F 221

483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to assess for a restraint or try alternatives prior to use of a restraint for 2 of 3 (Residents #2 and 6) sampled residents with restraints.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 8/20/03 with a readmission date of 5/19/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, Osteoporosis and Paroxysmal Atrial Fibrillation. Review of the Daily Skilled Nurses Notes documented the following:
   a. 5/20/10 - "Soft soft [belt] restraint in place due to resident attempt to get up [without] assist."
   b. 5/21/10 - "Soft belt restraint for safety; Resident attempt to get up without assist."
   c. 5/22/10 - "Wears soft belt restraint release 2 q [every] hrs [hours] for safety."

Review of the Minimum Data Set (MDS) signed as complete on 5/26/10 revealed no documentation the resident was restrained.
Review of the physician's orders dated 5/21/10 revealed no order to restrain the resident.

During an interview in the survey room on 5/22/10 at 1:50 PM, the MDS nurse stated, "I don't know if acceptable POC."

SIGNED

Amita Manar, NHA

DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

7/8/2010
STATEMENT OF DEFICIENCIES
ND PLAN OF CORRECTION

KIRBY PINES MANOR

F 221
Continued From page 1
they [staff] charted on the wrong patient or what.*

The facility failed to complete a restraint
assessment, try alternatives prior to the use of a
belt restraint or obtain a physician's order for
the use of a belt restraint.

2. Medical record review for Resident #8
documented an admission date of 4/15/10 with
diagnoses of Parkinson's, Atrial Fibrillation, and
Hypertension. Review of the nurse's notes
documented Resident #8 experienced a fall after
an unassisted transfer from the bed on 4/22/10 at
4:00 AM and at 10:55 AM a soft belt restraint was
implemented. The care plan dated 4/23/10
documented, "...PROBLEMS: At risk for falls and
fall related injuries related to a hx [history] of
falls..." There was no documentation that the
least restrictive restraint was attempted or an
alternative was attempted prior to the
implementation of the belt restraint.

During an interview in the Director of Nursing's
(DON) office on 6/23/10 at 9:40 AM the DON
stated, "...I see what you mean about
interventions for falls... we didn't do anything
different. We should have tried a bed alarm..."

F 278
SS=D

483.20(g) - (l) ASSESSMENT
ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the
resident's status.

A registered nurse must conduct or coordinate
each assessment with the appropriate
participation of health professionals.

A registered nurse must sign and certify that the
assessment is completed.

F 221 Measure to ensure systematic changes:
- Notification to the Director of Nursing
  or designee prior to initiating any
  restraint.
- Verification from the review of the
  medical record that the least
  restrictive measures or devices have
  been implemented.
- Implementation of the restraint
  committee to monitor restraint
  applications

Person(s) Responsible: Director of Nursing
Licensed Nurses
CNAs

Target Date: 7/15/10

Monitoring of corrective actions to ensure
compliance:
- Notification of the Director of Nursing
  or designee prior to the application of
  a restrictive device.
- Ongoing re-in-service for nursing
  staff on the facility's restraint policy
  and protocol.
- Reporting the use of restrictive
devices in PA (Potential/Actual) and
  QA meetings.
- Include restrictive device reporting
  for CNAs.

Person(s) Responsible:
Designated tasks to: Director of Nursing
  QI Nurse
  Staff Nurses

Target Date: 7/15/10

End F221 Response
Kirby Pines Manor

STATEMENT OF DEFICIENCIES AS OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

446199

ADDRESS

3398 Kirby Road
MEMPHIS, TN 38115

STREET ADDRESS, CITY, STATE, ZIP CODE

06/23/2010

DATE SURVEY COMPLETED

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Statement of Deficiencies as of Correction

F278 Continued From page 2

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

- This is based on medical record review and interviews, it was determined the facility failed to accurately complete the Minimum Data Set (MDS) for a restraint and/or falls for 2 of 9 (Residents #2 and 5) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 6/20/03 with a readmission date of 5/19/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, Osteoporosis and Paroxysmal Atrial Fibrillation. Review of the Daily Skilled Nurses Notes documented the following: e. 6/20/10 - "Soft soft [belt] restraint in place due to resident attempt to get up [without] assist..."

