<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 280 SS=D</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</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 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:
- Complaint investigation for TN00030426
- Based on policy review, medical record review, observation and interview, it was determined the facility failed to revise the care plan for 1 of 1 (Resident #1) sampled residents who were receiving medicare services during this complaint investigation. The facility in which this complaint investigation was conducted had 30 federally certified beds and 90 additional beds that were state licensed only. Additional citations were written for state licensure violations.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

YHA

**DATE**

12/5/12

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 findings stated above and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited as an approved plan of correction is requisite to continued program participation.
F280. Continued From page 1

The findings included:

Review of the facility's care plan policy documented, "...Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change..."

Medical record review for Resident #1 documented an admission date of 8/14/12 and a readmission date of 8/23/12 with diagnoses of Prostate Cancer, Hyposmolarity, Anemia, Hyponatremia, Parkinson's Disease, Osteoporosis, Hypothyroidism, Hypertension, Diabetes Mellitus, acute Respiratory Failure, Senile Dementia, Pneumonia, Muscle Weakness, Symbolic Dysfunction, Constipation and Insomnia. Review of the care plan dated 9/24/12 documented, "...At risk for weight variance related to Tube feeding related to diagnosis of oropharyngeal dysphagia... Provide feeding as ordered..." Review of a physician's order dated 10/17/12 documented, "Sugar-free desserts and sugar-free syrup..." Review of a physician's order dated 10/21/12 documented, "...ADA [American Diabetic Association] Diet..." Review of the Certified Nursing Assistant (CNA) documentation sheet dated from 10/16/12 to 11/14/12 confirmed Resident #1 received a plate of food and the percentage of the food the resident consumed was recorded by the CNA's.

Observations in Resident #1's room on 11/13/12 at 2:40 PM and 4:00 PM and on 11/14/12 at 9:40 AM, 11:45 AM, and 3:30 PM, revealed no tube feeding being given to Resident #1.

F280 Right to Participate Planning Care/Revised Care Plan

Resident #1 was discharged home.

Corrective Statement: As a part of our Quality Improvement Program, the facility will continue to revise and update care plans on an on-going basis, as the resident's condition and information change.

Compliance Practice: The MDS nurse will audit the care plans of residents that currently reside within the facility for accuracy and compliance to ensure the care plan reflects the resident current status. MDS nurse will separately audit care plans as it relates to physician orders and tube feeding.

Dates of Correction: 12/09/2012

Monitored By: As a member of the interdisciplinary team the MDS nurse will monitor care plans.

Monitoring Practice: The MDS nurse will update care plans weekly preceding the Interdisciplinary Team Meeting and PRN.
**continued from page 2**

During an interview in Resident #1’s room on 11/13/12 at 2:40 PM, the resident’s responsible party stated the resident had passed his swallowing test and was eating solid foods.

During an interview in the staff breakroom on 11/15/12 at beginning at 8:45 AM, the Director of Nursing (DON) was asked who was responsible for revising the resident’s care plan. The DON stated the Minimum Data Set nurse, the unit managers and the staff nurses updated the care plans. The care plan was not revised to reflect Resident #1’s current status.

**F 280**
483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on review of shower schedules, medical record review and interview, it was determined the facility failed to provide bathing and personal hygiene needs for 1 of 1 (Resident #1) sampled residents who was receiving medicare services during this complaint investigation. The facility in which this complaint investigation was conducted had 30 federally certified beds and 90 additional beds that were state licensed only. Additional citations were written for state licensure violations.

The findings included:

FE312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Resident #1 was discharged home.

**Corrective Statement:** As part of our Quality Improvement Program, the facility will initiate a compliance practice that alerts the charge nurse that assistance is needed to complete an ADL task. Refusal of an ADL task will be documented in the Medical Records.

**Compliance Practice:** The facility will endeavour to have ADL’s completed and documented as scheduled. To ensure compliance the charge nurse is responsible for overseeing, auditing and documenting of ADL tasks if resident refuses other options will be explored to ensure good personal hygiene.

**Dates of Correction:** 12/03/2012

**Monitored By:** Charge Nurse and Unit Manager.

**Monitoring Practice:** The Unit Managers will audit ADL’s for compliance weekly.
F 312 Continued From page 3

Medical record review for Resident #1 documented an admission date of 8/14/12 and a readmission date of 8/23/12 with diagnoses of Prostate Cancer, Anemia, Hyponatremia, Parkinson’s Disease, Osteoporosis, Hypothyroidism, Diabetes Mellitus, Hypertension, Acute Respiratory Failure, Senile Dementia, Pneumonia, Muscle Weakness, Symbolic Dysfunction, Constipation and Insomnia. Review of the 5 day minimum data set (MDS) dated 8/15/12 revealed section C cognitive patterns documented a cognitive summary score of 2 indicating severe cognitive impairment. Review of the 30-day MDS dated 9/21/12 documented a cognitive summary score of 6 which was better, however still indicated severe cognitive impairment. Section G functional status for the 8/15/12 and 9/21/12 MDS documented the resident required extensive assistance and one person physical assist for bathing and personal hygiene.

