april8 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES

e process	PRINTED: 03/15/2013 FORM APPROVED OMB NO. 0938-0391
	(X3) DATE SURVEY

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMBIA	O. 0938-039		
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED				
		345002	B. WING_	···		0	C 3/06/2013		
NAME OF PE	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	;			
KINDRED	TRANSITIONAL CARE	REHAB-CYPRESS POINTE		2006 S 16TH ST WILMINGTON, NC 28401					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE :	(X5) COMPLETION DATE		
F 329 SS=D	Each resident's drug unnecessary drugs. drug when used in exiduplicate therapy); or without adequate moindications for its use adverse consequences should be reduced or combinations of the resident, the facility resident, the facility resident, the facility resident, the facility resident, and resident drugs as diagnosed and do record; and resident drugs receive gradual behavioral interventic contraindicated, in addrugs. This REQUIREMEN by: Based on observation of the way and in the facility	regimen must be free from An unnecessary drug is any excessive dose (including r for excessive duration; or initoring; or without adequate ex; or in the presence of es which indicate the dose r discontinued; or any reasons above. ensive assessment of a must ensure that residents intipsychotic drugs are not eless antipsychotic drug to treat a specific condition focumented in the clinical as who use antipsychotic al dose reductions, and	F	329	It is the policy and practice of the facility to practice the "5 Rights" a correctly administer all medication according to physician orders. Resident Specific: Resident #1 was administered the I.V. antibiotic on 2/28/2013 by the licensed nurse. Upon discovery o incident immediate action was tak The resident was assessed by the Licensed Nurse, vital signs were t resident was alert and oriented, the was no change in her baseline combirector of Nursing did an immed review of medication allergies, the resident did not have sensitivity to in the penicillin family as that was I.V. drug that was incorrectly give The Assistant Director of Nursing notified the physician of the error Physician gave orders for vitals si each shift, monitor for any change condition or signs and symptoms adverse reaction. The Staff Pharm was notified of the I.V. medication error, he inquired if allergies had checked, stated that he would doc the error and to notify the Physici further orders. The Family discovery of the I.V. medication error; the DN ADNS, and Executive Director specification of the I.V. medication error; the DN ADNS, and Executive Director specification of the I.V. medication error; the DN and told them that an investigation beginning immediately.	wrong of this en. aken, ere dition. iate of drugs s the gns of nacist n been ument an for vered S, poke			

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.

(Submitted 5 Signature 4/8/2013). SHA

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TITLE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION MANSER:	1		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345002	8. WING			03	C V08/2013	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE 8	L REHAB-CYPRESS POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 2008 S 16TH ST WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LEG IDENTIPYING INFORMATION)	ID PREF TAC	īΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROXIDERICITY)	BE	(XS) COMPLETION DATE	
F 329	1. Resident #1 was a the hospital on 02/27/diagnoses of colonic hemicolectomy and of Record review of the written on 02/27/13 direvealed an order for (Zyvox) 3.375 grams every 6 hours for seveny 6 hours for 6	dmitted to the facility from (13 with cumulative neoplasm requiring ellulites of the incision site. physician orders sheet uring the admission process, Piperacillin/Tazobactam via IV (intravenous) route en days. Medication Variance Report evealed Resident #1 (3 million units IV and of Piperacillin. A rag and labeling was noe Report. The IV bag ame of the drug (Penicilin on units), the expiration date ame of another resident of the Administrator and Nursing (ADON) on I, they revealed that they ident #1 had received the 2/28/13 at 7 AM. The that she and the Director of DON were in a meeting 28/13 when the house et them. The house that Resident #1 had a visit r. The family member hanging on the pole and ther resident's name on the ed that she and the DON is room immediately to start	F	329	Administrator and Director of Nursin informed at approximately 10am of medication error; the licensed nurse responsible for the error was remove the floor immediately, pending investand later terminated. The resident's signs were taken as per physician or adverse reaction was noted. Resident #2 had an I.V. antibiotic or the physician. Several doses were leterfrigerator and not signed off as given the IM antibiotic, which was ordered given weekly times three weeks, it were received from the pharmacy and was entirely omitted; the staff pharmacis that they never received the order for Penicillin I.M. Upon discovery, the was immediately notified and provide instruction to draw a lab sample with value called to him to assist him in determining whether or not to reorder omitted medication. Based on the latthe medication was deemed unneces was not reordered. Corrective Action for all Potentially On 2/28/2013 the Assistant Director Nursing immediately completed a 10 audit of all IV Medications ordered administered in the facility. Each I. medication was validated against the order, the MAR, and the I.V. medicateing administered. No other errors noted. All IV antibiotics infusing we to be per MD order. On 3/6/2013 the Data Entry LPN and Medical Records Coordinator compliance the correct information was documented on the charts and MAR.	he I.V. who was d from tigation vital ders; no dered by t in the en on to be as not thereby stated ohysician ed the the r the b value, sary and Effected of 0% and being V. original tion were re found I the eted a arts to		

