N 682 Basic Services

Resident #1, #2 and #5 Care Plans and C.N.A. Communication sheets have been updated and revised to reflect their current clinical status.

Corrective Statement: As part of our Quality Improvement Program, the facility will continue to revise and update care plans on an on-going basis, as the residents' condition and information changes with input from appropriate disciplines, the resident and/or the residents' family or the resident's representative.

Compliance Practice: The MDS nurse will audit the care plans of residents' that currently resident 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, changes in diet order, tube feeding and incontinence.

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.
### Division of Health Care Facilities

#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** TN7912  
**(X2) MULTIPLE CONSTRUCTION**  
A. BUILDING  
B. WING  
**(X3) DATE SURVEY COMPLETED:** 11/15/2012  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3535 KIRBY ROAD  
MEMPHIS, TN 38115

#### NAME OF PROVIDER OR SUPPLIER

KIRBY PINES MANOR

<table>
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<tr>
<th>ID 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 PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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| N 682     |     | Continued From page 1  
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 10/10/12 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.  
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.  
During an interview in Resident #1's room on 11/13/12 at 2:40 PM, the responsible party (RP) stated that the resident had passed his swallowing test and was eating solid foods.  
The care plan was not revised to reflect Resident #1's change from tube feeding to a solid food diet.  
3. Medical record review for Resident #2 documented an admission date of 5/6/11 with a readmission date of 4/27/12 with diagnoses of Congestive Heart Failure, Coronary Artery Disease, Atrial Fibrillation, Peptic Ulcer Disease, Permanent Pacemaker, Degenerative Joint Disease, Reflux, Gastrointestinal Hemorrhage, Depressive Disorder, Personal History of a Fall, Hypertension, Neuropathy, Coronary Artery Bypass Surgery, Hip Fracture, Hyperlipidemia, | N 682 |     | N682 Basic Services  
Resident #1, #2 and #5 Care Plans and C.N.A. Communication sheets have been updated and revised to reflect their current clinical status.  
**Corrective Statement:** As part of our Quality Improvement Program, the facility will continue to revise and update care plans on an on-going basis, as the residents’ condition and information changes with input from appropriate disciplines, the resident and/or the residents' family or the resident's representative.  
**Compliance Practice:** The MDS nurse will audit the care plans of residents' that currently resident 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, changes in diet order, tube feeding and incontinence.  
**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.
N 682 Continued from page 2

Pneumonia, and Arthritis. Review of the Minimum Data Set (MDS) dated 8/10/12 revealed section C for cognitive status documented a cognitive summary score of 5 indicating severe cognitive impairment and section H bladder and bowel documented the resident is always continent of bladder and bowel.

Review of the care area assessment summary (CAA) dated 8/10/12 documented, "...Is totally continent of bowel and bladder. Requires peri care every two hours and pm [as needed]..."

Review of the communication sheet / activities of daily living (ADL) care plan documented Resident #1 was continent of bowel and at times continent of bladder.

Observations of Resident #2 revealed the resident was alert to self with confusion and disoriented speech on the following date and times:
a. In the A hall on 11/13/12 at 1:25 PM and 4:15 PM
b. At the A/B nurses station on 11/14/12 at 10:10 AM, c. In the A/B Hall dining and activity area on 11/14/12 at 12:00 PM.
d. In Resident #2’s room on 11/14/12 at 2:30 PM and on 11/15/12 at 3:15 PM.

During an interview at the A/B Hall nurses’ station on 11/13/12 at 1:30 PM, Nurse #2 was asked if the nurses and CNAs had a care plan to follow specific to each individual resident. Nurse #2 stated the ADL book contained the communication sheet / ADL care plan.

During a telephone interview in the staff break-room on 11/15/12 at 11:00 AM, Resident #2’s RP was asked if the resident was receiving N682 Basic Services

Resident #1, #2 and #5 Care Plans and C.N.A. Communication sheets have been updated and revised to reflect their current clinical status.

Corrective Statement: As part of our Quality Improvement Program, the facility will continue to revise and update care plans on an on-going basis, as the residents' condition and information changes with input from appropriate disciplines, the resident and/or the residents’ family or the resident’s representative.

Compliance Practice: The MDS nurse will audit the care plans of residents’ that currently resident 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, changes in diet order, tube feeding and incontinence.

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.
N 682 Continued From page 3

the personal hygiene and incontinent care needed. The RN stated during a visit to the facility about a week and a half ago the resident looked "...pretty bad...they [facility] could do better... [named Resident #2] is sleeping or doesn't feel well they skip him... I believe they didn't come back through to check him... I don't feel like they clean him... Sometimes he does dribble [urinary incontinence] and there's an odor... You can walk up to him and smell it... because of the wetness, they should be making sure they [residents] get cleaned..."

The care plan was not revised to reflect Resident #2's change in status from continent to incontinent of bowel and bladder or the frequency the resident needed to be checked for incontinence and assisted with personal hygiene care.