2. MDS Assessment performed on 6/19/10 with a diagnosis of Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, Osteoporosis and Paroxysmal Atrial Fibrillation. The MDS assessment incorrectly documented a restraint on Resident #2 totaling 10 hours per week. The MDS noted that the resident was not getting up to use the bathroom which was incorrect.

Corrective action(s) for those immediately affected:

- Resident’s MDS assessments will be reviewed and corrected if applicable to ensure accuracy as per their current status.

Person(s) responsible: MDS Nurse
Target Date: 7/15/10

- License nursing staff will be re-in-services on appropriate documentation of resident to reflect the resident's current status.

Person(s) responsible: Unit Managers [and/or] Designee
Target Date: 07/15/2010

Identification and correction of other residents with the potential to be affected:

- All residents' orders and medical records will be reviewed and if applicable, coded on the MDS and/or falls, bed/chair alarms, restraints, and etc. These items will be noted on resident MDS.

Person(s) responsible: Unit Managers [Licensed Nurse, MDS Nurse] [and/or] Designee
Target Date: 7/15/10 and on-going

Measure to ensure systematic changes:

- One random MDS assessment per week will be selected by the Director of Nursing or designee for review to ensure accuracy.

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<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 278</td>
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<td>F 278</td>
<td>Any deficiencies found will</td>
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<td></td>
<td>b. 5/21/10 - &quot;Soft belt restraint for safety; Resident attempt to get up without assist...&quot;</td>
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<td>be discussed with the MDS coordinator for corrections.</td>
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<td>c. 5/22/10 - &quot;Wears soft belt restraint release 2 q [every] hrs [hours] for safety&quot;. Review of the Minimum Data Set (MDS) with an assessment reference date of 5/23/10 and signed as complete on 5/26/10 revealed no documentation the resident was restrained, yet nurses progress notes reflect the resident had a restraint in use.</td>
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<td>Person(s) Responsible: Director of Nursing</td>
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<td>Unit Managers</td>
<td>MDS Nurse</td>
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<td>Target Date - 7/15/10 and on-going</td>
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<td>Monitoring of corrective actions to ensure deficiency will not occur:</td>
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<td>- Continue to utilize current tracking tool to monitor residents that have falls, restraints, bed/chair alarms, and pacemakers (if applicable) in order to ensure MDS was coded accurately.</td>
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<td>- This tool will be audited monthly.</td>
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<td>Person(s) responsible:</td>
<td>QI Nurse</td>
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<td>Target Date: 7/15/2010 and on-going</td>
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<td>F 280</td>
<td>Corrective action(s) for those immediately affected:</td>
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<td>483.20(d)(3), 483.10(k)(2) RIGHT TO</td>
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<td>- Resident care plans will be reviewed and corrected to ensure accuracy as per resident’s current status.</td>
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<td>PARTICIPATE PLANNING CARE-REVISE CP</td>
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<td>Unit Managers</td>
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<td>Target Date: 7/15/10</td>
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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to
### F 280 Continued From page 4

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, observations, and interviews, it was determined the facility failed to revise the care plans to reflect the current status for falls, pacemaker and/or bed alarms for 5 of 9 (Residents #1, 4, 5, 6 and 7) sampled residents observed.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 5/21/10 with diagnoses of Alzheimer's Dementia, Severe Alcoholic Neuropathy, Benign Brain Tumors and Seizures. Review of the nurses' notes documented Resident #1 experienced a fall on 5/27/10. The care plan dated 5/31/10 documented, "...PROBLEMS: At risk for falls and fall related injuries related to hx [history] of falls,

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<th>COMPLETION DATE</th>
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<td>F 280</td>
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<td>License nursing staff will be re-in-serviced on updating the resident's care plan interventions for falls, restraints, and other care issues.</td>
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Person(s) responsible: QI Nurse

Unit Managers [and/or] Designee

Target Date: 07/15/2010

Identification and correction of other residents with the potential to be affected:

- All residents' orders and if applicable for interventions such as falls (including bed/Chair alarms), restraints, pacemakers, etc. will be placed on resident care plans and interventions as such will be implemented.