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		345002	B. WING			03/	06/2013
	OVIDER OR SUPPLIER TRANSITIONAL CARE 8	REHAB-CYPRESS POINTE		20	EET ADDRESS, CITY, STATE, ZIP CODE 006 \$ 16TH ST VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	Ε	(XS) COMPLETION DATE
F 329	would not surrender if the facility to copy the The DON and ADON orders and against the determined that an elattending physician whe ordered the reside checked every shift. ADON he did not expadverse complication to penicillin, and that penicillin family of me had administered the removed from the flood Director of Nursing with questions and answer form, dated 02/28/13 who had administere investigation form revassigned to Resident started the IV antibiod The investigation form the investigation form do nurse #1): You did not went into (resident#1 nurse #1 was "I know ixit I don't remember (Resident)." "Q (que check for allergies?" was "Yes I checked passing her medications."	/ kag from the pole and to facility staff but did allow to facility staff but did allow to labeling in her presence. reviewed the clinical chart e IV bag labeling and it was ror had occurred. The vas notified by the ADON and ent to have vital signs The physician told the vect Resident #1 to have any is since she was not allergic piperacillin was in the edications. The nurse who is wrong medication was or and interviewed by the tho documented the vers on a facility investigation and signed by the nurse d the wrong medication. The vealed that Nurse #1 was if 1 on 02/28/13 and she tic at approximately 6 AM. In revealed that when nurse tooked at the resident's is, medication dose and route in, nurse #1 answered "I d saw cillin on it." The cumented "O (question to obt check the bag once you 's) room?" The answer from w I looked down at the bag rehecking the name estion to nurse #1): Did you The answer from nurse #1 for allergies when I was	F	329	On 03/06/2013 the Data Entry LPI reviewed all I.V., I.M., and P.O. orders for antibiotics within the pa 45 days; the orders were compared against the pharmacy records to as that no orders had been missed. A MARs that included antibiotic ord were reviewed to assure medication were being given as ordered. The Assistant Director of Nursing inspected each medication room a refrigerator for expired, outdated of discontinued medications or those residents who had been discharged assure that only those medications appropriate for current use remain in the facility. The Pharmacy Consultant comple his monthly review of all charts to assure there were no additional error omissions. There were no additional errors found. Systemic Corrections: The Staff Development Coordinate completed re-training of all licens staff on all shifts on the "Five Rig of Medication Administration". To training began on 02/28/2013 and completed 03/09/2013. On 03/13/2013 the Pharmacy Consultant completed an in-service licensed nurses on "Medication Administration 101" and specification and/or omissions.	ast il issure ill iers ons and or of il to is ed ited or rors cor ed ints ihis was	
	In an interview with t	he Administrator on 03/06/13			and/or omissions.		

