STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-CYPRESS POINTE	2006 S 16TH ST WILMINGTON, NC 28401

(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 This complaint investigation survey was conducted in conjunction with a follow up on a complaint investigation survey. This survey was originally conducted on 4/22/13 and 4/23/13. The survey team went back to the facility on 4/30/13 to obtain additional information.	F 000	***Resident Specific***: On 04/14/2013 Resident #3 was administered Resident #6 bag of I.V. medications; it was same antibiotic but the incorrect dose. Upon discovery the RN notified the Director of Nursing, the P.A.C.E. Physician, and the Power of Attorney which is her mother. The Resident was monitored for any adverse reaction; itching, rash, shortness of breath and/or mental status change. DNS began investigation into event; the RN Supervisor that administered the wrong dose was suspended and later terminated. The Physician who was called stated a trough was not indicated secondary to resident receiving lower dose but trough level was drawn on 04/15/2013 from prior order. Vancomycin dose was increased by physician on 04/16/2013. Resident #3 was assess by Physician on 04/15/2013 with no medication changes; pt doing well.	
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 interview and record review the facility failed to prevent a medication error for 2 of 5 residents receiving intravenous antibiotic infusions, Resident #3 and Resident #6. Findings included: 1. Resident #3 was admitted to the facility on 04/12/13 from the hospital with cumulative diagnoses of lumbar spine discitis (an infection in the spaces inside the vertebrate), chronic pain and deconditioning with orders to treat an infection by intravenous route (IV). Review of the resident's clinical records revealed Resident #3 had two orders for antibiotic intravenous (IV) infusion: Cefepime 2 Grams via IV every 12 hours (Administer at 10 AM and 10 PM) and Vancomycin 850 milligrams (mg) via IV every 12 hours (at 2 PM and 2 AM). The medication variance report for Resident #3 of	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Fred V. Cotten — TITLE: Administrator — (X6) DATE: 5/20/13

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 4/14/13 revealed Nurse #4 (Registered Nurse (RN) supervisor) offered to help Nurse #3 because she was running behind schedule. Nurse # 4 told Nurse #3 that she should go on with her medication pass and Nurse #4 would hang the two intravenous infusions that were due at 2 PM. Nurse #3 went to the medication refrigerator and withdrew two bags of Vancomycin (one for Resident #3 and one for Resident #6). She compared the 5 rights (the right patient, right medication, right strength, right route and right frequency) with the infusion record, Medication Administration Record (MAR) and the original physician order and then went to the medication cart to have the RN sign off the 5 rights on the MAR, infusion record and IV bag. Nurse #3 then went back to passing medications. Nurse #4 then took both bags into Resident #3 room and hung and infused Resident #6's IV bag of medication into Resident #3. Nurse #4 then went to Resident #6's room and hung and infused Resident #3's IV bag of antibiotic therapy into Resident #6. Resident #3 physician's order was for 850 mg of Vancomycin and Resident #6 order was for 800 mg of Vancomycin. In an interview with the Administrator and Director of Nursing (DON) on 4/30/13 at 10 AM, the Administrator stated that during their investigation of the medication error that happened on 4/14/13, they discovered that the the Staff Development Coordinator (SDC) did not instruct the nursing staff that two nurses needed to check the 5 rights in the resident's room before administering IV medication, per the facility current practice.	F 281	On 04/14/13 Resident #6 was administered resident #3 bag of IV medication; it was the same antibiotic but the incorrect dose. Upon discovery the RN notified the Director of Nursing, the Resident, and the Physician. The Resident was monitored for any adverse reaction; itching, rash, shortness of breath and/or mental status change. DNS began investigation into event; the RN Supervisor that administered the wrong dose was suspended and later terminated. The Physician that was notified gave telephone order to continue dose as ordered of Vancomycin 800mg as scheduled for 2100; draw Vancomycin trough as previously ordered for 04/15/2013. Results were reported to Physician, Vancomycin trough with in normal limits. The facility has established a procedure where by two licensed nurses must verify the I.V. medication is correct using the "5 Rights of Medication Administration". A special I.V. team has been formed that consists of Nursing	

