

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186049 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/10/2012 |
| 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 | F 000 | | |
| F 281 SS=0 | <p>An abbreviated survey (KY #18237 and KY #18280) was conducted on 05/09/12 and concluded on 05/10/12 to determine the facility's compliance with Federal requirements. KY #18237 and KY #18280 were found to be substantiated with deficiencies cited at the highest scope and severity of a "D."</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a newly admitted resident's interim care plan was revised to the address the resident's onset of behaviors during a short-term stay in the facility for one resident (#2), in the selected of four residents.</p> <p>Findings include: A review of the facility's policy/procedure for "Care Plan-Goals and Objectives" (no date), revealed a preliminary plan of care to meet the residents' immediate needs shall be developed for each resident within twenty-four hours of admission. The Interdisciplinary Team will review the Attending Physician's order, dietary needs, medications and implement a nursing care plan to meet the residents' immediate care needs. The preliminary care plan will be used until the staff can conduct the comprehensive assessment and</p> | F 281 | <p>483.20(k)(3)(i) Services Provided Meet Professional Standards</p> <ol style="list-style-type: none"> 1. Resident #2 was discharged on 3/10/12 to the Bowling Green Medical Center and was not accepted for return due to being a danger to self and/or others. 2. An Audit was conducted on 5/29/12 thru 5/30/12 on newly admitted residents within the past thirty days to make sure the interim care plan was revised to address any new onset of behaviors or other incidents. 3. Revised Policy titled "Care Plan-Preliminary" on 5/29/2012. Administrator In-Serviced facility staff on revised policy on 5/30/12 to include: After a behavior has just occurred and the Behavior Mapping Record is addressed, the care plan will be revised at that time. Also, during morning clinical meetings, if revision was required on a care plan, that care plan will be reviewed to ensure that it was updated. | 5/30/2012 |

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

Stephanie Semrce

TITLE

Administrator

(X6) DATE

6/1/2012

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 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 281 | <p>Continued From page 1 develop an interdisciplinary care plan.</p> <p>A record review revealed the facility admitted Resident #2 on 02/27/12 with diagnoses to include Psychosis and Anxiety.</p> <p>A review of a Behavioral Mapping Record, dated March 2012, revealed Resident #2 exhibited behaviors on 03/01/12, to include being resistive to care, being verbally abusive, throwing objects, dangerous wheelchair maneuvers, socially inappropriate behavior, physically aggressive behavior, and screaming/yelling. There was no evidence of a revised interim care plan implemented to address the resident's behaviors. Further review revealed, on 03/06/12, behaviors included being verbally abusive, physically aggressive, and screaming/yelling. There was no evidence of a revised interim care plan implemented to address the resident's behaviors.</p> <p>A review of a nurse's note, dated 03/07/12 at 12:25 AM, revealed Resident #2 became physically aggressive toward Resident #3 and required one to one supervision until he/she was transferred to the hospital. Resident #3 sustained minor swelling to his/her forearm.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator, on 05/10/12 at 10:00 AM, revealed there was an interim care plan for Resident #2; however, there were no interventions to address the behaviors identified by the staff or documentation of the resident's behavior on the Behavior Mapping Record since admission. She stated the staff should have updated the resident's interim care plan after each behavior was identified.</p> | F 281 | <p>4. CQI Form N-19 titled "RAI Process" was revised on 5/29/12. N-19 will be completed by DON or designee weekly for 4 weeks then monthly for 3 months then quarterly thereafter.</p> <p>5. Completion Date 5/30/12</p> | |

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| F 281 | Continued From page 2 | F 281 | | | |
| F 282 SS=D | <p>An interview with the Director of Nursing (DON), on 05/10/12 at 9:15 AM, revealed Resident #2 did not have any new interventions on his/her interim care plan to address the behaviors the resident exhibited. The interventions on the interim care plan were dated 02/27/12, which was the resident's admission date to the facility, and no further updates were completed even though new behaviors were identified.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and a review of the facility's policy and procedure, the facility failed to ensure services were provided or arranged by qualified persons in accordance with each resident's written plan of care for one resident (#1), in the selected sample of four residents. Resident #1 was care planned not to be within arms' length of any other residents; however, on 04/25/12 at 8:30 AM, it was reported that Resident #1 bit another resident (#4), causing a skin tear on the second finger of Resident #4's right hand.</p> <p>Findings Include: A review of the facility's policy/procedure, Care Plan-Goals and Objectives, undated, revealed</p> | F 282 | <p>483.20(k)(3)(ii) Services By Qualified Persons/Per Care Plan</p> <ol style="list-style-type: none"> Staff was in-serviced 5/30/2012 on Resident #1 plan of care. An audit of ten residents with a history of behaviors was completed on 5/30/12 thru 5/31/2012 by Administrative staff to ensure services were provided or arranged by qualified persons in accordance with each of those residents' plan of care. Revised Policy titled, "Care Plan Goals and Objectives" on 5/29/12. Administrator In-Serviced Facility staff on revised policy on 5/30/12. | 5/31/2012 | |

