STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345273	A. BUILDING _____ B. WING _____	C 08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL EAST GREENSBORO	2401 SOUTH SIDE BOULEVARD GREENSBORO, NC 27406

(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 164 SS=D	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 resident's 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 record review, family and staff interviews, the facility failed to protect confidential medical information for 2 of 3 sampled residents (Resident #4 and Resident #5). Findings included: An interview with a family member (FM) of	F 164	F-164 - This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of	9/3/16

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

Electronically Signed | 08/29/2016

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F 164	Continued From page 1 Resident #3 was conducted on 8/12/16 at 9:15 AM. The FM stated he had received the medical records, as requested, from the facility for Resident #3 and noticed the names of 2 residents (Resident #4 and Resident #5) on 2 separate pages within the medical record for Resident #3. He stated he had laboratory results for Resident #4 and a copy of a prescription for Resident #5. A review of the closed medical record for Resident #3 was conducted on 8/12/16 at 11:45 AM and revealed lab results for Resident #4 and a copy of a prescription for Resident #5 were included in the closed medical record of Resident #3. An interview was conducted on 8/12/16 at 12:10 PM with the Director of Nursing (DON). He stated if someone requested medical records they are entitled to see them. He stated the medical records coordinator handled those requests and anything requested, for example laboratory results, diagnostic tests and results, nursing notes, physician progress notes and orders, was sent. He also stated the facility staff just completed training related to the Health Insurance Portability and Accountability Act (HIPAA) to review patient privacy laws, and the staff was also in serviced annually on HIPAA. He stated, " The medical records coordinator pulls information from the electronic medical record and the entire closed record (paper chart) for any information that was requested. " An interview was conducted with the medical records coordinator on 8/12/16 at 12:50 PM. She stated, " I get my information to send out to the family from the electronic medical record, and the paper chart. Laboratory results are typically on paper so I photocopy them and include them in the records I send out. A urinalysis and urine culture and sensitivity would get pulled from the	F 164	the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. How corrective action will be accomplished for those residents found to have been affected by the deficient practice : The medical record for resident #3, #4 and # 5 were all audited on 8/12/16 by the Medical Records Clerk to ensure that there was no other Resident medical information filed in the charts. Resident #4 as well as the RP for Resident # 4 was informed by the Director of Nursing on 8/12/16 that a copy of lab results was erroneously placed in another chart and that the family member received that that record. The Medical Director was also informed. Resident # 5 as well as the RP for Resident # 5 was informed by the Director of Nursing on 8/12/16 that a copy of a prescription was erroneously placed in another chart and that the family member received those records. The Medical Director was also informed. The Medical Records Clerk was in-serviced by the Administrator on HIPPA concerning personal privacy/confidentiality of records on 8/12/16. The Administrator in-serviced the Medical	

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F 164	Continued From page 2 paper record. Copies of physician written prescriptions are kept in the paper chart. A physician writes a prescription for a resident who is being discharged home, and the nurse makes a copy of it to put in the chart. This way, if a patient calls back and says they lost their prescription we can go back in the paper chart and look for it. I usually check each page of the medical record before I send it out to a family and make sure all the pages have the same name and identification number on all the pages. If someone gets the wrong chart, or pieces of a chart for someone else that would not be good. " An interview was conducted on 8/12/16 at 1:30 PM with the facility Administrator. She stated, " My expectations for HIPAA is that we protect the privacy rights of our residents. They are continually educated on HIPAA. I would not expect a family member to get the wrong medical information or information for another resident mixed in with their family member ' s medical record. "	F 164	Records Clerk on the weekly medical records audit that she will perform weekly x 3 months on 8/15/16. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice : The Medical Records Clerk and the Administrative Team performed a chart audit of all active patient records on the unit to ensure that no other patient records were erroneously filed in the charts on 8/15/16. The Staff was in-serviced by the Administrator on HIPPA and the personal privacy /confidentiality of records 8/12/16 and 8/15/16 . The patient records were moved to a closed keyed file cabinet at the Nurses Station in view of a camera on 8/22/16. The closed patient medical records were audited by the Medical Records Clerk to ensure that no records were erroneously filed on 8/17/16. The Medical Records Clerk will perform weekly x 3 months a audit of resident medical records to ensure proper filing. She will bring findings to the Performance Improvement Committee Monthly x 3 Months for any recommendations. A discharge audit will be performed going forward by the Medical Records Clerk of	

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F 164	Continued From page 3	F 164	each resident's medical record to ensure proper filing of the record that no other record were erroneously filed. A double check system was initiated for all medical records request . The Medical Records Clerk will bring to the Director of Nursing and or Nurse Manager who will then review the record before it is released to ensure that no other resident information is mixed in with the record. The Staff Development Nurse will educate annually all staff and upon hire the new staff on the HIPPA regulation related to personal privacy /confidentiality of patient records. What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur. The Medical Records Clerk will perform weekly audits of the resident medical records . The Administrator will perform weekly audits and results of those audits will be presented to the Performance Improvement Committee Monthly x 3 Months for any recommendations. How the facility plans to monitor its performance to make sure that solutions are maintained : The Director of Nursing will do HIPPA rounds weekly to ensure personal privacy and confidentiality of personal and clinical records of the residents and in-service or council the staff.	