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F 281	Continued From page 2 In an interview with Nurse #3 on 4/30/13 at 11 AM, she stated that she did not go back into Residents #3 or #6's room to check on the infusion because Nurse #4 had told her that Nurse #4 would also do the required saline flush after the infusion ran. She stated that she had attended the in-service (on 3/11/13) on the 5 rights, passed the verbal challenge by the SDC but the SDC did not tell her that two nurses had to go into the resident's room and verify the 5 rights before administering IV medications. Review of an "Investigation Report Form" of 4/15/13 revealed the DON interviewed Nurse #3 on 4/15/13. The write up of the interview revealed that Nurse #3 stated that the SDC did not instruct her to have two nurses in the resident's room to verify the 5 rights before administering IV medications. Review of an "Investigation Report Form" of 4/15/13 revealed the DON interviewed Nurse #4. The write up of the interview revealed that Nurse #4 did not remember if the SDC instructed her to have two nurses in the resident's room to verify the 5 rights before administering IV medications. Nurse #4 was not available for interview at the time of the survey. An interview was conducted on 4/30/13 at 3:30 PM with Nurse #5 who discovered the medication error when she went into Resident #3 room and saw that the empty IV bag had Resident #6's name on it. Then, she immediately called Nurse #6 on the other station to see what infusion was hanging in Resident #6's room. It was discovered that Resident #6 also had an empty infusion bag	F 281	Administration (DON, ADON, MDS R.N., Supervisor for first and second shift); each member received a four hour training on I.V. administration by Eric Wilson, RN, BSN, I.V. infusion leader. ***Corrective Action for all Potentially Effected Residents:*** Medication competency was conducted from 4/14 thru 5/20/13 on 100% of all licensed nurses and medication aides. On May 16th and 17th, 2013 Karen Clark, RN, MSN nursing instructor from Western Piedmont Community College is providing additional education on medication administration as directed. A post test was completed by each licensed nurse in attendance; post test results were scored and remedial education was provided with any licensed nurse that received a score less than 70%. A medication observation check list that encompassed the "5 Rights of Medication Administration" was completed on all licensed nurses requiring additional education.	

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F 281	Continued From page 3 on the IV pole and it had Resident #3's name on it. Nurse #5 stated she called the Director of Nursing to report the errors on the 2 residents. She was instructed to call the attending physician and the family of Resident #3 and talk to Resident #6 who was alert and oriented and his own responsible party. The attending physician told Nurse #5 to call the pharmacy and "even out " the total number of milligrams per day on the next infusion. In an interview with the DON and Assistant Director of Nursing on 04/30/13 at 12 noon, they stated that their expectation was that not only two nurses would do comparison of the 5 rights of Medication Administration at the medication cart, both nurses would again do the 5 rights in the resident's room with no exceptions. 2. Resident #6 was admitted to the facility on 03/16/13 with cumulative diagnoses of diabetes mellitus, peripheral vascular disease and was on intravenous (IV) antibiotic therapy for a non healing wound on his foot. Review of the resident's clinical records revealed that a telephone order was written on 04/12/13, "Vancomycin 800 mg IV (intravenously) every 12 hours." The medication variance report for Resident #6 of 4/14/13 revealed Nurse #4 (Registered Nurse (RN) supervisor) offered to help Nurse #3 because she was running behind schedule. Nurse # 4 told Nurse #3 that she should go on with her medication pass and Nurse #4 would hang the two intravenous infusions that were due at 2 PM. Nurse #3 went to the medication	F 281	Ongoing audit special focus from 04/14 to 05/01/2013 on I.V. medication; completed by data entry licensed nurse and medical records coordinator. Resident #3 and #6 I.V. medication and orders reviewed by Director of Nursing during investigation. Root Cause Analysis was conducted regarding resident #3 and #6 by the Director of Nursing; the root cause analysis identified that there was a misunderstanding that the "5 Rights of Medication Administration" was to be performed at the bedside with two licensed nurses. All licensed nurses were re-educated on this step in the procedure. A root cause analysis will be conducted on all medication errors in the facility.	

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F 281	Continued From page 4 refrigerator and withdrew both bags of Vancomycin (one for Resident #3 and one for Resident #6). She compared the 5 rights (the right patient, right medication, right strength, right route and right frequency) with the infusion record, Medication Administration Record (MAR) and the original physician order and then went to the medication cart to have the RN sign off the 5 rights on the MAR, infusion record and IV bag. Nurse #3 then went back to passing medications. Nurse #4 then took both bags into Resident #3 room and hung and infused Resident #6's IV bag of medication into Resident #3. Nurse #4 then went to Resident #6's room and hung and infused Resident #3's IV bag of antibiotic therapy into Resident #6. Resident #3 physician's order was for 850 mg of Vancomycin and Resident #6 order was for 800 mg of Vancomycin. In an interview with the Administrator and Director of Nursing (DON) on 4/30/13 at 10 AM, the Administrator stated that during their investigation of the medication error that happened on 4/14/13, they discovered that the SDC did not instruct nursing staff that two nurses needed to check the 5 rights in the resident's room before administering IV medication, per the facility practice. In an interview with Nurse #3 on 04/30/13 at 11 AM, she stated that she did not go back into Residents #3 or #6's room to check on the infusion because Nurse #4 had told her that Nurse #4 would also do the required saline flush after the infusion ran. She stated that she had attended the in-service (on 3/11/13) on the 5	F 281	***Systemic Corrections***: An I.V. team was established to ensure resident safety and accuracy in administration of I.V. medications. Education provided to selected Registered Nurses by Eric Wilson, R.N., BSN PharMerica I.V. specialist. Training was completed on 04/08/2013, professional standards of vascular access devices the basics of intravenous therapy. Random audits on I.V. administration/ documentation and licensed nurses/ medication aides medication pass will be conducted by Director of Nursing/designee or Pharmacy Nurse Consultant; various shifts three times weekly equal to 50% of staff being reviewed monthly x 90 days.	