Person(s) responsible: Unit Managers

Licensed Nurse

MDS Nurse [and/or] Designee

Target Date: 7/15/10

Measure to ensure systematic changes:

- One random MDS assessment/per week will be selected by the Director of Nursing or designee for review to ensure accuracy.

Any deficiencies found will be discussed with the MDS coordinator for corrections.

Person(s) Responsible: Director of Nursing

Nurse Managers [and/or] Designee

Target Date: 7/15/10
F 280 Continued From page 5

There was no documentation of new interventions put into place to prevent further falls after the resident fell on 5/27/10.

During an interview at the C-wing nurses' station on 6/22/10 at 10:00 AM, the Skilled Unit Manager confirmed the facility had no documentation of new interventions put into place after Resident #1's fall on 5/27/10.

2. Medical record review for Resident #4 documented an admission date of 5/11/10 with diagnoses of Left Hip Fracture, Coronary Artery Disease, Hypertension and Degenerative Joint Disease. Review of the pre-operative clearance report dated 5/4/10 and the admission nursing assessment form date 5/11/10 did not document the resident had a pacemaker. A physician's telephone order dated 5/12/10 documented the resident was to have a bed alarm. The care plan dated 5/21/10 documented the resident had a pacemaker and was at risk for falls and fall related injuries. The bed alarm was not on the care plan.

During an interview in the survey room on 6/22/10 at 2:30 PM, the Minimum Data Set (MDS) Coordinator stated, "Pacemaker is an error on the care plan. The bed alarm has been added now."

3. Medical record review for Resident #5 documented an admission date of 4/2/10 and a readmission date of 5/28/10 with diagnoses of Hypokalemia, Diabetes Mellitus, Atrial Fibrillation, Coronary Artery Disease, Pacemaker, Sleep Apnea, Hypertension, Hyperlipidemia, Depression, Congestive Heart Failure, Dementia, and a history of Myocardial Infarction. Review of the physician's orders dated 5/1/10 documented...
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<th>(X4) ID</th>
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<th>PRIVEX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 280</td>
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<td>Continued From page 6. &quot;...PT. [physical therapy] TX [treatment] 5X/WK [five times per week] FOR 30 DAYS FOR THERE [therapeutic] EX [exercise] ...GAI TRNG [training], TRANSFER/BED MOBILITY TRNG, PT [patient]/CAREGIVER TRNG... ALARM TO BED AND WHEELCHAIR D/T [due to] POOR SAFETY AWARENESS.&quot; The care plan updated on 5/28/10 documented the resident had falls on 5/14/10 and 5/21/10. A nurses' note documented the resident fell from the bed on 6/16/10. There were no new interventions documented on the care plan after the resident fell on 5/21/10 and 6/16/10. During an interview in the survey room on 6/22/10 at 3:00 PM, the MDS Coordinator confirmed that there were no new interventions put into place after the falls on 5/21/10 and 6/16/10. 4. Medical record review for Resident #6 documented an admission date of 4/15/10 with diagnoses of Parkinson's, Atrial Fibrillation, and Hypertension. Review of the nurse's notes documented Resident #6 experienced a fall after an unassisted transfer from the bed on 4/22/10 and another fall on 4/26/10. The care plan dated 4/23/10 documented, &quot;...PROBLEMS: At risk for falls and fall related injuries related to a hx of falls on 4/17/10. During an interview in the Director of Nursing's (DON) office on 6/23/10 at 9:40 AM, the DON stated, &quot;...I see what you mean about interventions for falls... we didn't do anything different.&quot; 5. Medical record review for Resident #7 documented an admission date of 4/16/10 with diagnoses of Hypothyroid, Congestive Heart</td>
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STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER: KIRBY PINES MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 3585 KIRBY ROAD MEMPHIS, TN 38115

ID PREFIX TAG: F 280

SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC Identifying Information)

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Failure, Anemia, Depression, Pacemaker, Hypertension, Dementia, and a Pacemaker. The current physician's orders dated 6/1/10 documented included an order that was initialed on 6/13/10 to: "...PLACE CHAIR ALARM ON WHILE IN W/C (wheelchair) D/T POOR SAFETY AWARENESS..." and an order initialed 5/18/10 for "...PT. TX TX/WK FOR 30 DAYS FOR THERE EX,... GAIT TRNG...". The nurses’ notes documented the resident had falls on 4/18/10, 5/6/10, 6/7/10, and 5/26/10. There was no documentation on the care plan of new interventions put into place after the resident fell on 5/6/10 and 5/26/10.