Facility ID: 923267

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETEO
		345002	B. WING			06/2013
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	& REHAB-CYPRESS POINTE	20	STREET ADDRESS, CITY, STATE, ZIP CODE 2006 S 16TH ST WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 329	at 1 PM, she stated an IV fluid bag from and set the bag on IV fluids was on the administrator that s staff member. Whe finished, she picked "cillin" on the bag, hung the bag, and e resident's name agreed the bag with antibit medication room ar She was then internher a question. She was then internher a question. She she could see the le room. She hung the patient and started peripheral site. She looked at the bag in correct resident's namediately alerted observation the DO patient name on the Resident #1), was F and was expired. A medication adminis patient, wrong drug that was hung] shoot the refrigerator prior.	that nurse #1 had removed the medication refrigerator the counter. Another bag of counter. Nurse #1 told the he stopped to talk to another in the conversation was I up the wrong bag and saw went to Resident #1's room, she never checked the ainst the bag of IV antibiotic. It to the Board of Nursing ealed: "On 02/28/13, at (AM) Nurse (#1) obtained IV otic from refrigerator in ad set it out on the counter. upted by a co-worker asking expicked up the bag noting that etters "cillin" and took it to the the IV and flushed the ortly after, the family arrived, oting that it did not have the ame on it, and (the family) I the Director of Nursing. Upon N noted that it was the wrong by bag (Resident #2 not Penicillin not [sic] Piparacillen dditional Comments: IV tered was expired, wrong . However it [the medication ald have been removed from	F 329	The Director of Nursing initiated a new form for the night shift licensed nurse perform weekly checks in the medications appropriate for current use are in the facility. In addition, the Director of Nursing or designee will audit each medication storage area on a weekly x 3 months and then bi-weekly ongoi assure this corrective action is sustain 100% of new written or telephone physician's orders are now reviewed clinical rounds by a member of the cl team on the next business day to assure orders are completed; medications are matched against the MAR to assure of transcription. Beginning 03/06/2013- Prior to any I medication being administered, two removes must now review the order, the medication, and sign off indicating a review of the Five Rights: Right patient, right medication, right right time, and right route in the residencem. Sustained Compliance: Staff Development Coordinator will complete random medication administration observation with all licensed nurses and medication aides monthly x 3 months then re-evaluate. Each observation will include at mini of 10 opportunities. These observation will be provided to the Director of Nu for review in Performance Improvem for 3 months. The Staff Development Coordinator will re-educate the licensed nurses and medication aid the re-education will be reflective the outcome of the medication observations.	basis ng; to ned. in inical ire all e orrect V nurses full dose, lent's	

Facility ID: 923267

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345002	B. WING				C 06/2013	
	OVIDER OR SUPPLIER TRANSITIONAL CARE &	REHAB-CYPRESS POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 2006 \$ 16TH ST WILMINGTON, NC 28401				
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F 329	Continued From page 4 The family removed the resident from the facility that afternoon and moved her to another skilled nursing facility in the area		F 329		All corrective action will be tracked an trended with changes in procedure mad appropriate. The results of this tracking be presented to the Process/Performanc Improvement Committee and the Medi Director on a monthly basis for review response to any negative outcomes.	e as g will ee cal		
	Administrator shared The label had Reside the medication as "Podose 3 mu (million un 30 minutes every 4 holds label indicated the medication expired or medication expired or Administrator was ask medication in the refri	ed "why was this gerator?" she stated that it it back to the pharmacy			Date of Compliance Immediate corrective action was initiat 02/28/2013. All corrective actions rela TAG 329 were completed by 3/22/2013	ted to		
F 333 SS=D	Penicillin GK were no nurses during the more Penicillin GK order was after the midnight dos given were left in the inadvertently were given 483.25(m)(2) RESIDE SIGNIFICANT MED ETHE facility must ensur any significant medical	I revealed several doses of the signed off as given by the east discontinued on 02/08/13 e. The doses that were not refrigerator and the to Resident #1. ENTS FREE OF ERRORS	F	333	It is the policy and practice of the facili practice the "5 Rights" and correctly administer all medications according to physician orders. Resident Specific: Resident #1 was administered the wron antibiotic on 2/28/2013 by the licensed Upon discovery of this incident immed action was taken. The resident was ass	g I.V. nurse. iate essed		
	Based on observation	n, staff interview, and record ed to prevent two significant			by the Licensed Nurse, vital signs were taken, resident was alert and oriented, t was no change in her baseline condition	here		