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F 281	Continued From page 5 rights, passed the verbal challenge by the Staff Development Coordinator (SDC) but the SDC did not tell her that two nurses had to go into the resident's room and verify the 5 rights before administering IV medications. Review of an "Investigation Report Form" of 4/15/13 revealed the DON interviewed Nurse #3 on 4/15/13. The write up of the interview revealed that Nurse #3 stated that the SDC did not instruct her to have two nurses in the resident's room to verify the 5 rights before administering IV medications. Review of an "Investigation Report Form" of 4/15/13 revealed the DON interviewed Nurse #4. The write up of the interview revealed that Nurse #4 did not remember if the SDC instructed her have two nurses in the resident's room to verify the 5 rights before administering IV medications. Nurse #4 was not available for interview at the time of the survey. An interview was conducted on 4/30/13 at 3:30 PM with Nurse #5 who discovered the medication error when she went into Resident #3 room and saw that the empty IV bag had Resident #6's name on it. Then, she immediately called Nurse #6 on the other station to see what infusion was hanging in Resident #6's room. It was discovered that Resident #6 also had an empty infusion bag on the IV pole and it had Resident #3's name on it. Nurse #5 stated she called the Director of Nursing to report the errors on the 2 residents. She was instructed to call the attending physician and the family of Resident #3 and talk to Resident #6 who was alert and oriented and his own	F 281	***Evaluated for Effectiveness:*** Performance Improvement to review audits monthly x 90 days to assure system change effective; performance improvement team to implement education and planning as needed from audit results. ***Date of Compliance:*** May 23, 2013 Identified instructors have agreed to their names being used for the POC.	

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F 281	Continued From page 6 responsible party. The attending physician told Nurse #5 to call the pharmacy and "even out" the total number of milligrams per day on the next infusion. In an interview with the DON and Assistant Director of Nursing on 04/30/13 at 12 noon, they stated that their expectation was that not only two nurses would do comparison of the 5 rights of Medication Administration at the medication cart, both nurses would again do the 5 rights in the resident's room with no exceptions.	F 281		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE
	345002	A. BUILDING: _____ B. WING _____	4/30/2013

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 164	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the residents records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview and record review, the facility failed to provide full visual privacy for 1 of 2 residents during an intravenous infusion (Resident #3)

Findings included:

Resident # 3 was admitted from the hospital with two orders for intravenous(IV) infusion.

An observation of the IV infusion on 04/22/13 at 2 PM revealed two nurses (Nurse #1 and the Assistant Director of Nursing (ADON)) entered Resident #3's room and left the door open. The resident resided in the bed nearest to the door. The privacy curtain was not pulled all around the residents bed and the resident was visible to individuals passing by in the hallway. The resident was in a wheelchair and wearing a therapeutic brace around her torso. Nurse #1 and the ADON removed the brace and positioned the resident on the bed. Then they prepared the resident for infusion. The access to the intravenous line is through a tube (port) inserted in the vein in the upper arm. Nurse #1 flushed the port on the upper left arm and hung the infusion. The door remained open and the resident visible to individuals passing by in the hallway during the entire process of preparing the infusion and allowing it to run. Both staff nurses left the room while the infusion was progressing without closing the door.

In an Interview with Nurse #1 on 4/22/13 at 2:30 PM she stated that she was very nervous about the observation and just forgot to close the door.

Interview with the Assistant Director of Nursing (ADON) on 04/23/13 at 5:00 PM revealed she had her back

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 164	Continued From Page 1 to the door during set up and infusion and was unaware the door was open Interview with the Director of Nursing andAdministrator on 04/23/13 at 4 PM revealed their expectation was the residents should be given privacy during an intravenous infusion by closing the door and pulling the privacy curtain around the resident.