Observations in Resident #7’s room on 6/22/10 at 8:40 AM, revealed Resident #7 seated in a w/c. Resident #7 self-propelled herself into the bathroom, transferred herself to the toilet and back to the w/c. Resident #7 then propelled herself back into the room and transferred herself into a bedside chair. There was no alarm on the w/c or on Resident #7.

Observations in Resident #7’s room on 6/23/10 at 9:30 AM, revealed Resident #7 seated in a bedside chair. Resident #7 stood and transferred herself into the w/c that was positioned in front of her. The brakes on the wheelchair were not locked, nor was there an alarm in place on the w/c or on Resident #7.

During an interview in the survey room on 6/25/10, at 8:30 AM, the MDS Coordinator was asked about interventions for falls on the care plan. The MDS Coordinator stated, "...I see what you are saying... the wheelchair alarm should have been on the care plan." The MDS Coordinator confirmed the facility had no documentation of...
Continued from page 8:

new interventions put into place after the falls on 6/6/10 and 6/25/10.

**309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**

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.

The requirements are not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to follow the physician’s orders for thromboembolic deterrent stockings (TEDS), a body alarm and a psychoactive medication was administered without an appropriate diagnosis for 4 of 9 (Residents #3, 4, 5 and 7) sampled residents.

The findings included:

1. Medical record review for Resident #3 documented an admission date of 4/21/10 with diagnoses of Compression Fracture to Lumbar 1, Left Rib Fracture, Degenerative Joint Disease, History of Cerebrovascular Accident (CVA), Chronic Obstructive Pulmonary Disease and Arthritis. Review of the physician’s orders dated 6/1/10 documented, “...Bilat [bilateral] TED Hose...” The care plan dated 6/5/10 documented, “...PROBLEMS: Resident requires assistance with ADL’s [activities of daily living] Related to weakness and dx [diagnosis] of CVA... bilateral TED Hose...”

Corrective action(s) for those immediately affected:

- Orders will be reviewed to ensure accuracy of implementation of devices.
- Licensed nursing staff will be re-in-services on monitoring compliance of physician orders.

Person(s) responsible: Unit Managers [and/or] Designees
Licensed Nursing Staff

Target Date: 7/15/2010

Identification and correction of other residents with the potential to be affected:

- Orders will be reviewed to ensure accuracy to reflect the current status of the resident
- If applicable, interventions such as applications of TEDs and body alarms will be implemented.

Person(s) responsible: Unit Managers [and/or] Designees
Licensed Nursing Staff

Target Date: 7/15/2010

Measure to ensure systematic changes:

- Monitoring to ensure compliance in application and to ensure the removal of TEDs and body alarms.

Person(s) responsible: Unit Managers [and/or] Designees
Licensed Nursing Staff

Target Date: 7/15/2010
F 309 Continued From page 9

Observations in Resident #3's room on 6/21/10 at 3:47 PM, revealed Resident #3 lying on her bed with no TED hose on.

Observations in the hallway on 6/22/10 at 9:05 AM revealed Resident #3 seated in a wheelchair with no TED hose on.

Observations in the Occupational Therapy room on 6/22/10 at 4:45 PM, revealed Resident #3 lying on her bed with no TED hose on.

During an interview at the C wing nurse's station on 6/22/10 at 4:55 PM, the Skilled Unit Manager was asked at what times did Resident #3 wear the TED hose. The Skilled Unit Manager stated, "She [Resident #3] has not had the TED hose on because they have been sent to laundry. I don't know the turn around time to get them [TED hose] back [from laundry]."

During an interview in the laundry on 6/22/10 at 5:30 PM, the Environmental Services Director was asked if there were any TED hose in the laundry. The Environmental Services Director showed the surveyor where all the socks and stockings were kept (individually wrapped in plastic wrap). There was one pink faded TED hose with no name on it. The Environmental Services Director stated any socks would be on the table.

