STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(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 A recert survey was conducted from 02/19/19 through 02/20/19. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/07/19 and was removed on 02/20/19. An extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, physician interview and staff interviews, the facility failed to maintain an environment as free from accident hazards as is possible by failing to discard a disposable razor safely after use. As a result, a disposable razor was found in the mouth of 1 of 5 sampled residents reviewed for accident hazards. Resident #1 was cognitively impaired. (Resident # 1) Immediate Jeopardy (IJ) began on 02/07/19 when	F 689	The plan for correcting this specific deficiency. On February 7, 2019 NA #2 notified Nurse #1 on incident with Resident #1. Resident #1's oral cavity was assessed for discoloration and open areas by Nurse #1. No injuries, redness or open areas noted. A procedure for implementing an acceptable plan of correction. On February 19, 2019 and February 20, 2019	2/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/08/2019

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 689	Continued From page 1 a disposable razor was found in the mouth of Resident # 1 whose cognition was severely impaired. Review of the resident's medical record and facility in-servicing records, as well as staff interviews, revealed after the 02/07/19 incident the staff was not in-serviced about how to discard disposable razors safely and root cause analysis was not completed to try and determine where and how the disposable razor was left next to Resident # 1. The IJ was removed on 02/20/19 when the facility implemented an acceptable credible allegation of IJ removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not IJ) to ensure monitoring of systems were carried out and employee in-servicing was completed. Findings included: Resident # 1 was admitted to the facility on 04/27/2018 with diagnoses including, dysphagia, dementia, and muscle weakness. The Quarterly Minimum Data Set (MDS) dated 1/9/2019 indicated the resident's cognition was severely impaired and no behavioral symptoms were noted. The MDS also indicated Resident # 1 required extensive assistance of 2 persons with bed mobility, dressing, and transfer and was independent with her eating. Resident # 1 had care plans for the following areas of concerns: Resident # 1 required a mechanical soft diet; The resident required extensive assistance with most activities of daily living (ADLs) check mouth after meal for pocketed food debris; report to nurse to provide	F 689	direct care givers were educated by the RN Supervisor, Staff Development Coordinator regarding the use of disposable safety razors at the bedside with an emphasis on resident safety, impaired cognition and Dementia diagnosis. Disposable safety razors are kept locked up in central supply and only nursing staff have access to them. Used disposable safety razors are placed in sharps containers in the resident's bathroom. This information will be included in the new employee orientation program for certified nurse aides and licensed nurses. The monitoring process to ensure that the plan of correction is effective and that specific deficiency remains corrected and/or in compliance. All Residents have the potential to be affected. On February 19, 2019 the licensed nurses and certified nurse aides checked all the resident's rooms for disposable safety razors. This was completed on February 19. 2019 on the day shift. 4 residents with a new disposable safety razor in their room were assessed by the RN supervisor for safety awareness and this was documented in their medical record. Those 4 residents were educated on keeping their 2 razors secure in their bedside stand and to be disposed in the sharps container in their bathroom after a one time use. They acknowledged and verbalized their understanding. This was completed on February 19, 2019. An audit was done on all resident's Brief	

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F 689	Continued From page 2 oral care to remove debris; Resident # 1 is in wheel chair when up out of bed; staff to assist with ADLs daily and encourage resident to participate in care as able. A nurse's note written by Nurse # 1 and dated 02/06/2019 documented, "Per Nurse Aide ((NA) # 2), she came to this nurse at 3:30 PM and reported that she found resident in her room in her bed with a used (disposable) razor blade in her mouth. This nurse immediately assessed patient and found no injuries at this time. Vital signs obtained and resident was monitored throughout the shift. Director of Nursing (DON) is aware, Medical Director (MD) and Power of Attorney (POA) aware. Incident report completed." An incident report written by Nurse # 1 and dated 02/07/2019 documented "Called to room per (NA # 2) who observed resident with dirty (disposable) razor blade in her mouth. Assessment completed per this nurse no injuries noted this time. Will monitor. Director of Nursing (DON) made aware. (Disposable) Razor blade was left at bed side table. Resident has dementia, she reached and picked (disposable) razor blade up and placed into her mouth. NA # 3 was interviewed on 02/19/2019 at 3:50 PM. NA # 3 reported she had an assignment at the facility as Restorative Aide (RA). NA # 3 reported she was not assigned to one particular resident at the facility but she visited residents and shaved them if she saw that they have chin hair or a long beard. NA # 3 indicated she recalled shaving Resident # 1 within the last 2	F 689	Interview for Mental Status (BIMs) assessment to validate current scores. Resident in question had new BIMs assessment done. Resident #1 BIMs score was 6. This was completed on February 20, 2019 by Social Services. Care Plan for Resident #1 updated on February 20, 2019 by the MDS RN regarding placing disposable items in mouth. Measure put in place or systemic changes made to ensure that the deficient practice will not occur. The administrative nurses will inspect 5 resident rooms for disposable safety razors or other items placing residents at risk (residents with BIMS of less than 10) 2 times weekly time 4 weeks, then weekly times 4 weeks to ensure compliance. The center plans to monitor performance to ensure correction is achieved and sustained. The Director of Nursing submitted the Performance Improvement Plan (PIP) to the Quality Assurance Process Improvement Committee (QAPI)on February 22, 2019. The QAPI committee accepted the plan and the audits. The Director of Nursing will report the findings of the audits to the QAPI committee monthly times 3 months or until a pattern of compliance is achieved.	

