

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

PRINTED: 10/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/22/2011
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 305 TAYLOR STREET #402 BUTLER, KY 41006	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	<p>An Abbreviated Survey Investigating ARO#KY00017004, #KY00017006 and #KY00017007 was conducted 09/14/11 through 09/22/11 with deficiencies cited with the highest scope/severity of a "D". ARO#KY00017006 was substantiated with a deficiency cited. ARO#KY00017004 and ARO#KY00017007 were substantiated with no deficiencies cited.</p> <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 and record review it was determined the facility failed to ensure the resident environment remained free of accident hazards for two (2) of eight (8) sampled residents (Resident #3 and #7). The facility failed to have a system in place to ensure residents did not have access to safety razors.</p> <p>On 08/20/11, Resident #3 had an altercation with his/her roommate, Resident #7, requiring staff intervention for separation, then was found in their room waving a safety razor in an angry and threatening manner.</p>	F 323	SEE Attachment	

RECEIVED
OCT 14 2011

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

Kevin W. [Signature]

TITLE

Administrator

(X8) DATE

10/13/2011

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 323	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility admitted the resident on 06/28/06, with diagnoses which included Mild Cognitive Impairment, Dysphagia, Anorexia, Difficulty in Walking, Chronic Pain, Depressive Disorder, Protein-Calorie Malnutrition and Delirium.</p> <p>Review of the most recent Quarterly Resident Assessment Instrument (RAI) revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated severe cognitive impairment.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/16/11 at 8:45 PM, revealed on 08/20/11 Resident #3 had been separated from his/her roommate, Resident #7, due to an altercation in which Resident #7 had pulled a clump of Resident #3's hair out. Resident #3 was taken to the nurses station following the altercation, however Resident #3 had some how made his/her way back to the room. She indicated she went to the room looking for Resident #3 and found him/her to be sitting with his/her back towards the door in front of the drawers next to the sink. She further stated she asked Resident #3 what he/she was doing and the resident turned his/her wheel chair around and she noted the resident was holding a safety razor, swiping it up and down in the air. She stated Resident #7 was in the room and Resident #3 was stating, "he/she is not going to pull my hair any more". CNA #1 stated she removed the razor from the resident's hand and took the resident back to the nurses station. Further interview revealed Resident #3 should not have had access to the razor and it</p>	F 323		
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F 323	<p>Continued From page 2 may have been left in the room after a CNA had shaved one (1) of the residents.</p> <p>Interview with Registered Nurse (RN) #1, on 09/21/11 at 7:03 PM, revealed CNA #1 had taken a safety razor from Resident #3 on 08/20/11 after the resident was waving the razor around in a threatening manner. She further stated Resident #3 and Resident #7 had an altercation earlier in the day in which Resident #7 had pulled a clump of Resident #3's hair out. Further interview revealed when CNA #1 found Resident #3 back in his/her room after the residents had been separated. Resident #3 had a razor in his/her hand and was stating, "he/she will not pull my hair any more". She further indicated residents should not have access to razors and the CNA's may have left the razor in her room. Further interview revealed razors are a safety hazard for residents and this was why they should not be left in the room.</p> <p>Interview with the DON and Assistant Director of Nursing (ADON), on 09/22/11 at 4:42 PM, revealed there was no written facility policy related to razors being in residents' rooms.</p> <p>Interview with Kentucky Medication Aide (KMA) #2, on 09/21/11 at 12:35 PM, revealed residents should not have access to safety razors. She further indicated the razors were kept in a locked linen closet and when CNA's were done using them, they were to throw them away in a sharps container.</p> <p>Interview with the Director of Nursing (DON), on 09/22/11 at 4:15 PM, revealed residents should not have unsupervised access to razors.</p>	F 323		

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Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

F 323

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.

1.) What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?

Resident number 3 was at risk related to resident # 3 had a BIMS score of 3 and was upset with resident #7. Resident #3 had access to a shaving razor. The razor was removed from resident #3's hand, when the staff approached the room. The room was searched and no other sharp edged items were found in the room. On 8/23/11 resident #7 was moved to a different room. Resident #7 was placed with a resident who does not get into others items. Resident #3 got a new roommate on 8/23/11 and through several different interviews had stated that she was content with new roommate.

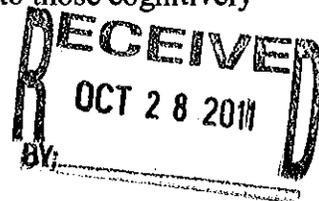
2.) How will facility identify other residents/patients having potential to be affected by the same deficient practice?

