### Statement of Deficiencies

<table>
<thead>
<tr>
<th>A. LAN of Correction</th>
<th>(X1) Provider/Supplier/Clinical Entity</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>445195</td>
<td></td>
<td>08/25/2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Provider or Supplier</th>
<th>Street Address, City, State, ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAPTIST MEMORIAL HOSP-Memphis SNF</td>
<td>6019 WALNUT GROVE ROAD MEMPHIS, TN 38120</td>
</tr>
</tbody>
</table>

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>SS = E</td>
<td></td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td></td>
<td></td>
<td></td>
<td>Actions taken are as follows:</td>
<td></td>
</tr>
</tbody>
</table>

**Policy and Procedure Review:**

- Reviewed the following policies:
  - Pressure Ulcer Prevention and Treatment Guidelines Policy
  - Anti-embolism Stockings
  - Sequential Compression Therapy
  - Verbal, Telephone and Written Orders Policy
  - Transcription of Orders
  - Specimen collection and labeling Procedure
  (Attachment A)

**Practice Changes:**

- Revised initial assessment to include validation by 2 staff members of initial skin assessment (Attachment B)
  2/1/2010

- Included dressing status in bedside rounding report to improve hand-off communication. (Attachment C)
  2/1/2010

- Implemented utilization of an electronic reminder system for review of active orders at the beginning of each shift. (Attachment D)
  9/1/2010

- Implemented utilization of specimen collection reminders on PCA hand off report too (Attachment E)
  8/1/2010

- Implemented weekly skin rounds to include prevalence and incidence of pressure ulcers (Attachment F)
  2/1/2010

---

**Laboratory Directors or Provider/Supplier Representative’s Signature:**

[Signature]

**Title:**

[Title]

**Date:** 9/10/10

---

*Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards or sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disposable 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 areducible 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.*
Disease, Malnutrition and Dementia. Review of the Nursing Assessments/Interventions flow sheets from admission on 11/26/09 to 12/5/09 revealed there was no documentation of any dressings or wounds to the left foot. Review of the Nursing Assessments/Interventions flow sheet dated 12/6/09 documented a dressing was “removed” with wound location to the “left foot” with an appearance of “dry blisters.” Review of a “Report of Consultation” dated 12/8/09 documented “…Apparently discovered to have skin breakdown [breakdown] L [left] heel, L [left] lateral [lateral] foot, L [left] dorsal foot, L [left] Achilles from reported unchanged Kerlix reported applied for sprained ankle + [and] not removed.”

During an interview in the confer[ence room on 8/25/10 at 11:15 AM, Nurse #3 stated the dressing was dated prior to Resident #10’s admission to the skilled nursing unit.

2. Medical record review for Resident #3 documented an admission date of 8/11/10 with diagnoses of Status Post Hemiarthroplasty, Hypertension, Right Hip Fracture, Hyponatremia, Dyslipidemia, diverticuloses and Urinary Retention. Review of the physician’s orders dated 8/11/10 documented, “…For prevention of DVT [Deep Vein Thrombosis]…Intermittent compression stockings…”

Observation in Resident #3’s room on 8/24/10 at 12:11 PM and 3:50 PM, revealed Resident #3 lying in bed without the intermittent compression stockings in place as ordered.

During an interview in the Nurse Manager’s Office on 8/25/10 at 1:50 PM, the Nurse Manager stated, “…Since they [Resident #3 and #5] are up we do not put the stockings on…We should have a doctors order…”

3. Medical record review for Resident #5 documented an admission date of 8/17/10 with diagnoses of Right Arm Fracture, Subarachnoid Hemorrhage, Long Term Use Anticoagulant, History of Peripheral Vascular Disease, history

Education:
- Provided education to nurses on review of dressings during bedside rounding report. (Attachment G)
- Provided education to nurses on utilization of an electronic reminder system for review of active orders at the beginning of each shift. (Attachment H)
- Provided training on Wound Care Part 1 to nurses through CE Direct (Attachment I)
- Provided training on Wound Care Part 2 to nurses through CE Direct (Attachment I)
- Provided education to nurses on “Save Our Skin” program which included “4 Eyes in 4 Hours” validation by 2 staff members of initial skin assessment
- Provided education to CNA on “Care of the Patients with Peripheral Arterial Disease” (Attachment I)

Performance Improvement, Monitoring and Reporting:
Developed weekly skin rounds monitor (Attachment F)
- Initiated daily review of admission documentation audit report from Horison Electronic Documentation (HED). (Attachment K)
- Nurse Manager to monitor wound care documentation by reviewing 30 bedside rounding report tools per month for compliance to wound care & dressing changes (Attachment C)
- MDS Coordinator will review all patients with intermittent compression stockings and present weekly @ discharge planning meeting

1/22/2010
9/9/2010
9/9/2010
9/9/2010
8/1/2010
2/1/2010
9/10/2010
9/25/2010
9/14/2010
100 %
100 %
100 %
100 %
100 %
July 100%
August 100%
100 %
100 %
Continued from page 2.

of Deep Vein Thrombosis/Pulmonary Embolus, Chronic Atrial Fibrillation, and Coronary Artery Disease. Review of the physician’s orders dated 8/17/10 documented, “...For prevention of DBT [Deep Vein Thrombosis]...Intermittent compression stockings…”

Observation in Resident #5’s room on 8/23/10 at 2:15 PM, revealed Resident #5 lying in bed without the intermittent compression stockings in place as ordered.

During an interview in Resident #5’s room on 8/24/10 at 8:20 AM, Resident #5 stated, “...She [Resident #5] has not worn them [the intermittent stockings] since she was in ICU [Intensive Care Unit]...”

During an interview in the Nurse Manager’s Office on 8/25/10 at 1:50 PM, the Nurse Manager stated, “...Since they [Residents #3 and #5] are up we do not put the stockings on...We should have a doctors order...”

4. Medical record review for Resident #6 documented an admission date of 8/9/10 with diagnoses that included Fractured left Femur, Congestive Heart Failure, Renal Insufficiency, Depression and Anemia. Review of the physician’s order dated 8/17/10 documented an order for a urinalysis and a urine culture and sensitivity (UA with C&S). the facility was unable to provide laboratory results for the UA with C&S ordered on 8/17/10.