STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	R-C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	**520 VALLEY STREET STATESVILLE, NC 28677**

(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 An on-site revisit was conducted on 8/7/19 and the facility is back into substantial compliance effective 08/07/19.	F 000		

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

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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:
	345128	A. BUILDING: _____ B. WING _____	8/7/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 658	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, Nurse Practitioner, and Medical Doctor interview the facility failed to prevent a significant medication error when Resident #1 was given 70 units of a long acting insulin that was intended for another resident. This affected 1 of 3 (Resident #1) resident investigated for significant medication error. The findings included: Resident #1 was initially admitted to the facility on 08/09/16 and was recently readmitted to the facility on 08/03/19. Her diagnoses included diabetes mellitus. Review of a care plan initiated on 05/29/18 and updated 08/06/19 read in part, Resident #1 has diabetes mellitus. The goal of the care plan read, Resident #1 will have no complications related to diabetes through the review date. The interventions included: diabetes medications as ordered by the doctor, blood sugar as ordered by the doctor, and observe/document/report any signs or symptoms of hyperglycemia or hypoglycemia. Review of a physician order for Resident #1 dated 06/08/19 stated, Basaglar (long acting insulin) 28 units daily for diabetes. Review of the quarterly Minimum Data Set (MDS) dated 07/15/19 revealed that Resident #1 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #1 received 7 days of insulin injections during the assessment reference period. Review of a nurses note dated 07/31/19 at 11:12 PM read in part, Resident #1 received 70 units of Tresiba (long acting insulin) in error. It was intended for the resident in 218 but given to Resident #1 instead. Nurse Practitioner (NP) was notified and order given to send Resident #1 to the Emergency Room (ER) for evaluation. Resident #1 remained alert and oriented x 3 and her blood sugar was 273 and remained asymptomatic. Family was notified and verbalized understanding. Emergency Medical Services notified to transport Resident #1 to the ER, she remained stable on disposition. The note was signed by Nurse #1. Review of a physician order dated 07/31/19 stated, send to ER for evaluation. Review of a preliminary report Discharge Summary dated 08/03/19 from the local hospital read in part, accidental overdose with Tresiba insulin. The patient was placed on a dextrose and half normal saline (intravenous fluids IVF) and initially monitored in the intensive care unit with every hour blood glucose

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 658	Continued From Page 1

checks. Resident #1's glucose remained stable and the IVFs were discontinued. Blood glucose was monitored overnight and remained stable. Resident #1 can resume her normal insulin regimen at discharge.

An observation and interview were conducted with Resident #1 on 08/06/19 at 8:47 AM. Resident #1 was resting in bed with her eyes open and was alert and verbal. She stated that she had just returned from the hospital because the facility had given her the wrong medication, but she could not recall which medication it was. Resident #1 stated she felt fine, but they went ahead and sent her to the hospital, and she had just returned.

An interview was conducted with Nurse #1 on 08/06/19 at 12:11 PM. Nurse #1 stated that 07/31/19 was a really busy night as she was the desk nurse and was overseeing 2 medication aides and Resident #1 had needed several things throughout the shift and she had been in and out of her room all night. Nurse #1 state that it was time for the resident in 218 to have her evening insulin and so she took the insulin pen out of the medication cart and dialed the prescribed 70 units and walked down the hallway to Resident #1's room (216) and walked in and spoke to Resident #1. After a brief conversation she administered the 70 units of Tresiba to Resident #1 in room 216 and as she exited the room someone stated to her that Resident #1 needed something else and she stated I just came out of her room. Nurse #1 state that at that moment she realized she had given Resident #1 the wrong insulin. Nurse #1 stated that she checked her blood sugar and at that time it was 279 and she called the NP and the Director of Nursing and called Resident #1's family. Nurse #1 stated that she went to Resident #1 and spoke to her and apologized for the error and explained that she was going to the ER to be evaluated. Nurse #1 stated that following the incident she completed the nurses note and the medication error report but had not been provided any in-service or education on medication administration following the medication error.

An interview was conducted with the NP on 08/06/19 at 4:13 PM. The NP stated that on 07/31/19 Nurse #1 called her and stated she had given Resident #1 70 units of Tresiba that was intended for the resident in room 218. The NP stated she asked Nurse #1 what other insulin's Resident #1 was prescribed, and it appeared that she was prescribed Basaglar insulin in the morning and then was given 70 units of Tresiba that evening in error. The NP stated that she was very concerned and instructed Nurse #1 to go ahead and send Resident #1 to the ER so she could be monitored more closely. She also stated she instructed Nurse #1 to notify the DON of the error. The NP stated that Resident #1 was a diabetic and was prescribed a different long acting insulin and thankfully she did not have any negative outcome from the medication error.

An interview was conducted with the Medial Doctor (MD) on 08/07/19 at 8:40 AM. The MD stated that he was aware of the medication error that occurred on 07/31/19 with Resident #1. He stated that he over saw her care in the intensive care unit as well. The MD stated that they contacted poison control and they recommended admitting Resident #1 and monitoring blood glucose every hour for 24 hours then decreasing it to every 2-4 hours. He indicated that they followed the recommendations of the poison control center and during her hospital stay her blood sugar did not drop and she was able to maintain a good control. The MD stated the medication error was a significant medication error that certainly could have had negative effects on Resident #1. He added that they caught the error and began treatment quickly and Resident #1 had no negative or lasting effects from the medication error that he was aware of.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 658	Continued From Page 2

An interview was conducted with the DON on 08/07/19 at 12:08 PM. The DON stated that on 07/31/19 Nurse #1 called her and stated that she had given Resident #1 the wrong insulin. Nurse #1 indicated that she had checked on Resident #1 and called the NP and she was being sent to the ER. The DON stated that she told Nurse #1 that she had to be careful when administering medication to make sure it was given to the right resident. The DON stated that she expected the nursing staff to administer medications to resident using the 6 rights of medication administration that include the right resident, the right medication, the right dose, the right time, the right route, and the right documentation.

An interview was conducted with the Administrator on 08/07/19 at 12:10 PM. The Administrator stated that she expected the nursing staff to administer medication using the 6 rights of medication administration that included: the right resident, the right medication, the right dose, the right time, the right route, and the right documentation. The Administrator stated that she had provided education to the Nurse #1 on 08/06/19 in the afternoon about medication administration.

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	345128	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	**520 VALLEY STREET STATESVILLE, NC 28677**

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F 000	INITIAL COMMENTS A complaint investigation survey and on-site follow up was completed on 8/7/19. There was a total of five allegations investigated and one was substantiated.	F 000		

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

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0176	A. BUILDING: _____ B. WING _____	R-C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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L 000	INITIAL COMMENTS An on-site revisit was conducted on 8/7/19 and the facility is back into substantial compliance effective 08/07/19.	L 000		

Division of Health Service Regulation

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{F 000}	INITIAL COMMENTS An on-site revisit was conducted on 8/7/19 and the facility is back into substantial compliance effective 08/07/19.	{F 000}		

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