

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

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  166049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  G 03/09/2012
NAME OF PROVIDER OR SUPPLIER  AUBURN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 139 PEARL ST., PO BOX 9 AUBURN, KY 42206		
(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 000	INITIAL COMMENTS  An abbreviated survey (KY #17908 & #17974) was conducted on 03/06-09/12 to determine the facility's compliance with Federal requirements. KY #17908 was unsubstantiated and KY #17974 was substantiated with deficiencies cited.	F 000	  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  1. Nursing applied Positioning Vest/ Harness to Resident (#2) on 3/9/2012 for posture, positioning and to decrease risk of falls. She was screened by Occupational Therapy for the device. The vest was found to be effective and safe for the resident. Resident placed on Q 15min. checks d/t behaviors on 3/19/2012.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interviews, record review and policy review, it was determined the facility failed to ensure one resident (#2) in the selected sample of eight received adequate supervision and assistance devices to prevent accidents. The facility failed to ensure a thorough investigations was completed to identify causal factors and to implement interventions to prevent fall recurrence. On 02/28/12 at 4:00 AM, Resident #2 was found lying on the floor in the resident's room. The supervisory assistive device (pressure alarm) was not sounding. At 5:15 AM, the facility found Resident #2 lying on the lobby floor actively bleeding from the bridge of his/her nose. The resident had been assisted up off of the his/her bedroom floor at 4:00 AM, placed in his/her wheelchair and taken to the lobby to sit alone	F 323			

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

TITLE

(X6) DATE

*Stephanie Service*

*Administrator*

*3-29-12*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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.

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F 323	<p>Continued From page 1</p> <p>while the staff continued their morning rounds. Interview with staff revealed they were going about doing their assigned duties on the hall and monitored the resident when they could.</p> <p>Findings include:</p> <p>A review of the policy entitled "Fall Prevention" revised 08/04/09, revealed a Comprehensive Side Rail/Device/Fall Assessment is completed on all residents upon admission/re-admission, quarterly, as needed (PRN), and with any significant change of condition. As with all events, residents are thoroughly assessed prior to moving from the site of the event. Skin, range of motion, neurological signs, level of consciousness, etc, are assessed to immediately identify any injury sustained. With all events, follow-up documentation must be done every shift x 24 hours if no injury noted and every shift x 48 hours if any injury is sustained.</p> <p>Resident #2 was admitted to the facility on 02/02/12 (readmitted on 02/15/12) with diagnoses to include Cerebral Vascular Accident (CVA), Dementia without Behavior Disturbance, Depressive Disorder and Hypertension. Assessment of Resident #2 revealed he/she was at risk for falls. A review of the Fall Assessment dated 02/03/12 revealed Resident #2 was assessed to be a falls risk and staff initiated a pressure alarm to his/her bed and wheelchair. A review of the comprehensive care plan "At risk for falls" dated 02/16/12 revealed staff was to keep the environment free clutter, keep frequent used items within reach, encourage the resident to ask for assistance, monitor condition of shoes and have repaired, restorative to evaluate and place</p>	F 323	<p>2. An audit on all alarms was completed on 3/29/2012. The alarms were checked for proper placement and function. A review of all falls that occurred within the past 90 days was completed on 3/29/2012. During the review, the IDT investigated each incident to identify causal factors and make sure the appropriate intervention to prevent another fall was in place.</p> <p>3. Staff was in-serviced on 3/26/2012 on Accident Prevention and Safety, Falls, and Restraints. The Administrator completed a CE for NHA on "Preventing Falls: Keeping Residents Safe" on 3/26/2012. The Fall Prevention Policy was revised on 3/27/2012 to state that after every fall that resident be placed on 15 min checks for 72 hours and charted on every shift for 72 hours. The IDT will</p>		

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F 323	<p>Continued From page 2</p> <p>In effective programs, therapy disciplines to screen, evaluate and treat indicated as needed, fall risk assessment done quarterly and as needed. A review of the admission Minimum Data Set (MDS) dated 02/16/12 revealed he/she had a Brief Interview of Mental Status (BIMS) score of "6". Resident #2 was severely impaired in his/her cognition and never made any decisions. He/she required extensive assistance of two staff with activities of daily living.</p> <p>A review of the nurses notes dated 02/26/12 at 4:00 AM, revealed the resident was found sitting in the middle of the floor of his/her bedroom. Registered Nurse (RN) #1 assessed the resident and found no injuries. The resident was care planned to have a pressure alarm to his/her bed and wheelchair. A phone interview with Registered Nurse (RN) #1, on 03/09/12 at 10:44 AM, revealed the resident had been found on the floor of his/her bedroom at 4:00 AM on 02/26/12. The resident was assisted back to his/her wheelchair. Resident #2 was taken to the lobby by the CNA. At 5:15 AM, RN #1 documented the resident was lying in the floor of the lobby actively bleeding from the laceration on the bridge of his/her nose. The nurse documented the fall was not witnessed and staff would treat the resident as a possible head injury. About 5:15 AM, RN #1 reported in interview the resident was found lying in the lobby floor and she was unable to recall if the alarm to his/her wheelchair was sounding. The resident was alone in the lobby at the time of his/her fall. She was unable to monitor the resident while she completed accu checks and/or tube feedings. A phone interview with Certified Nursing Assistant (CNA) #2, on 03/09/12 at 8:56</p>	F 323	<p>investigate each fall to determine adequate supervision, assistance device, and causal factors and implement resident specific intervention.</p> <p>4. A new CQI Form N-31 titled, "Fall Safety/Accident Investigation Inspection", was implemented and will be completed every week for 4 weeks, then quarterly thereafter.</p>	3/29/2012	

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F 323	<p>Continued From page 3</p> <p>AM, revealed she did not witness Resident #2's fall on 02/26/12. She assisted with getting the resident in the wheelchair, but did not see the resident afterwards. During rounds they were answering call lights and helping the other residents get up. She revealed the resident was watched when they could because the two aides working the hall were helping other residents at the time.</p> <p>The resident also complained of pain in his/her right arm and hip. RN #1 contacted the physician and he ordered for the resident to be sent to the local hospital for evaluation and treatment. Additionally, the family was notified of the incident. The record revealed at 8:00 AM, the facility transferred Resident #2 to the hospital for evaluation. At 11:00 AM, Resident #2 returned to the facility having been diagnosed with a nasal contusion and treated with the Derna bond skin adhesive. Staff was to monitor the abrasion to the nose for five days.</p> <p>An interview with the Director of Nursing (DON), on 03/07/12 at 6:07 PM, revealed the resident had two falls on 02/26/12. The resident was found in the floor at 4:00 AM with no injuries and the staff assisted the resident up and placed him/her in their wheelchair. The staff placed the resident in the lobby afterwards and at 5:15 AM, Resident #2 was found in the lobby floor. Resident #2 was observed bleeding from the bridge of his/her nose and the staff sent the resident out for evaluation at the local hospital. During the fall at 5:15 AM, the resident was left unsupervised while staff was getting other residents up. The resident had a tendency to lean to the right and she thought the resident</p>	F 323			

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F 323	Continued From page 4 probably leaned to far resulting in him/her falling out of the wheelchair. The DON revealed the incident was unwitnessed. She revealed the staff did not supervise the resident while he/she was sitting in his/her wheelchair in the lobby.	F 323			