

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

PRINTED: 04/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BAPTIST REHABILITATION-GERMANTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 EXETER ROAD GERMANTOWN, TN 38138
---	---

(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 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and <del>assessment</del> <i>5/31/14 PPH</i></p>	F 431	<p>Medications are locked unless attended by or in the line of sight of the nurse.</p> <p>The storage of medications, including locking of unattended medications, was discussed in the monthly staff meeting. The Administrator and Director of Nursing conducted these meetings.</p> <p>The Director of Nursing will perform at least two random observations each day she works on different shifts, with different nurses, to assure medications are properly stored and attended.</p> <p>This information will be reported monthly at the Skilled Performance Improvement Committee.</p> <p>Failure to comply with proper storage and attendance of medications will result in disciplinary action for the employee involved.</p> <p style="text-align: center;"><b>RECEIVED</b> <b>MAY 05 2014</b></p>	<p>April 22, 2014</p> <p>April 22, 2014</p> <p>May 6, 2014</p> <p>April 22, 2014</p>
---------------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca DeRose</i>	TITLE <i>Administrative</i>	(X6) DATE 5-1-14
--	--------------------------------	---------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445499</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BAPTIST REHABILITATION-GERMANTOWN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2100 EXETER ROAD GERMANTOWN, TN 38138</b>		
(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 431	<p>Continued From page 1</p> <p>interview, it was determined the facility failed to ensure 1 of 2 (Nurse #1) medication nurses did not leave medications or the medication cart unlocked, unattended and out of the line of sight during medication administration.</p> <p>The findings included:</p> <p>Review of facility's "Medication Carts" policy documented, "...PROCEDURE... D. Medication Cart Security... 2. Medication carts are locked whenever nursing or pharmacy personnel are not present..."</p> <p>Observations in room 205B on 4/8/14 at 7:25 AM, Nurse #1 left the medication cart unlocked, unattended and out of the line of when entering room 205B to perform an accucheck and administer medications on the far side of the room with curtain pulled.</p> <p>Observations in room 205B on 4/8/14 at 7:30 AM, Nurse #1 placed a medication cup with 2 unopened pills on the bedside table and turned her back to the table while disposing of the accucheck items in a sharps container and got a new pair of gloves from Bed A's side of the room.</p> <p>During an interview in the hallway on 4/8/14 at 7:38 AM, Nurse #1 was asked if it was acceptable to leave the medication cart unlocked. Nurse #1 stated, "If it's here [pointing to the cart] where I can see it..." Nurse #1 was asked if she could see the medication cart at all times. Nurse #1 stated, "Well, no."</p> <p>During an interview at the skilled nurses' desk on 4/8/14 at 8:10 AM, the Director of Nursing (DON) was asked about leaving medications unattended</p>	F 431			

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

PRINTED: 04/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445499</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BAPTIST REHABILITATION-GERMANTOWN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2100 EXETER ROAD GERMANTOWN, TN 38138</b>		
(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 431	Continued From page 2 on a bedside table in a resident's room. The DON stated, "You should always be right there with them [medications]." The DON was asked about leaving the medication cart unlocked during administration of medications in a resident's room. The DON stated, "If it [medication cart] is out of your sight and you are in the room, that's a no-no."	F 431			
F 441 SS=F	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (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.  (b) Preventing Spread of Infection (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 the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	A sufficient amount of Tubersol has been released for the entire facility. PPD testing has resumed for employees. The acting Employee Health nurse is responsible for providing the PPD testing for employees. PPD testing for all employees will be completed.  In the event of another Tubersol backorder, a physician would sign health statements declaring an employee free of communicable disease.  Monthly audits will be conducted to assure that employees have current annual documentation stating they are free from communicable disease. Any employee who is not current will not be allowed to work until this has been corrected. This information will be reported monthly at the Skilled Performance Improvement Committee.	May 3 , 2014  April 30, 2014  May 6, 2014	

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

PRINTED: 04/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445499</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BAPTIST REHABILITATION-GERMANTOWN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2100 EXETER ROAD GERMANTOWN, TN 38138</b>		
(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 441	<p>Continued From page 3 hand washing is indicated by accepted professional practice.</p> <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 policy review, review of personnel files and interview, it was determined the facility failed to ensure that staff who have direct contact with the residents are free from communicable disease for 5 of 5 (Two new employees, the Registered Dietician, the Social Worker and the Activity Director) personnel files reviewed.</p> <p>The findings included:</p> <p>Review of the facility's "PRE-EMPLOYMENT HEALTH EVALUATIONS" policy documented, "...Document communicable disease history including tuberculosis, hepatitis... Perform TB [tuberculosis] skin testing..."</p> <p>Review of the personnel files for 2 new hire employees, the Registered Dietician, the Social Worker and the Activity Director had no documentation of the five employees being free from communicable disease.</p> <p>During an interview in the conference room on 4/7/14 at 5:15 PM, the Administrator was asked if the staff were given a TB skin test. The Administrator stated, "We do those screenings [2013 Tubersol shortage screening only testing</p>	F 441			

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

PRINTED: 04/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445499</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BAPTIST REHABILITATION-GERMANTOWN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2100 EXETER ROAD GERMANTOWN, TN 38138</b>		
(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 441	Continued From page 4 deferred] because of the Tubersol shortage." The Administrator was asked if there was something in the personnel files signed by a physician indicating the staff was free from communicable disease. The Administrator stated, "That's all we do."  During an interview in the conference room on 4/8/14 at 9:56 AM, the Administrator was asked if she could tell from looking at the TB screening form, if the employees were free from communicable disease. The Administrator stated, "All that is done at Corporate. That's the process (TB screening form) we have now."	F 441			

RECEIVED  
MAY 05 2014