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F 689	Continued From page 3	F 689		

weeks but she did not recall the date when she shaved her. NA # 3 reported Resident # 1's family member had asked her to shave Resident # 1 on 02/01/2019. NA # 3 reported she did not recall leaving a disposable razor on Resident # 1's bed side table. She also reported the staff were trained to use a new disposable razor once and dispose them in the safety trash can where the sharp items were disposed in which was behind the bathroom door. She indicated they did not reuse the disposable razors. She further stated she usually kept the disposable razors in her pocket for easy access and also the disposable razors were kept in the medication room at the nurse's station.

NA #1 (7-3 shift) who was assigned to Resident # 1 on 02/07/2019 was interviewed on 02/19/2019 at 3:40 PM. NA #1 reported she did not recall leaving or taking a disposable razor in Resident # 1's room. NA # 1 reported she did sometimes shave Resident # 1's chin hair, but she did not recall shaving Resident # 1 on 02/07/2019.

NA # 2 (3-11 shift) who was assigned to Resident # 1 on 02/07/2019 was interviewed on 02/19/2019 at 3:45 PM. NA # 2 reported she just had reported to work at 3:00 PM on 02/07/2019 and while she was passing by Resident # 1's room she noticed a blue disposable razor in Resident # 1's mouth. NA # 2 reported that the part that was in the Resident 1's mouth was the sharp blades of the disposable razor. She also reported the disposable razor had been used because it did not have the safety cap on. NA # 2 stated she took the disposable razor out of Resident # 1's mouth and threw it in the sharp items container behind the resident's bathroom door. She then

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F 689	Continued From page 4	F 689		

reported the incident to Nurse # 1.

Nurse # 1 (3-11 shift) who was assigned to Resident # 1 on 02/07/2019 was interviewed via telephone on 02/19/2019 at 1:30 PM. Nurse # 1 reported she went to Resident # 1's room in the afternoon about 3:30 PM because NA # 2 found Resident # 1 with a disposable razor in her mouth. Nurse # 1 reported she was asked by Director of Nursing (DON) to write an incident report about the disposable blade that was found in Resident # 1's mouth.

Observation of Resident # 1 on 02/19/2019 at 1:45 PM revealed the resident sitting in wheel chair beside her bed. The bedside table was next to the resident. The table had crackers and a white cup with a straw. The Resident was observed reaching for crackers and asking for help from a Nurse assistant to open up the cracker packages. The resident was observed putting the crackers in her mouth. No disposable razors were observed in Resident #1's drawer or on the bed side table.

Nurse #2 (7-3 shift) who was assigned to Resident # 1 on 02/07/2019 was interviewed on 02/19/2019 at 2:00 PM. Nurse #2 reported Resident # 1 had no history of chewing items that are not food. She reported Resident #1 liked to snack on items like cookies and crackers all the time. Nurse # 2 reported she was not aware of Resident # 1 being found with a disposable razor in her mouth. Nurse #2 reported Resident # 1 was usually very organized with her bed side table and she was surprised 1st shift Nurse's Aide or Nurse did not see the disposable razor on Resident # 1's bed side table. She further reported the disposable razors were kept in the

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F 689	Continued From page 5	F 689		

medication room by the nurse's station.

The Director of Nursing (DON) was interviewed on 02/19/2019 at 4:00 PM. The DON reported she was aware of the disposable razor found in Resident # 1's mouth but she did not follow up to find out about the outcome of the investigation. She reported she was not aware the investigation had not been completed by the hall nurse. DON reported she was not aware of how the disposable razor got in Resident # 1's room since the resident could not get out of her bed independently. The DON reported disposable razors were always kept in the medication room by the nurse's station.

The Administrator was interviewed on 02/19/2019 at 4:27 PM. The Administrator reported she was not aware how the disposable razor got on the table Resident # 1's bed side table and she did not recall completing the investigation to conclude how Resident # 1 got access to the disposable razor blade that she put in her mouth. She further reported her expectation was to complete an investigation within 48 hours but they failed to complete the investigation in reference to Resident # 1's incident on 02/7/2019.

The Physician was interviewed on 02/20/2019 at 9:30 AM. The Physician reported his expectation was for the facility to safely discard the disposable razors after each use. He reported the facility always notified him with any change of Resident # 1's condition. The Physician also stated it had not been reported to him before 02/7/2019 that Resident # 1 was putting items in her mouth that were not edible.

