during a physical therapy session, the resident was...assisted to the floor..." The DON and Nurse #3 were unable to provide additional documentation in the medical record that the 10/28/11 fall occurred, proof of investigation or new interventions to prevent future falls.</p>	F 323	<p>Improvement Committee will determine the necessity for continue monitoring.</p>	PIC
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure that residents were free from significant medication errors when 1 of 10 (Resident #3) sampled residents received the incorrect dose of intravenous Magnesium Sulfate.</p> <p>The findings included:</p> <p>Medical record review for Resident #3 documented an admission date of 10/27/11 with diagnoses of Head and Neck Cancer, Respiratory Failure Atrial Fibrillation and Vancomycin Resistant Enterococcus. Review of a physician's orders dated 11/4/11 documented, "...Magnesium sulfate 4 GM [grams] in 100 cc [cubic centimeters] NS [normal saline] IV [intravenous] over 4 [4 hours] today & [and] PRN [as needed] Mag [serum magnesium level] , [less than] 1.8..."</p> <p>Review of the laboratory results dated 11/5/11 documented, "...Magnesium 1.5..." Review of the "Medication Administration Report (MedAdmin)" and</p>	F 333	<p><u>Actions taken are as follows:</u></p> <p><u>Immediate Action for Resident #3:</u></p> <ul style="list-style-type: none"> Pharmacy will dispense all Magnesium 4 GM IV bolus orders will as written over the 4 hours as indicated. Nursing will review the physician's medication order with the electronic order which appears in the electronic MAR for correctness prior to confirming order for administration. <p><u>Revised Practice:</u></p> <ul style="list-style-type: none"> Instructions for all pharmacist were communicated via email on proper order entry for the Medication Administration Record (MAR). Skilled Nursing Facility Pharmacist will review all residents with orders of Magnesium IV bolus for appropriate dispensing and administering. <p><u>Education and Practice Review:</u></p> <ul style="list-style-type: none"> The Director of Nursing will review the Medication Administration Policy with all nurses. <p>Attachment VII</p> <ul style="list-style-type: none"> The Director of Nursing will review with 	<p>Completed 11/9/11</p> <p>Completed 11/9/11</p> <p>Completed 11/11/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p>

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F 333	<p>Continued From page 9</p> <p>The "Admin Rx" (administered medication) dated 11/5/11 documented that Magnesium Sulfate 2 GM IV in 50 ML was given at 9:25 AM.</p> <p>Review of the laboratory results dated 11/6/11 documented, "...Magnesium 1.1..." Review of the "MedAdmin" and the "Admin Rx" dated 11/6/11 documented that Magnesium Sulfate 2 GM IV in 50 ML was given at 5:50 AM.</p> <p>Review of the laboratory results dated 11/8/11 documented, "...Magnesium 0.9..." Review of the "MedAdmin" and the "Admin Rx" documented that Magnesium Sulfate 2 GM IV in 50 ML was given at 8:03 AM.</p> <p>Observations in Resident #3's room on 11/8/11 at 8:53 AM revealed an infused IV bag of 2 GM Magnesium Sulfate in 50 ML NS dated 11/8/11 and timed 8:03 AM hanging on the IV pole.</p> <p>During an interview at the medication cart in the high hall on 11/8/11 at 11:30 AM, Nurse #4 was asked what dose of Magnesium Sulfate was given this am. Nurse #4 confirmed that she had given the Magnesium Sulfate 2 GM IV in 50 ML dose.</p> <p>During an interview at the high hall nurses' station on 11/8/11 at 2:50 PM, the Pharmacist confirmed that the current order for Magnesium Sulfate 4 GM in 100cc NS as needed for a Magnesium of , 1.8 was not transcribed to the "Medication Administration Report" and the Medication Profile Report.</p> <p>During an interview in the conference room on 11/8/11 at 4:40 PM, the Director of Nursing and the Administrator confirmed that the incorrect does of Magnesium Sulfate was given.</p> <p>The administration of the wrong dose of Magnesium resulted in significant medication errors.</p>	F 333	<p>all nurses their responsibility in 24 hours chart check for review of orders for completeness and accuracy.</p> <p>Attachment VIII</p> <ul style="list-style-type: none"> The 24 hour chart check process will be documented and reported daily to the Director of Nursing. <p>Attachment IX</p> <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> The Skilled Nursing Facility Pharmacist will review order entry for 10 patients per month who are prescribed Magnesium IV bolus to ensure that order entry process is followed and appropriate documentation of medication administration is complete. The Director of Nursing will review the 24 hour chart check documents for compliance. <p>Attachment IX</p> <ul style="list-style-type: none"> The findings will be reported to the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time the Performance Improvement Committee (PIC) will determine the necessity for continued monitoring. 	<p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/6/11 and continuing as directed by PIC</p>