	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345002	B. WING			03	/06/2013
	F PROVIDER OR SUPPLIER RED TRANSITIONAL CARE	& REHAB-CYPRESS POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 2006 S 16TH ST WILMINGTON, NC 28401			
(X4) PRE TA	X (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F	intravenous antibiotic (Resident #1) and fai intramuscular injectic (Resident #2) for two for medication error. 1. Resident #1 was a the hospital on 02/27 diagnoses of colonic hemicolectomy and of the written on 02/27/13 diagnoses of colonic hemicolectomy and of Record review of the written on 02/27/13 diagnoses of colonic hemicolectomy and of Record review of the written on 02/28/13, a revealed an order for (Zyvox) 3.375 grams every 6 hours for severy 6 hours for	administering the wrong medication to one resident ding to administer three ons of antibiotic to a resident of three residents reviewed Findings included: admitted to the facility from 7/13 with cumulative neoplasm requiring cellulites of the incision site. physician orders sheet during the admission process, in Piperacillin/Tazobactam via IV (intravenous) route ren days. Medication Variance Report revealed Resident #1 K 3 million units IV and of Piperacillin. A pag and labeling was noce Report. The IV bag arme of the drug (Penicillin from units), the expiration date arme of another resident of the Administrator and Nursing (ADON) on M, they revealed that they ident #1 had received the 2/28/13 at 7 AM. The that she and the Director of DON were in a meeting 28/13 when the house		333	Director of Nursing did an immediate review of medication allergies, the res did not have sensitivity to drugs in the penicillin family as that was the I.V. of that was incorrectly given. The Assis Director of Nursing notified the physic of the error; the Physician gave orders vitals signs each shift, monitor for any change in condition or signs and symptoms of adverse reaction. The S Pharmacist was notified of the I.V. medication error, he inquired if allerg had been checked, stated that he would document the error and to notify the Physician for further orders. The Fandiscovered the I.V. medication error; DNS, ADNS, and Executive Director spoke with the family immediately up discovery of the I.V. medication error told them that an investigation was beginning immediately. Administrator and Director of Nursin were informed at approximately 10am the I.V. medication error; the licensed nurse who was responsible for the errow was removed from the floor immediate pending investigation and later termin The resident's vital signs were taken a physician orders; no adverse reaction noted. Resident #2 had an I.V. antibiotic order by the physician. Several doses were I in the refrigerator and not signed off a given on the IM antibiotic, which was ordered to be given weekly times three weeks, it was not received from the pharmacy and was thereby entirely omitted; the staff pharmacist stated that they never received the order for Penic I.M. Upon discovery, the physician with mediately notified and provided the instruction to draw a lab sample with the instruction to d	dident de la	