The Administrator was notified of the Immediate

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F 689	Continued From page 6 Jeopardy on 02 /20/19 at 10:30 AM. On 02/20/19 the facility provided an acceptable credible allegation for Immediate Jeopardy removal that included the following: The plan of correcting the specific deficiency including the processes that led to the deficient practice cited on 2/20/2019 at approximately 11:00 AM: Description of Incident: On 02/07/2019 at approximately 3:30pm, Resident #1 was observed in her room, in bed, with over bed table in front of her (resident in semi-private room) by NA #2. NA #2 observed Resident #1 with a disposable razor in her mouth with lips closed around the disposable razor. The aide asked Resident #1 to hand her the disposable razor and resident removed the disposable razor from her mouth and handed it to NA #2. The (Brief Interview for Mental status (BIMs) on Resident #1 on 02/20/19 is 6. Corrective action will be accomplished for the resident found to have been affected by the deficient practice: The resident's oral cavity was assessed for discoloration and open areas by Nurse #1. No injuries, redness or open areas noted on 2/7/2019 The resident RP (Responsible Party) and MD (Medical Doctor) were notified of the incident on 02/7/19, per information form incident report. Resident # 1 was not seen by MD on 02/7/19. On the a.m. (morning) of 02/19/19 the incident report was given to Executive Director, the information in reference to Resident # 1 being	F 689		

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F 689	Continued From page 7	F 689		

found with a disposable razor was reviewed and in-servicing of staff about safely disposing of disposable razors by RN (Registered) nurse manager the in-service was completed 2/20/2019. Investigation initiated at this time. A call was made by the Administrator to the family member regarding Resident #1 and razors. Administrator educated family on the facility providing the disposable razors so we ensure safely disposing of disposable razor after use. I asked her not to bring any in. Upon investigation, a late entry was made by Nurse # 1 on 02/12/19 in Resident 1's medical record stating on 02/6/19 incident occurred. Incident report submitted by same Nurse # 1, indicated incident as occurring on 02/7/19. NA #2 stated 02/7/19 as date of occurrence. Since Nurse #1 is no longer employed as of 02/15/19, cannot validate actual date of incident report completion or whom Nurse 1 gave report to.

All residents have the potential to be affected. Upon notification on the incident, 02/19/19, the Executive Director instructed the RN supervisors to have the Licensed Nurses and NA's to check all resident rooms for disposable razors. This was completed on 02/19/19 on 7-3 shift. 3 Residents with disposable razors in their room were assessed for safety awareness and this was documented in their medical record. Those 3 residents were educated on keeping their razors secure in their bed side stand. They acknowledge and verbalized understanding. This was completed on 02/19/19.

An audit was done on all residents BIMS assessment to validate current scores. Resident in question had new BIMs assessment done. Resident #1 BIMs score was 6. This was

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F 689	Continued From page 8	F 689		

completed on 2/20/19 by Social Services. Care Plan was updated on 02/20/19 by the MDS RN regarding placing disposable razor in mouth.

Measures put into place or systemic changes made to ensure that the deficient practice will not occur: 02/19/19 and 02/20/19 direct care givers were re-educated by the Nursing Supervisor and Executive Director on the timeliness of reporting incidents and accidents with emphasis on reporting and documenting the incidents in the medical record. The direct care givers were also educated regarding the use of disposable razors at the bed side with an emphasis on resident safety, impaired cognition and dementia diagnosis. This information will be included in the orientation program for direct care givers. Disposable razors are kept locked up in central supply and only nursing staff have access to them. Used disposable safety razors are placed in sharps containers in the resident's bathroom.

The administrative nurses will inspect 5 resident rooms for disposable razors or other items placing resident at risk (residents that have BIM score of less than 10) 2 times weekly times 4 weeks, then weekly times 4 weeks to ensure ongoing compliance.
Facility plans to monitor it performance to make sure the solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will submit the PIP (Performance Improvement Plan) to the Quality Assurance Process Improvement committee on 02/22/19.The Director of Nursing will report the findings of the audit to the Quality Assurance and Process Improvement Committee monthly times 3 months or until a pattern of compliance is achieved.

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F 689	Continued From page 9 The title of the person responsible for implementing the acceptable plan of correction: The Administrator is responsible for implementing this acceptable credible allegation of compliance Immediate Jeopardy removal date: 02/20/19 Validation: Immediate Jeopardy (IJ) was removed on 02/20/19 at 6:30 PM. Validation of the credible allegation for IJ removal was completed as evidenced by interviews with nurses and nursing assistants related to in-servicing which was received as a result of the survey. Any staff members not receiving the in-servicing prior to IJ removal were not allowed to clock in for work again until receiving the in-servicing. Review of the facility's monitoring revealed no disposable razors were found in residents' rooms who were cognitively impaired.	F 689		