2. Medical record review for Resident #4 documented an admission date of 5/11/10 with diagnoses of Left Hip Fracture, Coronary Artery Disease, Hypertension and Degenerative Joint Disease. Review of the admission physician orders dated 5/11/10 documented the resident

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F 309 Monitoring of corrective actions to ensure deficiencies will not occur:
- Random resident and chart audits per DON or designee.  
Person(s) responsible: Unit Managers [and/or] Designees Licensed Nursing Staff
Target Date: 7/15/2010

Corrective action(s) for those immediately affected:
- Orders will be reviewed to ensure accuracy of the diagnosis for anti-psychotic medication.
- If not present, the physician ordering the anti-psychotic will be contacted to obtain a correlating diagnosis.
was to receive Risperidone (antipsychotic medication) 0.5 milligrams by mouth at bedtime. There was no documentation of a diagnosis to substantiate why the resident was receiving the Risperidone. Review of the physician’s orders dated 5/11/10 documented to have a psychiatric consult, which documented unknown reason for resident to have Risperidone. The facility failed to have a documented diagnosis for the need of the administration of an antipsychotic medication.

3. Medical record review for Resident #5 documented an admission date of 4/2/10 and a readmission date of 5/28/10 with diagnoses of Hypokalemia, Diabetes Mellitus, Atrial Fibrillation, Coronary Artery Disease, Pacemaker, Sleep Apnea, Hypertension, Hyperlipidemia, Depression, Congestive Heart Failure, Dementia, and a history of Myocardial Infarction. Review of the physician’s orders dated 5/11/10 documented an order for “...TED HOSE/KNEE-HIGH TO BIL [bilateral] LE [lower extremities]...”

Observations in Resident #5’s room on 6/21/10 at 10:23 AM and 1:40 PM, revealed Resident #5 lying in bed with his bilateral lower extremities elevated on a pillow with no TED hose on.

4. Medical record review for Resident #7 documented an admission date of 4/16/10 with diagnoses of Hypothyroid, Congestive Heart Failure, Anemia, Depression, Hypertension, Dementia, and a Pacemaker. Review of the physician’s orders dated 3/11/10 documented an order initiated 5/13/10 for “...PLACE CHAIR ALARM ON WHILE IN W/C [wheelchair] DJT POOR SAFETY AWARENESS...” The nurses’ notes documented the resident had falls on 4/15/10, 5/8/10, 5/7/10 and 5/23/10.
Observations in Resident #7's room on 6/22/10 at 8:40 AM, revealed Resident #7 seated in a w/c at the bedside. Resident #7 self-propelled herself into the bathroom, transferred herself to the toilet and back to the w/c. Resident #7 then propelled herself back into the room and transferred herself into a bedside chair. There was no alarm on the w/c or on Resident #7.

Observations in Resident #7's room on 6/23/10 at 9:30 AM, revealed Resident #7 seated in a bedside chair. Resident #7 stood and transferred herself into a w/c. The brakes on the w/c were not locked. There was no alarm on the w/c or on Resident #7.

During an interview in the survey room on 6/23/10 at 1:45 PM, the Minimum Data Set (MDS) Coordinator was asked if Resident #7 had a body alarm on. The MDS Coordinator stated, "...she did not have one [body alarm] on this morning... but, I went and got one and put it on her... they [staff] take it off the chair and attach it to the bed [when the resident goes to bed]..." The MDS Coordinator was asked if the resident had an alarm in her room. The MDS Coordinator stated, "...I didn't see one..."

F 323
Corrective action(s) for those immediately affected:
- Resident medical records will be reviewed and corrected to ensure the accuracy of the fall care plan as it reflects the resident's current status.