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F 164	Continued From page 4	F 164	The Director of Nursing , Medical Records Clerk and Administrator will bring to the Performance Improvement Committee their findings from the weekly audits and HPPA rounds for any recommendations by the Committee. This plan has been reviewed by the Medical Director and the Performance Improvement Committee and approved 8/29/16.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the accuracy of 1 of 3 sampled residents (Resident #3) medical records by including the medical information of two other residents (Resident #4 and Resident #5) in Resident #3 ' s closed record.	F 514	F-514 - The plan of correction is the center's credible allegation of compliance. Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of	9/3/16

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F 514	Continued From page 5 Findings included: A review of the quarterly Minimum Data Set (MDS) dated 4/28/16 revealed Resident #3 was admitted to the facility on 2/2/16 and was discharged to the hospital on 7/20/16. Resident #3 was cognitively impaired, and required extensive assistance to complete all activities of daily living (ADLs). A review of the closed medical record for Resident #3 was conducted on 8/12/16 at 11:45 AM and revealed laboratory results (a urinalysis and urine culture and sensitivity) for Resident #4 and a copy of a medication prescription for Resident #5 included in the closed medical record of Resident #3. An interview was conducted on 8/12/16 at 12:10 PM with the Director of Nursing (DON). He stated the facility staff just completed training related to the Health Insurance Portability and Accountability Act (HIPAA) to review patient privacy laws, and the staff was also in serviced annually on HIPAA. The DON confirmed other resident ' s medical information was erroneously placed in Resident #3 ' s medical record. An interview was conducted with the medical records coordinator on 8/12/16 at 12:50 PM. She stated, " I get my information to send out to the family from the electronic medical record, and the paper chart. Laboratory results are typically on paper so I photocopy them and include them in the records I send out. A urinalysis and urine culture and sensitivity would get pulled from the paper record. Copies of physician written prescriptions are kept in the paper chart. A physician writes a prescription for a resident who is being discharged home, and the nurse makes a copy of it to put in the chart. This way, if a patient calls back and says they lost their prescription we can go back in the paper chart	F 514	the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. How corrective action will be accomplished for those residents found to have been affected by the deficient practice : A chart audit was performed by the Medical Record Clerk on the medical records of resident #3, #4 and # 5 on 8/12/16 to ensure organization and accuracy of the record. The Medical Records Clerk was in-serviced by the Administrator on 8/12/16 regarding accuracy and organization of the Resident Medical Record.. Residents #4 and #5 were notified ,their RP's and the Medical Director on 8/12/16 by the Director of Nursing that lab results and the prescription was found in Resident #3's record obtained by Resident #3's family member. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The active Residents records were all audited on 8/15/16 by the Medical Record Clerk and the Administrative Team for organization and accuracy. The Closed Resident records were	

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F 514	Continued From page 6 and look for it. I usually check each page of the medical record before I send it out to a family and make sure all the pages have the same name and identification number on all the pages. If someone gets the wrong chart, or pieces of a chart for someone else are mixed in the wrong chart that would not be good. " She also confirmed other resident ' s medical information was erroneously placed in Resident #3 ' s medical record which was provided to Resident #3 ' s family. An interview was conducted on 8/12/16 at 1:30 PM with the facility Administrator. She stated, " My expectations for HIPAA is that we protect the privacy rights of our residents. They are continually educated on HIPAA. Medical records need to be accurate and not have medical information for someone else mixed up in it. She also confirmed other resident ' s medical information was erroneously placed in Resident #3 ' s medical record which was provided to Resident #3 ' s family.	F 514	audited by the Medical Records Clerk on 8/17/16. What measures will be put in place or systemic changes to ensure the deficient practice will not occur : A weekly audit was performed on resident records on 8/15/16 by the Medical Records Clerk and will done weekly there after. A discharge audit form was started for all patient discharge records on 8/15/16 to be done by the Medical Records Clerk to ensure organization and accuracy. The Medical Records Clerk was in-serviced by the Administrator 8/15/16 on the proper use of the form. How the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will review records that are to be released to ensure accuracy and organization thru the double check system with the Medical Records Clerk and any findings will be presented to the Performance Improvement Committee for recommendations Monthly x 3 Months - 9/3/16. The Director of Nursing and the Nurse Manager will perform weekly rounds and review of the Resident records on the unit to ensure that each Resident clinical record is kept in accordance with accepted professional standards and any findings will be presented to the Performance Improvement Committee	

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F 514	Continued From page 7	F 514	Monthly x 3 Months for any recommendations - 9/3/16. This plan has been reviewed by the Medical Director and the Performance Improvement Committee and approved 8/29/16.	