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<p>F 371 SS=D</p>	<p>483.35(i) FOOD PROCEURE, STORE/PREPARE/SERVE – SANITARY</p> <p>The facility must –</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that food was served under sanitary conditions on 2 of 2 (11/7/11 and 11/8/11) days during kitchen observation.</p> <p>The findings included:</p> <p>Observations in the kitchen on 11/7/11 starting at 9:35 AM and on 11/8/11 starting at 11:50 AM revealed 4 of 4 male dietary workers with facial hair were preparing food in the kitchen without wearing a beard/mustache restraint.</p> <p>During an interview in the hall outside the kitchen entrance on 11/8/11 at 12:00 PM, the Dietary Manager confirmed that male dietary workers with facial hair were not wearing beard/mustache restraints.</p>	<p>F 371</p>	<p><u>Actions taken are as follows:</u></p> <p><u>Immediate Action:</u></p> <ul style="list-style-type: none"> Mustache and beard coverings were obtained and adorned. <p><u>Practice Change:</u></p> <ul style="list-style-type: none"> The Director of Food and Nutrition added mustache and beard coverings to the CMS/Regulatory Checklist that is completed monthly as a part of process monitoring. The Director of Food and Nutrition added mustache and beard coverings to the daily checklist that is turned into the Patient Services Dietary Manager for review. <p><u>Education:</u></p> <ul style="list-style-type: none"> Review mustache and beard covering requirements with staff during staff meetings. <p><u>Policy and Procedure Revision:</u></p> <ul style="list-style-type: none"> The Director of Food and Nutrition added mustache and beard coverings as a part of appropriate dress code and attire for kitchen staff in the Department Orientation Checklist. <p><u>Performance Improvement, Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> The Director of Food and Nutrition will review of results of CMS/Regulatory Checklist monthly and report to the Skilled Nursing Facility Performance Improvement Committee quarterly. 	<p>Completed 11/9/11</p> <p>Completed 11/11/11</p> <p>Completed 11/18/11</p> <p>Completion Date 12/8/11</p> <p>Completed 11/18/11</p> <p>Completion Date 12/8/11</p>
<p>F 441 SS=D</p>	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program</p>	<p>F 441</p>	<p><u>Actions taken are as follows:</u></p> <p><u>Policy and Procedure Revision:</u></p> <ul style="list-style-type: none"> Add statement to the Policy and Procedure Manuals on Wound Vacuum devices "The vacuum and vacuum tubing is kept and maintained off the floor". 	<p>Completion Date 12/8/11</p>

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F 441	<p>Continued From page 11</p> <p>The facility must establish an Infection Control Program under which it –</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit 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. <p>c) Linens. Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility staff failed to ensure wound vacuum (vac) machines and tubing were not touching the floor to prevent the potential development of an infection for 2 of 3 (Residents #2 and 8) sampled residents with a wound vac.