STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING _____________________________
B. WING _____________________________

DATE SURVEY COMPLETED
C 08/14/2014

MULTIPLE CONSTRUCTION

NAME OF PROVIDER OR SUPPLIER

AUTUMN CARE OF RAEFORD

STREET ADDRESS, CITY, STATE, ZIP CODE

1206 N FULTON STREET
RAEFORD, NC  28376

SUMMARY STATEMENT OF DEFICIENCIES

(F) 323 9/11/14

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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 observation, staff and resident interviews and review of the medical record, the facility failed to determine the cause of a fall and place interventions after falls for 1 of 3 residents (Resident # 3) that was reviewed for falls.

Findings included:

Resident #3 was admitted on 5/13/13 with diagnoses that included peripheral vascular disease, Alzheimer’s disease, hypertension, joint pain and generalized muscle weakness.

Progress notes for 4/22/14 at 3:53 AM, indicated the resident was sitting on the floor in front of her wheelchair. She stated she was trying to go to the bathroom. The note indicated non-skid socks were in place and the call light was on the bed. The intervention used was to reinforce the use of the call bell.

The Annual Minimum Data Set (MDS), dated 5/6/14, indicated the resident had severe cognitive impairment, scoring 0 on her Brief Interview for Mental Status (BIMS). The MDS indicated the resident required limited assistance.

Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the conclusions stated on the Statement of Deficiencies. This Plan of Correction is prepared and submitted solely because of requirements under State and Federal Law.

For the resident affected: Due to resident’s increased confusion and behaviors reported by the State Surveyor, Nurse #1 and the NA, a UA/C&S was done immediately. Side rail pads were also added to side rails in an effort to prevent Resident #3’s limbs from getting caught in railing. The preliminary results returned on 8/15/2014 which appeared to be showing a probable UTI. The MD ordered Cipro HCI mg BID x 7 days. On 8/20/2014, the complete UA/C&S results were received and revealed Resident # 3 had E. Coli UTI. MD was made aware and reviewed results. MD ordered Cipro to be discontinued and a new order for Rosephin 1gm/ vial injection solution QD x

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

Electronically Signed

08/21/2014

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.
### F 323

Continued From page 1

with transfers. There had been one fall since the prior assessment.

Review of Resident # 3's care plan indicated falls was identified as a focus area on 05/13/13. Goals listed to assist the resident in having no falls included the use of proper and non-skid footwear when out of bed, a flat call bell and total lift for transfers. There was no documentation on the care plan that indicated new interventions were added after the April 2014 fall.

An observation was made on 8/14/14 at 9:15 AM. Resident # 3 was observed in bed with the side rails up. The resident was lying cross-wise the bed with her head over the rail closest to the door and her feet over the opposite rail. The bed was in a high position. Nurse # 1 was requested to intervene to keep the resident from falling. Nurse # 1 and a nursing assistant (NA) repositioned the resident in bed.

Resident # 3 was observed on 8/14/14 at 1:46 PM. The resident was sitting in the wheelchair with the flat call bell placed on the bed. The resident was unable to locate the call bell and reached down to the floor when asked to find the bell.

NA # 1 was interviewed on 8/14/14 at 1:58 PM. She stated she was familiar with Resident # 3. The NA stated Resident # 3 was at risk for falls. Interventions identified by the NA for fall prevention included moving the wheelchair away from the bed so the resident would not try to get up, peek in the room when walking by the room and getting her up if she was agitated. The NA stated prior to this morning she had not seen the resident hanging over the rails, adding the

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resident was more agitated than usual today.

On 8/14/14 at 2:09 PM, Nurse # 2 was interviewed. Nurse # 2 was the lead nurse for B hall and stated he was familiar with Resident # 3. Nurse #2 stated Resident # 3 was alert and oriented to family only and was unable to remember instructions. He stated you could instruct her on calling for help prior to getting up, the resident would be able to verbalize and may even understand, but she would be unable to recall that information. Nurse # 2 was unaware of the April 2014 fall, but was aware the resident had previous falls. Nurse # 2 stated the expectation was for the nurse on duty to place immediate interventions at the time a resident fell. The nurse would also be expected to communicate the fall and intervention to the on-coming nurse as well as add it to the 24 hour report.

Nurse # 1 was interviewed on 8/14/14 at 3:04 PM. She stated she was not familiar with Resident # 3. The nurse stated when she entered Resident # 3’s room this morning she was lying across the bed with her head on the rail and her feet hanging off the other side. Nurse # 1 added she and a NA repositioned the resident.

The Assistant Director of Nursing (ADON) was interviewed on 8/14/14 at 3:11 PM. She stated when a resident fell it was the expectation for the nurse to assess the resident. If there were no injuries, the expectation would be for all staff involved to discuss what happened to determine the cause of the fall. The nurse on duty would be expected to place an immediate intervention. The ADON was unsure if it were facility policy to complete an Event Investigation report, adding the fall could be identified by an ALERT note.

areas of concern are found, the audit will then be reduced to weekly x 3 months. Any areas of concern will be discussed in the quarterly Quality Assurance Meeting and addressed accordingly.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1206 N Fulton Street, Raeford, NC 28376

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The ADON reviewed the progress note for the April 2014 fall and acknowledged there was no Event Investigation or new intervention for this fall. The ADON added with a score of 0 on the BIMS, education and reminders would not be an appropriate intervention for Resident #3.

On 8/14/14 at 3:43 PM, the Administrator was interviewed. She stated it was the facility policy to complete an Event Investigation and initiate immediate interventions after each resident fall. The Administrator reviewed the progress notes and the care plan for Resident #3 and acknowledged there were no new interventions added. She acknowledged an Event Investigation had not been completed for the April 2014 fall. The Administrator stated since the Event Investigation had not been completed, there was no trigger for the fall, and therefore, no intervention had been added.

The Director of Nursing (DON) was interviewed on 8/14/14 at 4:37 PM. She stated it was the facility policy to complete an Event Investigation after a resident fall. This was important, she added, in tracking and trending falls to determine the root cause of the fall. The expectation would be for the nurse on duty to add a new intervention at the time of the fall. The DON acknowledged there was no Event Investigation and intervention added for Resident #3’s April 2014 fall. She added with a BIMS score of 0, Resident #3 could not be educated or reminded to call for assistance.