NAME OF PROVIDER OR SUPPLIER STABLE TO DRESS, CITY, STATE, ZIP CODE 2006 8 18TH 9T WILMINGTON, NC 28401		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CYPRESS POINTE PRETIX PROVIDER OF JUMINARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USE DENTIFYING INFORMATION) F 333 Continued From page 6 supprisor told them that Resident #1 had a visit from a family member. The family member looked at the IV bag hanging on the pole and noted that it had another resident's name on the bag. The ADON stated that she and the DON went to Resident #1's room inmediately to start an investigation. The family member had removed the empty IV bag from the pole and would not surrender it to facility staff but did allow the facility to copy the labeling in her presence. The DON and ADON reviewed the clinical chart orders and against the IV bag labeling and it was determined that an error had occurred. The attending physician notified by the ADON and he ordered the resident to have vital signs checked every shift. The physician told the ADON he did not expect Resident #1 had a visit from a family member had administered the wrong medication was removed from the floor and interviewed by the Director of Nursing who documented the questions and answers on a facility investigation form, date do 1228/13 and signed by the nurse who had administered the wrong medication. The								С	
CAUID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR USE IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (PLOST BE PRECEDED BY PILL REGULATORY OR USE IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (PLOST BE PRECEDED BY PILL REGULATORY OR USE IDENTIFYING INFORMATION) PREFIX TAG F 333 Continued From page 6 Supervisor told them that Resident #1 had a visit from a family member. The family member looked at the IV bag hanging on the pole and noted that it had another resident's name on the bag. The ADON stated that she and the DON went to Resident #1's room immediately to start an investigation. The family member had removed the empty IV bag from the pole and would not surrender it to facility staff but did allow the facility to copy the labeling in her presence. The DON and ADON reviewed the clinical chart orders and against the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON he did not expect Resident #1 to have any adverse complications since she was not allergic to penicillin, and that piperacillin was in the penicillin family of medications. The nurse who had administered the wrong medication was removed from the foor and interviewed by the Director of Nursing who documented the questions and answers on a facility, investigation form, date d0228/2813 and signed by the nurse who had administered the wrong medication. The			345002	B. WING			03.	/06/2013	
F 333 Continued From page 6 supervisor told them that Resident #1 had a visit from a family member. The family member looked at the IV bag hanging on the pole and noted that it had another resident's name on the bag. The ADON stated that she and the DON went to Resident #1's room immediately to start an investigation. The family member had removed the empty IV bag from the pole and would not surrender it to facility staff but did allow the facility to copy the labeling in her presence. The DON and ADON reviewed the clinical chart orders and against the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident to have vital signs checked every shift. The physician told the ADON he did not expect Resident #1 to have any adverse complications since she was not allergic to penicillin, and that piperacillin was in the penicillin family of medications. The nurse who had administered the wrong medication was removed from the foor and interviewed by the Director of Nursing whother or not to reorder the omitted medication. Based on the lab value, the medication was deemed unnecessary and was not reordered. Corrective Action for all Potentially Effected On 2/28/2013 t he Assistant Director of Nursing immediately completed of all IV Medications ordered and being administered in the facility. Bach LV. medication was validated against the original order, the MAR, and the LV. medication was validated against the original order, the MAR, and the LV. medication being administered. No other errors were noted. All IV antibiotics infusing were found to be per MD order. On 3/6/2013 the Data Entry LPN and the Medical Records Coordinator completed a 100% audit of allergy stickers on charts to assure the correct information was documented on the charts and MAR's. On 03/6/2013 the Data Entry LPN reviewed all I.V., I.M., and P.O. orders for antibiotics within the past 45 days; the orders were compared against the pharmacy records to assure the cord			REHAB-CYPRESS POINTE		2006 S 16TH ST				
supervisor told them that Resident #1 had a visit from a family member. The family member looked at the IV bag hanging on the pole and noted that it had another resident's name on the bag. The ADON stated that she and the DON went to Resident #1's room immediately to start an investigation. The family member had removed the empty IV bag from the pole and would not surender it to facility staff but did allow the facility to copy the labeling in her presence. The DON and ADON reviewed the clinical chart orders and against the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident to have vital signs checked every shift. The physician told the ADON he did not expect Resident #1 to have any adverse complications since she was not allergic to penicillin, and that piperacillin was in the penicillin family of medications. The nurse who had administered the wrong medication was removed from the floor and interviewed by the Director of Nursing immediately completed a 100% audit of all IV medication was validated against the original order, the MAR, and the LV. medications ordered and being administered in the facility. Each I.V. medication was validated against the original order, the MAR, and the LV. medication was validated against the Visag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident the IV bag labeling and it was determined that an error had occurred. The attending physician was notified by the ADON and he ordered the resident the IV. we dications ordered and being administered in the facility. Each I.V. medications ordered and being administered in t	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	PREFIX (EACH CORRECTIVE ACTION SHOULD BY TAG CROSS-REFERENCED TO THE APPROPRI				
assigned to Resident #1 on 02/28/13 and she started the IV antibiotic at approximately 6 AM. The investigation form revealed that when nurse #1 was asked if she looked at the resident's name, expiration date, medication dose and route prior to administration, nurse #1 answered "I looked at the bag and saw cillin on it." The investigation form documented "Q (question to nurse #1): You did not check the bag once you went into (resident#1's) room?" The answer from nurse #1 was "I know I looked down at the bag	F 333	supervisor told them to from a family member looked at the IV bag hoted that it had anoth bag. The ADON state went to Resident #1's an investigation. The removed the empty IV would not surrender it the facility to copy the The DON and ADON orders and against the determined that an enattending physician who had determined that an enattending physician who he did not expending the residenched every shift. ADON he did not expending the penicillin, and that penicillin family of mehad administered the removed from the floodirector of Nursing who had administered investigation form reveassigned to Resident started the IV antibiotion. The investigation form date prior to administration looked at the bag and investigation form docurse #1): You did not went into (resident#1's	that Resident #1 had a visit The family member langing on the pole and her resident's name on the did that she and the DON room immediately to start family member had I bag from the pole and to facility staff but did allow labeling in her presence. The last had beling in her presence. The last had occurred. The last notified by the ADON and to have vital signs from the document to have vital signs from the physician told the lest Resident #1 to have any as since she was not allergic biperacillin was in the dications. The nurse who wrong medication was ar and interviewed by the last had been and signed by the nurse lest the wrong medication. The leased that Nurse #1 was lest the wrong medication. The leased that Nurse #1 was lest the wrong medication. The leased that Nurse #1 was lest on 02/28/13 and she could at the resident's medication dose and route in nurse #1 answered "I saw cillin on it." The lanswered "O (question to lacked the bag once you so room?" The answer from	F	333	determining whether or not to reorder omitted medication. Based on the lab value, the medication was deemed unnecessary and was not reordered. Corrective Action for all Potentially Effected On 2/28/2013 the Assistant Director of Nursing immediately completed a 100% audit of all IV Medications ordered and being administered in the facility. Each I.V medication was validated against the original order, the MAR, and the I.V. medication being administered. No of errors were noted. All IV antibiotics infusing were found to be per MD ord On 3/6/2013 the Data Entry LPN and Medical Records Coordinator complet 100% audit of allergy stickers on char assure the correct information was documented on the charts and MAR's. On 03/06/2013 the Data Entry LPI reviewed all I.V., I.M., and P.O. orders for antibiotics within the pa 45 days; the orders were compared against the pharmacy records to as that no orders had been missed. A MARs that included antibiotic ord were reviewed to assure medication were being given as ordered. The Assistant Director of Nursing inspected each medications or those residents who had been discharged	. ther er. the ed a ts to St I sure II ers ns		