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #2 documented an admission date of 6/21/11 with diagnoses of Septicemia, Stage III Sacral Decubitus, Diabetes Mellitus, Mass of Ovary, Hypothyroidism, Hypertension, and Coronary Artery Disease. Review of the physician's orders dated 6/21/11 documented, "...ET [enterstomal therapy] following for wound care, noted wound vac placed on 9/30/11..." Review of the Minimum Data Sets (MDS) dated 7/2/11 	F 441	<p><u>Practice Change:</u></p> <ul style="list-style-type: none"> • Add vacuum machine and tubing placement to hourly rounding process by staff. <p><u>Education:</u></p> <ul style="list-style-type: none"> • Review policy and practice changes in staff meetings for both Nursing and Skilled Nursing Facility Rehabilitation Staff. • Place reminder and tip sheets in locations within the nursing stations on bulletin boards, conference room, lounge. • Place reminder and tip sheets in the Rehabilitation Department's lounge and conference room. <p><u>Performance Improvement, Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> • The Director of Nursing and/or designee will monitor compliance of wound vacuum and tubing off floor during daily rounds. • Results of monitoring will be reported to the Skilled Nursing Performance Improvement Committee quarterly. 	<p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p>
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F 441	<p>Continued From page 12</p> <p>2. and 9/18/11 documented "...Section O Special Treatments, Procedures, and Programs...M. Isolation or quarantine for active infectious disease..."</p> <p>Observations in Resident #2's room on 11/7/11 at 9:55 AM, 2:25 PM and 4:30 PM, revealed the wound vac machine sitting in the floor and the wound vac tubing touching the floor.</p> <p>During an interview at the low hall nurses' station on 11/8/11 at 11:50 AM, Nurse #2 was asked where the wound vac machine and tubing should be kept. Nurse #2 stated, "...not on the floor...on the bed, off the floor..."</p> <p>3. Medical record review for Resident #8 documented an admission date of 10/25/11 with diagnoses of Infected Nonhealing Wounds of the Left Lower Extremity, Diabetes Mellitus, Hypertension, Anemia, Critical Ischemia of the Left Lower Extremity and Deconditioning. Review of a physician's order dated 0/25/11 documented, "...wound care...wound vac with pulse lavage..."</p> <p>Observations in Resident #8's room on 11/8/11 at 10:30 AM, revealed wound vacuum collection system placed on floor under bed.</p> <p>During an interview in the Director of Nursing's (DON) office on 11/8/11 at 3:05 PM, the DON, "I would expect that the wound vac would be off the floor."</p>			
F 502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that facility failed to obtain laboratory tests as ordered by the physician for 1 of 10 (resident #9) sampled residents.</p> <p>The findings included:</p>	F 502	<p>Actions taken are as follows:</p> <p><u>Education and Practice Review:</u></p> <ul style="list-style-type: none"> The Director of Nursing will review with all nurses their responsibility in 24 hours chart check for review of orders for completeness and accuracy. The 24 hour chart check process will be documented and reported daily to the Director of Nursing. <p>Attachment IX</p>	<p>Completion Date 12/8/11</p> <p>Completion Date 12/8/11</p>

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F 502	Continued From page 13 Medical record review for Resident #9 documented an admission date of 10/21/11 with diagnoses of Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Hypertension and Arthritis. Review of a physician's order dated 11/2/11 documented, "...uric acid in a.m. (11-3-11)..." The facility was unable to provide documentation or results that the uric acid level was completed as ordered. During an interview at the high hall nurses' station on 11/8/11 at 3:00 PM, Nurse #5 stated, "I do not see the results for the uric acid level. I called the lab, and they said it was not done."	F 502	<u>Performance and Improvement Monitoring and Reporting:</u> <ul style="list-style-type: none"> The Director of Nursing will review the 24 hour chart check documents for compliance. The Director of Nursing and/or designee will randomly monitor 5 charts per week to check for compliance with order follow-through. The findings will be reported to the Skilled Nursing Facility Performance Improvement Committee at the December meeting and until March 2012. At that time the Performance Improvement Committee (PIC) will determine the necessity for continued monitoring. 	Completion Date 12/8/11 Completion Date 12/8/11 Completion Date 12/6/11 and continuing as directed by PIC