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| F 282 | <p>Continued From page 3</p> <p>that goals and objectives were entered on the resident's care plan so that all disciplines have access to such information and were able to report whether or not the desired outcomes were being achieved. Goals and objectives were reviewed and/or revised when the desired outcome was not achieved. Changes in the resident's condition must be reported to the Minimum Data Set (MDS) Coordinator so that a review of the resident's assessment and care plan could be made.</p> <p>A record review revealed the facility admitted Resident #1 on 12/22/10 with diagnoses to include Motor Vehicle Accident with Brain Trauma with a Right Ventricular Peritoneal Shunt, Legally Blind, Left Hemiparesis, Mental Retardation, History of Seizures, and Anxiety Disorder. A review of the annual MDS, dated 12/03/11, revealed the facility coded Resident #1 to be severely cognitively impaired.</p> <p>A review of Resident #1's care plan, At Risk for Altered Mood State, reviewed 12/05/11, and updated 01/12, revealed he/she was not to be within arm's length of any other residents or any other objects, and to report any behaviors to the Charge Nurse promptly. Further review of the care plan, dated 02/27/12, revealed he/she exhibited behaviors to include screaming, yelling, crying/tearful, and repetitive physical movements.</p> <p>A review of the nurse's notes, dated 04/25/12 at 8:30 AM, revealed Resident #1 bit Resident #4 on his/her second finger on his/her right hand which caused a skin tear measuring 0.5 centimeters (cm) x 1 cm.</p> | F 282 | <p>4. CQI Form N-19 "RAI Process" was revised on 5/29/12. N-19 will be completed by DON or designee weekly for 4 weeks then monthly for 3 months then quarterly thereafter.</p> <p>5. Completion Date 5/31/12</p> | | |

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| F 282 | <p>Continued From page 4</p> <p>An interview with Resident #4, on 05/09/12 at 3:00 PM, revealed he/she was bitten by Resident #1, and did not know the reason why this occurred. He/she stated it happened so quickly, that before he/she knew it, Resident #1 had bitten his/her hand and it was bleeding.</p> <p>An interview with Certified Nurse Aide (CNA) #2, on 05/09/12 at 3:15 PM, revealed, on 04/25/12, after the meal, each of the CNAs were assisting the residents back to their rooms. During this time, she observed Resident #1 who had Resident #4's hand and was pulling him/her towards him/her. Resident #4's hand was bleeding at that time.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 05/09/12 at 3:30 PM, revealed that she was notified by CNA #2 that Resident #4's finger was bleeding. She stated she questioned Resident #1 about biting Resident #4, and Resident #1 told her that he/she did bite Resident #4. Resident #1 was placed on 15 minute checks at that time. She revealed Resident #1 was care planned not to be within arms' length of any other residents.</p> <p>An interview with the MDS Coordinator, on 05/09/12 at 4:00 PM, revealed that she was responsible for updating the care plans. She stated that in January 2012, Resident #1 was pulling books off the nurse's station and that he/she added the intervention to his/her care plan for him/her not to be in arms' reach of any objects or other residents. She stated she felt that Resident #1 was too close to Resident #4 and grabbed his/her hand; however, the care plan was not followed.</p> | F 282 | | | |