Person(s) Responsible: Unit Managers
MDS Nurse
Director of Nursing
[and/or] Designee

Target Date: 7/15/10
This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations, and interviews, it was determined the facility failed to ensure the safety of 4 of 7 (Residents #5, 6, and 7) sampled residents observed with a history of falls by not implementing new fall interventions after residents sustained falls.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 5/21/10 with diagnoses of Alzheimer’s Dementia, Severe-Acute Alcoholic Neuropathy, Benign Brain Tumors, and Seizures. Review of the nurses’ notes documented Resident #1 experienced a fall on 5/27/10. The care plan dated 6/31/10 documented, "...PROBLEMS: At risk for falls and fall related injuries related to a hx [history] of falls, unsteady gait..." There was no documentation of new interventions put in place to prevent further falls after the resident fall on 5/27/10.

During an interview at the C wing nurses’ station on 6/22/10 at 10:00 AM, the Skilled Unit Manager confirmed there was no documentation of new interventions put into place after the fall on 5/27/10.

2. Medical record review for Resident #5 documented an admission date of 4/2/10 and a readmission date of 5/29/10 with diagnoses of Hypokalemia, Diabetes Mellitus, Atrial Fibrillation, Coronary Artery Disease, Pacemaker, Sleep Apnea, Hypertension, Hyperlipidemia, Depression, Congestive Heart Failure, Dementia, and a history of Myocardial Infarction. Review of
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<td>Measure to ensure systematic changes:</td>
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<td>the physician's orders dated 6/1/10 documented</td>
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<td>&quot;...PT, [physical therapy] TX [treatment] EX/NK</td>
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<td>be monitored for 72 hours and PRN for</td>
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<td>[five times per week] FOR 30 DAYS FOR THERE</td>
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<td>high fall risk behavior (attempts to</td>
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<td>[therapeutic] EX [exercise],... GAIT TRNG</td>
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<td>transfer/ambulate without assistance,</td>
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<td>[training], TRANSFER/ BED MOBILITY TRNG, PT</td>
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<td>unsteady gait, increased agitation or</td>
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<td>[patient]/CAREGIVER TRNG... ALARM TO BED</td>
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<td>confusion) and documentation</td>
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<td>AND WHEELCHAIR D/T [due to] POOR SAFETY</td>
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<td>including interventions will</td>
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<td>AWARENESS...&quot; The care plan dated 5/28/10</td>
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<td>be implemented to reflect the resident</td>
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<td>documented the resident had falls on 6/14/10 and</td>
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<td>current status.</td>
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<td>5/21/10. A nurse's note documented Resident #5</td>
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<td>- All residents with high fall risk</td>
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<td>fell from the bed on 6/16/10. There was no</td>
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<td>behavior and/or a current fall will be</td>
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<td>documentation of new interventions put in place</td>
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<td>discussed in the fall committee and</td>
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<td>to prevent further falls after the resident fell</td>
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<td>implementation of interventions as it</td>
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<td>on 5/21/10 and 6/16/10.</td>
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<td>reflects resident's current status.</td>
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<td>During an interview in the survey room on 6/22/10</td>
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<td>Person(s) Responsible: Unit Managers</td>
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<td></td>
<td></td>
<td></td>
<td>at 3:00 PM, the Minimum Data Set (MDS)</td>
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<td></td>
<td>Licensed Nurse</td>
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<td>Coordinator confirmed that there was no</td>
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<td>MDS Nurse</td>
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<td>documentation of new interventions put in place</td>
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<td>Therapy</td>
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<td>after the falls on 5/21/10 and 6/16/10.</td>
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<td>Restorative CNA</td>
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<td></td>
<td>4. Medical record review for Resident #6</td>
<td></td>
<td></td>
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<td>[and/or] Designee</td>
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<td></td>
<td></td>
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<td>documented an admission date of 4/15/10 with</td>
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<td>Target Date: 7/15/10</td>
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<td></td>
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<td>diagnoses of Parkinson's, Atrial Fibrillation, and</td>
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<td>Monitoring of corrective actions to ensure</td>
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<td>Hypertension. Review of the nurse's notes</td>
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<td>deficiencies will not occur.</td>
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<td>documented Resident #6 experienced a fall after</td>
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<td>- Fall committee will meet biweekly</td>
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<td>an unassisted transfer from the bed on 4/22/10</td>
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<td>where residents with high risk fall</td>
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<td>and another fall on 4/26/10. Review of the care</td>
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<td>behavior and/or recent falls will be</td>
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<td>plan dated 4/23/10 documented, &quot;...PROBLEMS:</td>
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<td>discussed for interventions as it</td>
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<td>At risk for falls and fall related injuries related to a</td>
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<td>reflects the resident's current status.</td>
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<td>slice of falls on 4/17/10.</td>
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<td>- All falls will be tracked and trended</td>
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<td>During an interview in the Director of Nursing's</td>
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<td>monthly and PRN.</td>
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<td>(DON) office on 6/23/10 at 9:40 AM, the DON</td>
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<td>Person(s) Responsible: Director of Nursing</td>
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<td></td>
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<td>stated, &quot;...I see what you mean about</td>
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<td>QI Nurse</td>
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<td>Interventions for falls... we didn't do anything</td>
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<td>Unit Managers</td>
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<td>different.&quot;</td>
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<td></td>
<td>[and/or] Designee</td>
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<td>6. Medical record review for Resident #7</td>
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<td>Target Date: 7/15/10</td>
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<tr>
<td>ID</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>COMPLIANCE DATE</td>
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</table>
| F  | 323 | Continued From page 14 documented an admission on 4/16/10 with diagnoses of Hypothyroid, Congestive Heart Failure, Anemia, Depression, Pacemaker, Hypertension, Dementia, and a Pacemaker. Review of the physician's orders dated 6/1/10 documented an order initiated on 6/13/10 for "...PLACE CHAIR ALARM ON WHILE IN W/C (wheelchair) D/T POOR SAFETY AWARENESS..." and an order initiated 5/18/10 for "...PT. TX TXW/K 30 DAYS FOR THERE EX... GAIT TRNG..." The nurses' notes documented Resident #7 had falls on 4/18/10, 5/6/10, 5/7/10, and 5/28/10. There was no documentation of new interventions put in place to prevent further falls after the resident fell on 5/6/10 and 5/28/10. Observations in Resident #7's room on 6/22/10 at 8:40 AM, revealed Resident #7 seated in a wheelchair at the bedside. Resident #7 self-propelled herself into the bathroom, transferred herself to the toilet and back to the w/o. Resident #7 then propelled herself back into the room and transferred herself into a bedside chair. There was no alarm on the w/o or on the resident. Observations in Resident #7's room on 6/23/10 at 9:30 AM, revealed Resident #7 seated in a bedside chair. Resident #7 stood and transferred herself into the w/o that was positioned in front of her. The brakes on the w/o were not locked. There was no alarm on the w/o or on the resident. During an interview in the survey room on 6/23/10 at 8:30 AM, the MDS Coordinator was asked about interventions for falls on the care plan. The MDS Coordinator stated, "...I see what you are saying..." The MDS Coordinator confirmed there...
QRBY PINES MANOR