F 514 SS=D	483.75(f)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are completed; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility to ensure medical records were maintained accurately and completely for 2 of 10 (Residents #3 and 6) sampled residents. The findings included: <ul style="list-style-type: none"> Medical record review for Resident #3 documented an admission date of 10/27/11 with diagnoses of Head and Neck Cancer, Respiratory Failure, Atrial Fibrillation and Vancomycin Resistant Enterococcus. Review of a physician's order dated 11/3/11 documented, "...Santyl ointment to sacral wound c [with] Adaptic gauze daily... apply Santyl ointment to wound bed..." Review of the 	F 514	<u>Actions taken are as follows:</u> <u>Regarding Wound Care Orders:</u> <u>Practice Change:</u> <ul style="list-style-type: none"> Discussion with Wound Care/Ostomy Nurse resulted in decision to designate that the medication be applied to wound. Patients with wound care orders will be monitored by Skilled Nursing Facility Pharmacist to review order entry terminology and order follow-through. <u>Education and Practice Review:</u> <ul style="list-style-type: none"> Education for Wound Care/Ostomy Nurses and Pharmacist was provided. The Director of Nursing will review with all nurses their responsibility in 24 hours chart check for review of orders. The 24 hour chart check process will be documented and reported daily to the Director of Nursing. Attachment IX <u>Performance and Improvement Monitoring and Reporting:</u> <ul style="list-style-type: none"> The Skilled Nursing Facility Pharmacist will review 10 patients per month who are prescribed wound care medications to review order entry process and documentation of medication administration is complete. 	Completion Date 12/8/11 Completion Date 12/8/11 Completion Date 12/8/11 Completion Date 12/8/11 Completion Date 12/8/11

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F 514	<p>Continued From page 14</p> <p>Medication Administration Record (MAR) dated 11/4/11 documented "...COLLAGENASE (SANTYL) 1 APPLIC [application] OINT [ointment] TOPL [topical] 2 TIMES A Day..."</p> <p>During an interview in the high hall nurses' station on 11/8/11 at 11:50 AM, the director of Nursing (DON) was asked to review Resident 3#'s physician's order for Santyl and the MAR. The DON confirmed the Santyl was to be applied daily. The DON stated, "...The MAR is a transcription error..."</p> <ul style="list-style-type: none"> Medical record review for Resident #6 documented an admission date of 10/27/11 with diagnoses of Osteopenia, Hypertension, Right Flank Pain, Left Lower Back Pain, Deconditioned Flank and Thoracic 7 Healing Compression Fracture. Review of the nurses' notes 11/3/11 documented, "...Oxygen LPM [liters per minute] 2lpm nasal cannula..." Review of the physician orders dated 11/2/11 through 11/7/11 did not include an order for oxygen therapy. <p>During an interview at the high hall nurses' station on 11/8/11 at 11:35 AM, Nurse #1 was asked to review Resident #6's medical record. Nurse #1 stated, "...The nurses' notes dated 11/3/11 documents oxygen at 2 liters... there is not order for oxygen... the nurse must have documented in error... She [Resident #6 was not on oxygen..."</p>	F 514	<ul style="list-style-type: none"> The Director of Nursing will review the 24 hour chart check documents for compliance. The findings will be reported to the Skilled Nursing Facility Performance Improvement Committee quarterly. <p><u>Regarding the Respiratory Therapy orders of O2:</u></p> <p><u>Education and Practice Review:</u></p> <ul style="list-style-type: none"> The Director of Nursing will review with all nurses and unit coordinators their responsibility to communicate changes in O2 orders to the Respiratory Therapy Department. The Director of Respiratory Therapy will review with all therapists their responsibility in responding to orders for respiratory treatments and changes. The 24 hour chart check process will be documented and reported daily to the Director of Nursing. <p>Attachment IX</p> <p><u>Performance and Improvement Monitoring and Reporting:</u></p> <ul style="list-style-type: none"> The Director of Nursing will review the 24 hour chart check documents for compliance. The Director of Nursing and/or designee will randomly monitor 5 charts per week to check for compliance with order follow-through. The Director of Respiratory Therapy and or designee will randomly monitor 5 charts per week to check for compliance with order follow-through. The findings will be reported to the Skilled Nursing Facility Performance Improvement Committee quarterly. 	<p>Completion Date 12/8/11</p>
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