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| F 282 | Continued From page 5 | F 282 | | |
| F 323 SS=D | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision to prevent accidents for two residents (#1 and #4), in the selected sample of four residents. It was reported, that on 04/25/12 at 8:30 AM, Resident #1 bit Resident #4, causing a skin tear on the second finger of Resident #4's right hand.</p> <p>Findings include: A review of the facility's policy and procedure, Accidents and Supervision, undated, revealed the</p> | F 323 | <p>483.25(h) Free of Accident Hazards/Supervision/Devices</p> <ol style="list-style-type: none"> 1. Resident #4 received treatment for the skin tear on 4/25/12. Facility staff was in-serviced by Administrator on Resident #1 plan of care on 5/30/12. 2. An audit of ten residents with a history of behaviors was completed Administrative staff on 5/31/12 to ensure that the residents' environment remains as free of accident hazards as is possible, and each resident receives adequate supervision to prevent accidents. 3. Administrator In-Serviced Facility staff on 5/30/2012 on Policy titled, "Accidents & Supervision." 4. CQI Form SS-3, "Reporting Resident's Incidents" will be completed weekly by the Social Services Director or designee for 4 weeks, then monthly for 3 months and quarterly thereafter. 5. Completion Date 5/31/12 | 5/31/2012 |

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| F 323 | <p>Continued From page 6</p> <p>facility would provide adequate supervision to prevent accidents. Supervision was enhanced when the facility determined that the supervision of a resident was necessary and provided supervision based on the individual residents assessed needs and the risk identified in the environment.</p> <p>A record review revealed the facility admitted Resident #1 on 12/22/10 with diagnoses to include Motor Vehicle Accident with Brain Trauma with a Right Ventricular Peritoneal Shunt, Legally Blind, Left Hemiparesis, Mental Retardation, History of Seizures, and Anxiety Disorder. A review of the annual Minimum Data Set (MDS), dated 12/03/11, revealed the facility coded Resident #1 to be severely cognitively impaired.</p> <p>A review of Resident #1's care plan, At Risk for Altered Mood State, reviewed 12/05/11, and updated 01/12, revealed he/she was not to be within arm's length of any other residents or any other objects, and to report any behaviors to the Charge Nurse promptly. Further review of the care plan, dated 02/27/12, revealed he/she exhibited behaviors to include screaming, yelling, crying/tearful, and repetitive physical movements.</p> <p>A record review revealed the facility admitted Resident #4 on 10/03/11, and was re-admitted to the facility on 03/21/12, with diagnoses to include Atrial Fibrillation, Hypertension, General Osteoarthritis, Fracture Neck of Femur, Gout, and Pressure Ulcer.</p> <p>A review of the quarterly MDS, dated 03/20/12, revealed the facility coded Resident #4 to be cognitively intact with a Brief Interview Mental</p> | F 323 | | |

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| F 323 | <p>Continued From page 7</p> <p>Score (BIMS) of 13.</p> <p>A review of the nurse's notes, dated 04/25/12 at 8:30 AM, revealed Resident #1 bit Resident #4 on his/her second finger on his/her right hand which caused a skin tear measuring 0.5 centimeters (cm) x 1 cm.</p> <p>An interview with Resident #4, on 05/09/12 at 3:00 PM, revealed he/she was bitten by Resident #1, and did not know the reason why this occurred. He/she stated it happened so quickly, that before he/she knew it, Resident #1 had bitten his/her hand and it was bleeding.</p> <p>An interview with Certified Nurse Aide (CNA) #2, on 05/09/12 at 3:15 PM, revealed, on 04/25/12, after the meal, each of the CNAs were assisting the residents back to their rooms. During this time, she observed Resident #1 who had Resident #4's hand and was pulling him/her towards him/her. Resident #4's hand was bleeding at that time.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 05/09/12 at 3:30 PM, revealed that she was notified by CNA #2 that Resident #4's finger was bleeding. She stated she questioned Resident #1 about biting Resident #4, and Resident #1 told her that he/she did bite Resident #4. Resident #1 was placed on 15 minute checks at that time. She revealed Resident #1 was care planned not to be within arms' length of any other residents.</p> <p>An interview with the MDS Coordinator, on 05/09/12 at 4:00 PM, revealed she added an intervention to Resident #1's care plan for him/her</p> | F 323 | | | |

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| F 323 | Continued From page 8 not to be in arms' reach of any objects or other residents. She stated she felt that Resident #1 was too close to Resident #4 and grabbed his/her hand. An interview with the Director of Nursing (DON), on 05/09/12 at 10:50 AM, revealed Resident #1 was care planned not to be within arms' length of any other residents; therefore, the care plan was not followed. No further explanation was provided. | F 323 | | | |