Review of the care area assessment summary (CAA) dated 8/30/12 documented, "...[named Resident #1] is dependent on staff for ADL [activities of daily living] care..."

Review of the current C-wing shower / bath schedule documented Resident #1 would receive a shower or full bath three days of every week: Tuesday, Thursday and Saturday on 3p-11p shift.

Review of the Certified Nursing Assistant (CNA) documentation for August starting from admission on 8/23/12 documented Resident #1 did not receive a full bath or shower until 8/28/12, 6 days from admission. The week of 9/2/12 to

F 312

F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Resident #1 was discharged home.

Corrective Statement: As part of our Quality Improvement Program the facility will initiate a compliance practice that alerts the charge nurse that assistance is needed to complete an ADL task. Refusal of an ADL task will be documented in the Medical Records.

Compliance Practice: The facility will endeavour to have ADL’s completed and documented as scheduled. To ensure compliance the charge nurse is responsible for overseeing, auditing and documenting of ADL tasks. If resident refuses other options will be explored to ensure good personal hygiene.

Dates of Correction: 12/03/2012

Monitored By: Charge Nurse and Unit Manager.

Monitoring Practice: The Unit Managers will audit ADL’s for compliance weekly.
NAME OF PROVIDER OR SUPPLIER

KIRBY PINES MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

3535 KIRBY ROAD
MEMPHIS, TN 38115

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<th>F 312</th>
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<tr>
<td>9/6/12</td>
<td>Resident #1 received one shower. 9/6/12.</td>
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<tr>
<td>9/8/12</td>
<td>The week of 10/7/12 to 10/13/12, the resident received 2 showers: 10/7/12 and 10/12/12. The week of 10/14/12 to 10/20/12 the resident received 2 showers: 10/15/12 and 10/19/12. The week of 10/21/12 to 10/27/12 the resident received 2 showers: 10/23/12 and 10/27/12. The week of 10/28/12 to 11/3/12 the resident received 2 showers: 10/30/12 and 11/2/12.</td>
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During an interview at the A/B hall nurses' station on 11/13/12 at 12:50 PM, Nurse #1 was asked if the facility followed a shower schedule for the residents and who was responsible for verifying the showers were done. Nurse #1 stated that the facility had been following the same process since 2008. The showers for the residents were scheduled either Monday, Wednesday and Friday or Tuesday, Thursday and Saturday. Additional showers were given as needed or desired by the residents. The CNA's initiated the showers or baths when they were done and the nurse in charge of the section also initiated at the end of each shift that the CNA assignments and documentation were complete. The same process was followed on all 3 units, C wing the medicare unit, A/B hall the private pay unit, and Job's way the Alzheimer's unit. |

During an interview in Resident #1's room on 11/13/12 at 2:40 PM, Resident #1's responsible party (RP) was asked if the resident received the personal care from the staff he needed. The RP stated that the resident had a history of Parkinson's and Dementia and cognitive impairment. The CNA's ask if the resident is ready to take a bath. If the answer is "No", they don't give him one. The RP stated that it is |

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F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Resident #1 was discharged home.

Corrective Statement: As part of our Quality Improvement Program the facility will initiate a compliance practice that alerts the charge nurse that assistance is needed to complete an ADL task. Refusal of an ADL task will be documented in the Medical Records.

Compliance Practice: The facility will endeavour to have ADL's completed and documented as scheduled. To ensure compliance the charge nurse is responsible for overseeing, auditing and documenting of ADL tasks. If resident refuses other options will be explored to ensure good personal hygiene.

Dates of Correction: 12/03/2012

Monitored By: Charge Nurse and Unit Manager.

Monitoring Practice: The Unit Managers will audit ADL's for compliance weekly.
**F 312** Continued From page 5
frustrating, the resident will need the shower or bath, but not get one, leaving the skin sticky with an odor. It's also upsetting when finding the resident wet or hearing the complaint, "I was cold and wet last night" stating this had occurred this morning 11/13/12.

During an interview in the C wing sitting area on 11/15/12 at 2:00 PM, Resident #1's RP was asked how things were going. The RP stated, "...[named Resident #1] was wet during the night...happens frequently...this am the clothes in the hamper were wet again..."

**F 312** ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Resident #1 was discharged home.

**Corrective Statement:** As part of our Quality Improvement Program the facility will initiate a compliance practice that alerts the charge nurse that assistance is needed to complete an ADL task. Refusal of an ADL task will be documented in the Medical Records.

**Compliance Practice:** The facility will endeavour to have ADL's completed and documented as scheduled. To ensure compliance the charge nurse is responsible for overseeing, auditing and documenting of ADL tasks. If resident refuses other options will be explored to ensure good personal hygiene.

**Dates of Correction:** 12/03/2012

**Monitored By:** Charge Nurse and Unit Manager.

**Monitoring Practice:** The Unit Managers will audit ADL's for compliance weekly.