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

F 323 Continued From page 15
was no documentation of new interventions put
into place after Resident #7's falls on 5/6/10 and
5/26/10...

F 441
483.65 INFECTION CONTROL, PREVENT
SPREAD, LINENS

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
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
infections.
**F 441 Continued From page 18**

Infection.

This REQUIREMENT is not met as evidenced by:

Based on policy review and observations, it was determined the facility failed to ensure 2 of 2 (Nurses #1 and 2) charge nurses thoroughly cleaned multi-use patient care equipment; did not pick medications up with their bare hands and then administer the medications to the resident or washed their hands using proper technique.

The findings included:

1. Review of the "Policy and Procedure for Multiple Equipment Use" documented "...Objective: To prevent the cross contamination and/or transmittal of bloodborne pathogens when utilizing any equipment on multiple residents. The goal is to ensure proper infection control practices. Any equipment that is used on multiple residents will be cleaned between each resident usage with the appropriate cleanser. The equipment will be wiped [wiped] down during usage as needed. Equipment will be removed and stored in supply area between usages..."

Observations in Resident #7's room on 6/22/10 at 8:40 AM, revealed Nurse #1 took a manual blood pressure (BP) cuff out of the medication cart and used it on Resident #7. Nurse #1 did not clean the BP cuff prior to or after using it on Resident #7. Nurse #1 took the BP cuff back to the medication cart and placed it into a drawer on the medication cart.