All cognitively impaired residents are at risk for accident hazards regarding razors. All residents charts were audited to ensure that any resident with poor cognition did not have access to razors. Any cognitively impaired resident means any resident with a BIMS (Brief Interview for Mental Status) score of 9 or less. The BIMS score is checked with each Minimum Data Set (MDS 3.0) that is done on each resident.

3.) What measures have been put into place and/or what systemic changes will the facility make to ensure the deficient practice does not recur?

Initial teaching moments (regarding razor use with cognitively impaired residents) were placed at each nurse's station and by the time clock (see attachment #1) on 8/22/11, to alert staff that no resident should have razors at the bedside. Staff is to read the teaching moments and then sign for acknowledgment of understanding. All resident rooms were searched and razors that were found were removed. Subsequent teaching moments were placed at both nurses station and by the time clock on 9/12/11 and again on 10/12/11.

The November resident newsletter will have an article for residents and families reminding them that razors are not to be left at the bedside, unless nursing gives permission. The newsletter article will remind families not to bring in any type of sharp object to those cognitively challenged residents.



A policy (see attachment #2) was written on 10/3/11, and placed at both nurses stations, in the dietary department and by the time clock to remind all staff that razors should not be left at the bedside for any residents, unless a nurse has instructed differently (for cognitive residents only). An educational memo (see attachment #3) is going out (Initiated 10/27/11) to all staff, to read and sign for further validation that all staff is aware of razors policy for the cognitively impaired residents. The educational memo was written by the DON. Instruction was given to staff by the DON and the ADON.

4.) How will the facility plan to monitor its performance to ensure that solutions sustained?
Random quality assurance room checks will be done (by the ADON, who is also the Quality Assurance Nurse) weekly for 1 month, then twice monthly x's 2 months, then monthly x's 1 quarter. Quality assurance audits will be done randomly for 1 year, thereafter to ensure continued compliance of razors policy. If razors are found in a "cognitively impaired residents room, then further teaching moments will be given to remind staff of the continued concern, to help continue with reeducation.

5.) Date that all corrections will be completed by:

All corrections regarding N219 will be completed by November 9, 2011.

Attachment #1

TEACHING MOMENT FOR RAZOR USE

Date: 10/12/2011

Subject(s): Razor found in room 15B1 and 6B1

Information (handouts) provided:

- ❖ Educated staffs on importance of razors not being keep in possession of residents whom are not alert and oriented, BIMS score less than 9.
- ❖ Razor policy and Procedure attached
- ❖ Copy of residents current BIMS scores attached

Attachment #2

River Valley Nursing Home Razor Policy and Procedure

F323 Free of accidents and hazards

The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Policy: It is the policy of River Valley Nursing Home to assure safety to all residents whom reside in the facility. Razors will not be left in resident's possession if the resident has a BIMS (Brief Interview for Mental Status) score of 9 or less, or nursing has assessed resident as "unsafe."

Procedure:

- Brief Interview for Mental Status (BIMS) will be done on all residents to establish cognition.
- If the BIMS is assessed and indicates that the resident is rarely or never understood, then the resident will not be allowed razors at the bedside, unless specifically documented by nursing.
- The facility has the right to restrict razors at the bedside, as deemed to be "a risk."
- BIMS score of 9 or less indicates cognitive impairment.
- Razors can be left in rooms of residents who are alert and oriented X 3 to use at their discretion, according to BIMS score.
- Residents who are not alert and oriented X 3, razors will be used per staff as needed, as indicated by BIMS score.
- BIMS scores are conducted with Annual, Quarterly, Change of Status, Admission assessments, and per the PPS schedule for Medicare A stay residents.

Initiated October 3, 2011

Attachment #3 Thursday, October 27, 2011

Teaching Moment Memo regarding razor use with cognitively impaired residents:

Attention staff member:

Please read the information and policy (attached) and sign, date, and return to my office. By signing and dating below, you are validating that you understand the importance of not leaving razors at the bedside, unless your nurse has given permission.

All residents are at risk of injury. Our jobs are to minimize and prevent the risk associated with potential injuries. No razors are to be left in any residents rooms (unless your nurse has stated differently).

All cognitively impaired residents are not to be allowed to keep razors at the bedside NO MATTER WHAT!

Quality assurance checks are continuing. If you are in a room and see a razor, please dispose of the razor IMMEDIATELY!

Thank you,

Truly Pennington RN DON

Employee Signature

date

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