STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 11/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview and record review the facility failed to maintain standard of practice as evidenced by using an incorrect syringe type, failing to follow manufacturers instruction for needle length and site of administration and failing to document the medication administration records that the injections had been administered for 2 of 2 residents (Residents #2 and Resident #11 for five doses administered that afternoon. Findings include: Manufactures package insert for Fluvirin (influenza virus vaccine stated: "Dosage and Administration: A separate syringe and needle or a sterile disposable unit should be used for each injection to prevent transmission of infectious agents from one person to another. Needles should be disposed of properly and not recapped [after use]." "Fluvirin should be administered as a single 0.5 ml intramuscular injection preferably in the region of the deltoid muscle of the upper arm. The vaccine should not be injected in the gluteal region (buttocks) or areas where there may a major nerve trunk. A needle of > (over)1 inch is preferred because needles < (under) 1 inch might be of sufficient length to penetrate muscle tissue in certain adults."	F 281	F 281 1) 11/3/11 Nurse was removed from unit. For the 5 residents, that were in questions, lab studies were preformed immediately-CBC, CMP ,Liver Function studies ,HIV screen, and hepatitis screen-per CDC recommendation. All results were negative. Repeat tests will be performed every 3 months ,for 1 year. Resident responsible parties were notified. If resident discharges, Information will be given regarding necessity of follow-up as scheduled. Lab results will be reviewed by Medical Director every 3 months for 1 year. 2) Nurse was removed from unit immediately .Influenza vaccine administration was suspended until 100% of licensed staff had completed the mandatory education and demonstration of proper use of needle and syringe safety. The demonstration of syringe safety became part of the orientation of all licensed personnel, when completing skills checklist, upon employment.	12/5/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
W. G. [illegible]	ADMINISTRATOR	12/5/11

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	Continued From page 1 In an interview with the Director of Nursing and Administrator on 11/21/11 at 2:50 PM, The Director of Nursing stated that she had fired a nurse on 11/04/11 for "Failure to follow Policies and Procedures with regards to Medication Administration (IM) [intramuscular] Injections." She produced a document signed and dated by her stating the facts of the incident. "On Thursday, November 11/03/11 (Nurse #1) RN administered a Flu Vaccine to (Resident #2) A Statement from Nurse #1 were obtained and she acknowledged her failure to follow policy and procedure surrounding Medication Administration (IM injections). The staff member (Nurse #1) was terminated and the incident was reported to the NCBON (North Carolina Board of Nursing) secondary to the allegation. In-services surrounding IM Injection Policy and Procedure were completed including demonstration of Safety Syringes." When asked for Nurse #1's statement the DON produced a handwritten statement with Nurse #1's signature dated 11/01/11 2:43 PM. The statement reads: "At approximately 1:30-2:30 P, I went to med room (100 Hall) with (Nurse #2) and obtained flu vaccine out of refrigerator and grabbed a handful of insulin syringes. I took them to two hundred hall And sat at the nurse's station and filled syringes with vaccine that I had in front of me. I placed the syringes in my metal closed clipboard with vial (of flu vaccine) and alcohol sponges. I gave approx 4-5 vaccines. My pattern has been when after I give a vaccine to put the syringe in the dirty need box on the nurses carts. I gave (Resident #11) his flu vaccine and then (Resident #2) When I	F 281	C) 11/4/11- Medical Director deemed the Director of Nursing and the Staff Development Coordinator competent to check off 100 % of licensed staff.100% of Nursing Staff received written information regarding Policy and Procedure of Administration of Injections.100%of all licensed staff demonstrated correctly how to utilize the needle safety cap. Demonstration of syringe safety, will be integrated into all licensed staff orientation, in addition to skill medication administration checklist. D) 100% of licensed personnel will have completed the medication administration skill checklist. Pharmacy consultant (RN) will provide assistance with competency completion. Training will be ongoing. Staff Development Coordinator will continue with annual competencies, in-services , as well as random demonstrations, regarding safe syringe utilization.	

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F 281	Continued From page 2 punctured (Resident #2) L (left) anterior thigh and pushed the plunger (on the syringe) - there was no injectable to go in. I withdrew needle. Resident #2 said 'there was nothing in there ...you shot me with a contaminated needle'. I told him that it was probably one that I had not filled with vaccine." When asked for the investigation of the incident on 11/21/11 at 3:30 PM, the Director of Nursing produced the following notes she had taken on 11/03/11 at 3:50 PM. "Reported to me that Nurse #1 potentially injected a resident with (statement not finished). Q (from DON) (Question) Tell me what happened. A (Answer from Nurse 1) When I came on, I went to 100 Hall at 1:30 ish and Nurse #2 allowed me in narc (narcotics) room to get new bottle of flu vaccine and stock number is 110/201 and reached over and got some insulin or TD (TB-tuberculin) syringes whatever I could get 0.5 ml (milliliters) out of and came to 200 hall. I asked DON to get some alcohol sponges out and I drew up syringes with vaccine. I did not count the number of syringes I had but just put them in my metal clipboard box. I gave approx 4-5 injections (I would need to see my paper to know who exactly I gave them to. My pattern has been to give injections then discard in needle box on cart. I gave (Resident #11) his injection-came out of his room- I saw Resident #2 in common areas- I do not know if I disposed of (Resident #11) needle- cause Resident #2 said "Am I next?" I took Resident #2 in a room and asked if he wanted in arm or leg and he said leg cause he couldn't feel anything. I picked up a syringe, injected into L (Left) anterior thigh, pushed plunger and it was at the end. Resident #2 said "Oh my God- you shot me with a needle already	F 281	E) Quality Assurance Committee will monitor the above monthly X 3,for compliance. Quality Assurance Committee Members: Administrator, Medical Director, Director of Nursing, Staff Development Coordinator and All Department Directors.	