4. Medical record review for Resident #5 documented an admission date of 8/22/11 with diagnoses of Arthritis, Osteoporosis, Anemia, Depression, Hypothyroidism, Personal History of a Fall, Constipation, B-complex Deficiency, Hypertension, and History of Left Hip Replacement. Review of the MDS dated 5/29/12 and 9/1/12 for section C cognitive patterns documented a cognitive summary score of 3 indicating the resident was severely impaired and section H bladder and bowel documented the resident was always incontinent of bladder and bowel.

Review of the CAA dated 9/1/12 documented, "...is totally incontinent of bowel and bladder..."

Review of the communication sheet / ADL care

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**Corrective Statement:** As part of our Quality Improvement Program, the facility will continue to revise and update care plans on an ongoing basis, as the residents' condition and information changes with input from appropriate disciplines, the resident and/or the residents' family or the resident's representative.

**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, changes in diet order, tube feeding and incontinence.

**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.
N 682 Continued From page 4

plan documented Resident #5 was incontinent of bowel and incontinent at times of bladder.

Observations of Resident #5 on the following dates and times revealed the resident was alert and oriented to person with confusion and disoriented speech:

- a. In Job's Way dining and activity area on 11/13/12 at 3:50 PM and 11/14/12 at 10:00 AM.
- b. In the resident's room on 11/14/12 at 2:45 PM.
- c. In the dining and activity area on 11/15/12 at 3:15 PM.

During a telephone interview in the staff break-room on 11/15/12 at 11:45 AM, the resident's RP was asked if Resident #5 received the personal hygiene and incontinent care needed. The RP stated the family hired a private sitter to be with the resident daily from 6:00 AM to 9:00 AM and 12:00 PM to 5:00 PM and the family "pops in" at different times of the day and night. The RP keeps a notebook in which are recorded occurrences and situations of concern and attends the care plan meetings every 3 months and shares the concerns with the facility staff present. The RP stated, "...battling with them for a long time... the dates are documented..." The RP stated, "...They [staff] don't change them [residents]... not checking on [the resident] at night at all..." The facility had told the RP they didn't want pull-ups at night, they wanted something more absorbent because the resident was waking up in the morning and the sheets were wet. A family member had visited (no data recorded) and found the resident sitting in the dining and activity area in a soiled diaper. They [staff] could smell the odor and the resident had skin breakdown at that point. During a visit on 7/21/12 during the daytime hours a family member found the resident with wet clothes.

N 682 Basic Services

Resident #1, #2 and #5 Care Plans and C.N.A. Communication sheets have been updated and revised to reflect their current clinical status.

Corrective Statement: As part of our Quality Improvement Program, the facility will continue to revise and update care plans on an on-going basis, as the residents' condition and information changes with input from appropriate disciplines, the resident and/or the residents' family or the resident's representative.

Compliance Practice: The MDS nurse will audit the care plans of residents' that currently resident 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, changes in diet order, tube feeding and incontinence.

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 5

sitting in a wet chair. When they asked the [named CNA] to help, the CNA did not know the resident was assigned to them for care. During a visit on 8/9/12, the resident was... found in a man’s room with poop everywhere wearing his underwear... The RP ended the interview with the question, "...Do you think that’s enough for now?..."

During an interview at the Job’s Way nurses’ station on 11/15/12 at 1:55 PM, Nurse #3 was asked if Resident #5 had a care plan for ADL care. Nurse #3 stated the resident's communication sheet in the ADL book was considered the care plan.

The communication sheet / ADL care plan was not revised to reflect Resident #5’s total incontinence or specify the frequency the resident needed to be checked for incontinence and assisted with peri-care.

5. Medical record review for RR #1 documented an admission date of 7/29/11 and a readmission date of 12/27/11 with diagnoses of Chronic Myelocytic Leukemia, Cardiovascular Disease, Arteriosclerosis, Coronary Artery Disease, Esophageal Reflux, Glaucoma, Gastrointestinal Hemorrhage, Chronic Obstructive Pulmonary Disease, Hypertension, Symbolic Dysfunction, Personal History of a Fall, Dysphagia, Parkinson's Disease, Neoplasm of the Prostate, Permanent Pacer, Renal Cell Cancer, and Carcinoma of the Thyroid. Review of the MDS dated 10/5/12 revealed section G functional status documented ADL assessment for transfer, dressing, personal hygiene and bathing the resident required extensive assistance with one person physical assist and eating was assessed as set up only.

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|       | Monitoring Practice: The MDS nurse will update care plans weekly preceding the Interdisciplinary Team Meeting and PRN.
Review of the current communication sheet/ADL care plan documented no information for RR #1's needs in the ADL care areas of transfers, bathing, dressing, and eating habits.

Observations in RR #1's room on 11/13/12 at 2:00 PM and 11/15/12 at 3:15 PM, revealed the resident alert and oriented to person and place with family and private sitter at bedside.