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	OVIDER OR SUPPLIER TRANSITIONAL CARE &	REHAB-CYPRESS POINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 2006 S 16TH ST WILMINGTON, NC 28401		, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTENENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	
F 333	check for allergies?" was "Yes I checked for passing her medication. In an interview with the at 1 PM, she stated the an IV fluid bag from the and set the bag on the IV fluids was on the conditional control of the staff member. When the staff member. When the staff member. When the staff member is the picked up "cillin" on the bag, we hung the bag, and she resident's name again. Review of the report to dated 02/28/13 reveal approximately 8:00 (A fluid bag with antibiotic medication room and a she was then interrup her a question. She patient and started the peripheral site. Shorti looked at the bag notic correct resident's namin immediately alerted the observation the DON in patient name on the bar Resident #1), was Per and was expired. Additional state of the s	checking the name stion to nurse #1): Did you The answer from nurse #1 or allergies when I was ons." e Administrator on 03/06/13 at nurse #1 had removed be medication refrigerator e counter. Another bag of ounter. Nurse #1 told the stopped to talk to another the conversation was p the wrong bag and saw nt to Resident #1's room, e never checked the st the bag of IV antibiotic. the Board of Nursing ed: "On 02/28/13, at M) Nurse (#1) obtained IV or from refrigerator in set it out on the counter. ted by a co-worker asking icked up the bag noting that ers "cillin" and took it to the e IV and flushed the y after, the family arrived, ng that it did not have the e on it, and (the family) e Director of Nursing. Upon noted that it was the wrong ag (Resident #2 not nicillin not [sic] Piparacillen tional Comments: IV	F	333	current use remained in the facility	ed his ure nal or ed nts of was sultant d tion risks ns. v form rform s to r on, the adit kly n is	
	and was expired. Addi medication administer						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-0391	
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	
 							С
<u> </u>		345002	B. WING			03/	06/2013
NAME OF PR	ROVIDER OR SUPPLIER			ı	EET ADDRESS, CITY, STATE, ZIP CODE		
KINDRED	TRANSITIONAL CARE 8	REHAB-CYPRESS POINTE		"	006 8 16TH 8T Vilmington, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPAL DEFICIENCY)		(XS) COMPLETION DATE
F 333	that was hung] should the refrigerator prior to the refrigerator prior to the refrigerator prior to the refrigerator prior to the nurse was suspe and terminated. A me done and the incident Board of Nursing. The family removed to that afternoon and monursing facility in the administrator shared The label had Reside the medication as "Pedose 3 mu (million union 30 minutes every 4 holds indicated the metrom the pharmacy on medication expired or Administrator was ask medication in the refrishould have been sen when the treatment er Record review of Residential of the monurses during the mor Penicillin GK were not nurses during the mor Penicillin GK order was	I have been removed from the incident." Inded pending investigation dication variance report was awas faxed to the N.C. The resident from the facility oved her to another skilled area In 03/06/13 at 10:30 AM, the the copy of the IV bag label, and #2's name. The label had enicillin GK (Pfizerpen), its), Administer 106 ml over ours Intravenously." The indication was dispensed to 20/04/13 and that the in 02/11/13. When the ited "why was this gerator?" she stated that it it back to the pharmacy inded on 02/08/13. Ident #2's Medication revealed several doses of it signed off as given by the inth of January, 2013. The is discontinued on 02/08/13 e. The doses that were not refrigerator and	C. The state of th	3333	Reginning 03/06/2013 - Prior to any IV	num num ons rsing ont ent les; of	
		imitted to the facility on es of dementia, arthritis and			related to TAG 333 were completed by 3/22/2013.		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345002	B. WING				C 06/2013
	ROVIDER OR SUPPLIER TRANSITIONAL CARE &	REHAB-CYPRESS POINTE		20	EET ADDRESS, CITY, STATE, ZIP CODE 906 S 16TH ST (ILMINGTON, NC 28401	. 00	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	On January 20, 2013 with an altered mental encephalopathy. He is on 01/24/13 with a Pleinserted central cather intravenous antibiotics. Review of Resident #2 the physician gave an "Dextrose 5% 60 millil Inject 3 million units (rhours for 10-14 days; Penicillin 2.4 million units for 10-14 days; Penicillin 2.4 million units for 3 weeks." The medication was a January, 2013 and the discontinue the Penicifor 14 days). Review of the January Medication Administrative revealed that one of Psigned off as given on dose of Penicillin GK on 01/28/13 at 2 PM. were not signed off as and 6 AM. During an interview or Administrative nursing the Penicillin GK dose signed off as given.	ictive pulmonary disease). The was sent to the hospital of status and metabolic returned from the hospital color (peripherally ter) suitable for giving status. The medical record revealed order on 01/25/13 for iters with Penicillin GK, and into the vein every 4 followed by Benzathine mits intramuscularly (IM) Thatted on the 25th of the order was clarified to allin GK on 02/08/13 (to give order was clarified to allin GK on 02/08/13 (to give order was not signed off as given two doses of Penicillin GK given on 01/30/13 at 2 AM The order was darked off as given two doses of Penicillin GK given on 01/30/13 at 2 AM The order was darked off as given two doses of Penicillin GK given on 01/30/13 at 2 AM The order was darked off as given two doses of Penicillin GK given on 01/30/13 at 2 AM The order was darked or not the order was not signed off as given two doses of Penicillin GK given on 01/30/13 at 2 AM The order was darked or not the order was not signed off as given two doses of Penicillin GK given on 01/30/13 at 2 AM	F	333	Kindred Transitional Care and Rehabilitation Cypress Pointe tal pride in providing excellent care our Residents and takes any and deficiencies extremely serious. Value the trust that the Residents Families have shown in our faciliprovide sage and quality care; outeam will work together to assure these deficiencies are corrected a maintained.	to all We and ity to or e that	