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F 281	Continued From page 3 used-that's been used on someone else. I said "No I think that was one I had not pulled up vaccine in. I went to ADON (assistant director of nursing who is also the SDC) office and spoke to ADON and said "Something bad has happened and I need to tell you what has happened "I gave Resident #11 a shot and after that I gave Resident #2 and there was no vaccine in syringe and he is saying I gave him a shot with contaminated needle." Continued interview with the Director Nursing revealed: Nurse #1 had not followed Policy and Procedure for IM injections and the following errors and breaks in aseptic technique had occurred: 1. Used insulin syringes (manufacturers package states needle are 1/2 inch long); this type of needle is not suitable for intramuscular injections. 2 Nurse had drawn up multiple syringes at one time (nursing standards indicate only one injection is drawn up at a time, the injection is given, the needle sheathed (covered to prevent nurse from getting a finger stick) and then disposed of in the sharps container, 3. The needles were not recapped after drawing up the flu vaccine to prevent contamination while traveling to a resident ' s room; she had placed them in a metal clipboard which is not an aseptic environment, 4 The flu vaccine stock bottle was also placed in the clipboard so it was potentially contaminated, 5. Nurse had used the same needle on two different residents; the safety lock sheath was not pulled up and locked after the first injection (the safety sheath is to prevent the staff member from getting stuck with a contaminated needle; it is a plastic sheath which when pulled up locks and recesses the used needle,	F 281		

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F 281	Continued From page 4 6. Nurse had administered the flu injection in the thigh of Resident #2 rather than the deltoid muscle of the upper arm, 7. And she had not properly disposed of the used syringe and needle after giving Resident #11 his flu injection. The Director of Nursing stated that the medication administration records had not been documented for vital signs (temperature, pulse and blood pressure) prior to giving the injections and the injections and sites were not signed off when she did her investigation. The records were provided to the survey team. In an interview with the ADON and Unit Manager at 4:00 PM in the 200 Hall med room, the unit manager revealed the types of syringes stocked; needles for IM injections were longer than the insulin needles. She demonstrated that the syringe/needle is removed from the sterile packaging, the plunger is withdrawn to the proper dose as indicated by the calibrations on the syringe, the stock vial is swabbed with an alcohol pad, the needle is inserted into a stock vial, the air is expelled and the plunger is then withdrawn to the volumetric dose calibration. The safety sheath can be partially raised to prevent contamination. The SDC (staff development coordinator) stated she had helped the DON to do the investigation of the incident and that she had conducted in-service for 100% of licensed staff by 11/04/11. Record review of the in-service training report titled: "Syringe disposal, after each use. 1. After drawing up medication- recap syringe until medication is administered. 2. After injection given-immediately engage safety cover (sheath) and deposit in red sharps	F 281		

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containers,
3.Injectable medications should be prepared at medication cart, recapped-taken to resident room- after ID resident-administer medication with correct needle size, engage syringe safety-take back to med car and deposit in red sharps contain
4. Refer to policy."

In an interview with Resident #2 on 11/21/11 at 3:45 PM, he stated Nurse #1 approached him in the day room and stated "[First Name] you're next" He stated Nurse #1 took him to a room, not his room, asked him if he wanted the shot in the arm or leg. Resident #2 said he would like it in the leg. He pulled up his left sweat pant leg and she stuck him above the knee in the thigh. The resident stated that the plunger didn't go down and there was no medicine in the syringe. He stated the nurse said "I stuck you with the wrong needle". The resident stated she passed a red box (sharps container) on the way to get me, why didn't she throw the used needle away before sticking me. He said he screamed at her and then lots of people came to talk to him. Resident #2 stated "I'm glad mine [labs done to screen for infectious blood borne disease]came back negative and I didn't get anything."

Nurse #1 refused interview when called on 11/21/11 at 4:20 PM.

Interviews with four licensed staff for validation (nurses #2, #3, #4 and #5) on 11/22/11 at 11:00 AM revealed all of them had been in serviced on intramuscular injections and infection control. All four could identify proper syringe selection, proper intramuscular injection technique and proper discarding of contaminated material.

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F 281	Continued From page 6 The SDC was conducting return to demonstrations with all staff at 3:00 PM on 11/22/11. She had developed a "injection competency tool" for monitoring. All licensed staff will be monitored for intramuscular injection competency on hire and yearly by the SDC.	F 281		