During an interview in RR #1's room on 11/13/12 at 2:00 PM, RR #1's RP was asked about the care the resident received at the facility. The RP stated, "...They really need more staff... Has a private sitter 12 hours each day who assists to feed meals..."

During an interview in RR #1's room on 11/15/12 at 3:15 PM, RR #1's RP was asked if the resident received the personal hygiene care needed. The RP stated, "...have found [named resident] wet up to the neck on his back... it does happen... take t-shirts home and wash the clothes. The basket will be heavy... If it happens once it's too much..."

The communication sheet/ADL care plan was not revised to reflect RR #1's transfer, bathing, dressing, and eating needs.

During an interview in the staff break-room on 11/15/12 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 MDS nurse, the unit managers and the staff nurses updated the care plans with changes in the residents' status.

During an interview in the staff break-room on 11/15/12 at 3:50 PM, the DON was asked if the resident was alert and oriented. The DON stated the resident was alert and oriented.
**N 690 Basic Services**

Unit Managers have reviewed ADL sheet of the affected residents to ensure bath/showers have been administered according to protocol.

**Corrective Statement:** As part of our Quality Improvement Program the facility will initiate 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.
N 690
Continued from page 8

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 sheet for August starting from admission on 8/23/12 documented the resident did not receive a full bath until 8/28/12, 6 days from admission. The week of 9/2/12 to 9/8/12 the resident received one shower on 9/6/12. The CNA did not document the shower or bath was refused by the resident. Review of the nurses notes for the 2 weeks did not document why a shower or bath was not given.

2. Medical record review for Resident #5 documented an admission date of 8/22/11 with diagnoses of Arthritis, Osteoporosis, Alzheimer's, Anxiety, Depression, Incontinence, Hypothyroidism, Personal History of a Fall, Constipation, Hypertension, B-complex Deficiency, and History of Left Hip Replacement. Review of the MDS dated 5/29/12 and 9/1/12 revealed section C cognitive patterns documented a cognitive summary score of 3 indicating the resident was severely impaired and section G functional status documented the resident required extensive assistance and one person physical assist for hygiene and bathing. Review of the CAA dated 9/1/12 documented, "...Requires assist with all ADLs..."

N 690 Basic Services

Unit Managers have reviewed ADL sheet of the affected residents to ensure bath/showers have been administered according to protocol.

Corrective Statement: As part of our Quality Improvement Program the facility will initiate 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.
Review of the current Job’s Way shower / bath schedule documented Resident #5 would receive a shower or full bath three days of every week, Tuesday, Thursday and Saturday on 3p-11p shift.

Review of the CNA documentation sheet documented the week of 10/14/12 to 10/20/12, Resident #5 received one shower on 10/16/12. The CNA did not document the shower or bath was refused by the resident. Review of the nurses notes for the 2 weeks do not document why the showers were not given.

3. Medical record review for RR #1 documented an admission date of 7/29/11 and a readmission date of 12/27/11 with diagnoses of Chronic Myelocytic Leukemia, Cardiovascular Disease, Arteriosclerosis, Coronary Artery Disease, Gastrointestinal Hemorrhage, Esophageal Reflux, Glaucma, Hypertension, Symbolic Dysfunction, Personal History of a Fall, Dysphagia, Parkinson’s Disease, Neoplasm of the Prostate, Permanent Pacemaker, Chronic Obstructive Pulmonary Disease, Renal Cell Cancer, and Carcinoma of the Thyroid. Review of the MDS dated 10/5/12 revealed section C cognitive patterns documented the resident was severely cognitively impaired and section G functional status documented the resident was totally dependent on staff and required one person physical assist for hygiene and bathing.

Review of the A/V hall shower / bath schedule documented RR #1 would receive a shower or full bath three days of every week: Monday, Wednesday and Friday on 7a-3p shift.

Review of the CNA documentation sheet documented the week of 10/7/12 to 10/13/12 RR

N 690

N 690 Basic Services

Unit Managers have reviewed ADL sheet of the affected residents to ensure bath/showers have been administered according to protocol.

Corrective Statement: As part of our Quality Improvement Program the facility will initiate 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.
N 690 Continued From page 10

#1 received one shower on 10/10/12. The CNA did not document the shower or bath was refused by the resident. Review of the nurses notes for the week do not document why the shower was not given.

During an interview at the AVB 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 on 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 of rooms also initiated at the end of each shift that the CNA assignments and documentation were complete. The same process was followed on all three units, C Wing, AVB Halls, and Job’s Way.

During an interview near the C wing nurses’ station on 11/15/12 at 10:15 AM, CNA #1 was asked what the CNAs were to do if a resident refused to shower or bathe. CNA #1 stated, “Let the nurse know the resident refused and chart R for refused [in the ADL book on the CNA documentation sheet].

N 690

N690 Basic Services

Unit Managers have reviewed ADL sheet of the affected residents to ensure bath/showers have been administered according to protocol.

Corrective Statement: As part of our Quality Improvement Program the facility will initiate 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.