**F 441**

- Random monitoring with return demonstration of proper hand washing

<table>
<thead>
<tr>
<th>Person(s) Responsible</th>
<th>QI Nurse, Unit Managers</th>
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<tr>
<td>Target Date</td>
<td>7/15/10</td>
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Monitoring of corrective actions to ensure deficiencies will not occur:

- A monthly audit checklist performance tool will be implemented to ensure monitoring of staff for infection control as related to multi-patient equipment, retrieval and handling of medications, and proper hand washing

<table>
<thead>
<tr>
<th>Person(s) Responsible</th>
<th>Director of Nursing, QI Nurse</th>
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<tbody>
<tr>
<td>Target Date</td>
<td>7/15/10</td>
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End of F441 Response
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>F441</th>
<th>F514</th>
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</table>
| F 441 | Continued From page 17 | 6/22/10 at 8:45 AM, revealed Nurse #1 dropped Resident #7’s Lisinopril tablet on top of the medication cart. Nurse #1 picked the Lisinopril tablet up with her bare fingers and placed it in a cup with Resident #7’s other medications. Nurse #1 then administered the medications to Resident #7.  
2. Observations in Resident #3’s room on 6/22/10 at 9:40 AM, revealed Nurse #2 went into Resident #3’s bathroom to wash her hands. Nurse #2 washed her hands, turned off the faucet with her bare hand, and then dried her hands with a paper towel. Nurse #2 should have dried her hands with a paper towel and then turned the faucet off with a clean dry paper towel to prevent recontamination of her hand. | |  
| F 514 | 483.75(1)(1) RES | RECORDS-COMPLETE/ACCURATE/ACCESSIBLE | Corrective action(s) for those immediately affected:  
- Residents’ medical record will be reviewed and corrected to ensure accuracy as per their current status.  
Person(s) responsible: Unit Managers Licensed Nurse [and/or] Designee  
Target Date: 7/15/2010  
- Licensed nursing staff will be inserviced on appropriate documentation including site of ostomies, colostomy, ileostomy, etc.  
Person(s) responsible: Unit Managers QI Nurse [and/or] Designee  
Target Date: 7/15/2010 |
**Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)**

| ID | PREFIX TAG | F 514 | Continued From page 18 of 9
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<td>complete and accurate medical records for 1 of 9 sampled residents.</td>
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The findings included:

- Medical record review for Resident #2 documented an admission date of 8/20/03 with a readmission date of 5/19/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, Osteoporosis, and Paroxysmal Atrial Fibrillation. Review of the Daily Skilled Nurses Notes documented the following:
  a. 5/19/10 - "Colostomy at [at] LUQ [left upper quadrant]."
  b. 5/20/10 - "Ostomy site to R [right] side..."
  c. 5/21/10 - "Has ostomy to left side..."
  d. 5/22/10 - "Ostomy to (R) side..."

The facility failed to accurately document which side Resident #2's colostomy was on.

During an interview in the survey room on 6/22/10 at 1:50 PM, the Minimum Data Set Nurse stated, "Patient [Resident #2] has a colostomy on the left. I went and looked."

**Identification and correction of other residents with the potential to be affected:**
- Residents medical records will be reviewed and appropriate documentation completed including the site of ostomies, colostomy, ileostomy, and etc.

**Person(s) Responsible:**
- Unit Managers
- Licensed Nurse
- [and/or] Designee

**Target Date:** 7/15/2010

**Measure to ensure systematic changes:**
- All admission assessments will be reviewed within 72 hours of admission for accuracy and completion
- Any deficiencies found will be discussed with license nurse or admission nurse for corrections

**Person(s) Responsible:**
- Unit Managers
- QI Nurse
- [and/or] Designee

**Target Date:** 7/15/2010

**Monitoring of corrective actions to ensure deficiencies do not occur:**
- A monthly audit/performance tool that will be implemented to ensure monitoring of residents that have ostomies, including colostomy, ileostomy, etc. and to ensure proper documentation of site.

**Person(s) Responsible:**
- Director of Nursing
- Unit Manager
- QI Nurse
- [and/or] Designee

**Target Date:** 7/15/2010

**End F514 Response**

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**RECEIVED**

**JUL 12 2010**