Facility ID: 923267

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		4/500		-			С
		345002	B. WING		·	03	/06/2013
	ROVIDER OR SUPPLIER TRANSITIONAL CARE 8	REHAB-CYPRESS POINTE		2	REET ADDRESS, CITY, STATE, ZIP CODE 006 \$ 16TH ST VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION CORRECTION CONTROL OF CONTROL			(X5) COMPLETION DATE
F 333	ordered protocol] orde 02/15/13, 02/22/13 ar signed off as given. Observation of the ref 03/06/13 at 1 PM reve medication in the refri On 03/06/13 at 12:41 signed statement which Penicillin IM not recei on or after 01/24/13 for statement was signed of the vending pharms. During an interview w 03/06/13 at 1 PM, she her they never got the doses of 2.4 mu of Be it was clearly marked the three doses of Be never sent to the facil record of any nurses of February, 2013 to say medication. During an interview w 11:10 AM, she stated nurse practitioner (NP stated they should get administer it. During an interview w 2 PM, she stated she physician who stated laboratory test done by	rigerator on the unit on ealed no penicillin IV or IM gerator. PM, the pharmacy faxed a ch stated, "Order for ved at [name of pharmacy] or (Resident #2). The I by one of the pharmacists acy. ith the administrator on e said pharmacy staff told e order for the three IM enzathine Penicillin although on the discharge orders, so not part to the pharmacy had no calling them on the 15th of they did not have the eith the ADON on 03/06/13 at she consulted with the elements on the action of the penicillin IM and the ADON on 03/06/13 at called the attending the wanted another efore the IM Penicillin was tether the missed doses	F	333			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345		345002	B. WING			C	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-CYPRESS POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2006 S 16TH ST WILMINGTON, NC 28401			3/06/2013
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 33	Continued From page protocol.	• 11	F	333			