DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345306	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IREDELL MEMORIAL HOSPITAL INC	557 BROOKDALE DRIVE 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 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the prescribed schedule for insulin administration resulting in an unscheduled dose of insulin being given to 1 of 1 residents (Resident #173) who received an insulin injection during the medication administration observation. The findings included: Resident #173 was admitted to the facility on 3/16/15 with cumulative diagnoses which included diabetes. During the medication administration observation on 3/17/15 at 8:27 AM, Nurse #1 was observed as she prepared and administered 25 units of Levemir insulin to Resident #173 as a subcutaneous (under the skin) injection. Levemir insulin (generic name of insulin detemir) is an intermediate to long-acting insulin. According to LexiComp, a comprehensive on-line medication database, Levemir insulin has an onset of action of 3-4 hours; peak effect of 3-9 hours; and duration of action of up to 23 hours. A review of Resident #173's admission orders dated 3/16/15 revealed a physician's order was written for 25 units of Levemir insulin to be injected subcutaneously once daily at 9:00 PM, with the first dose scheduled for 3/16/15 at 9:00	F 333	It is the policy of this facility to ensure that all residents are free of any significant medication errors. Actions taken towards accomplishing this goal: Immediate Actions: 1) Director of Nursing notified of medication error. 2) Physician notified of medication error and orders received to hold further insulin on 3/17/15 and to change scheduled insulin administration from the evening to the morning starting the next day. 3) Resident #173's blood glucose was monitored every two hours for 12 hours on 3/17/15 to ensure stable blood glucose level with no hypoglycemic events. Subsequent Actions: (Corrective Actions & Systemic Changes) 1) Policy on "Proper Administration of Medication Administration", with a strong emphasis on insulin administration was reviewed with all scheduled nurses.	 3/17/15 3/17/15 3/17/15 3/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsay B. Smith, NHA
TITLE: Administrator
(X6) DATE: 03/26/2015

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 333	Continued From page 1 PM. A review of the resident's electronic medical record revealed there was no documentation on the resident's Medication Administration Record (MAR) to indicate the resident had been given the Levemir insulin on 3/16/15. Documentation on the MAR indicated an injection of 25 units of Levemir insulin was given to the resident on 3/17/15 at 8:30 AM (as observed during the medication administration observation). An interview was conducted with Nurse #1 on 3/17/15 at 2:42 PM. During the interview, inquiry was made as to why there was a discrepancy between the scheduled time of insulin administration for Resident #173 and the time it was observed to be given. Nurse #1 stated that the electronic MAR had indicated the insulin was due that morning. She questioned whether a new order had possibly been received to change the administration time of the Levemir insulin. Upon review of Resident #173's MAR, Nurse #1 reported that she could not find any indication that the insulin administration time had been changed. Nurse #1 then stated is was possible the Levemir insulin had not been given the previous night (3/16/15) and may have been "carried over" by the electronic MAR to the morning of 3/17/15, prompting her to administer a dose of the insulin. Nurse #1 reported she did not recall the electronic MAR providing any type of alert about the medication being administered at the wrong time. On 3/17/15 at 2:50 PM, Nurse #1 was observed as she consulted with the hall's Charge Nurse (Nurse #2). On 3/17/15 at 2:55 PM, Nurse #2 stated she had contacted the facility's pharmacy by telephone and reported the pharmacy did not have a record of an order change for Resident	F 333	2) Iredell Memorial Hospital Diabetes Clinician provided inservice education to all scheduled nursing staff on the signs and symptoms of hyper-any hypoglycemia, and added to staffing huddles through 3/25/15. 3) QA Team met to discuss significant medication errors and recommendations were received for compliance and safety purposes. The recommendations were for each oncoming nurse to review the off going nurse's MAR and Nursing Task List prior to accepting the medication cart to ensure all medications have been administered or accounted for. 4) The facility's Quality Assurance Program was updated to include monitoring of proper insulin administration under the supervision of the Director of Nursing. 5) QA Team recommendations that are mentioned above in #3 were reviewed with all nursing staff and implemented immediately.	3/18/15 3/18/15 3/18/15 3/25/15

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F 333	Continued From page 2 #173's Levemir insulin. The current order indicated Levemir insulin was to be administered once daily at 9:00 PM. Nurse #2 stated the resident's physician would need to be contacted and informed the Levemir insulin had been administered to Resident #173 at 8:30 AM on 3/17/15. An interview was conducted with Nurse #3 on 3/17/15 at 2:57 PM. Nurse #3 was the 2nd shift nurse who cared for Resident #173 from 3:00 PM to 11:00 PM on 3/16/15. Nurse #3 reported the 3rd shift nurse had called him last evening (3/16/15) to inquire whether or not he had given Resident #173 her 9:00 PM dose of Levemir insulin. Nurse #3 reported he clearly recalled giving the resident a 9:00 PM dose of Levemir insulin, but stated he apparently had not documented the insulin administration on the resident's MAR. Nurse #3 indicated he asked the 3rd shift nurse to document that the 9:00 PM insulin dose had been given to Resident #173 on 3/16/15. He stated that he had planned to make an additional notation about the missed documentation of the insulin administration when he returned to work on 3/17/15. A follow-up interview was conducted with Nurse #2 on 3/17/15 at 3:03PM. Upon further review of Resident #173's medical record, Nurse #2 reported a Nursing Progress Note was written by the 3rd shift nurse on 3/17/15 at 12:55 AM. The note read, "Scheduled insulin, Levemir, given per (Nurse #2), verified to (3rd shift nurse) by (Nurse #2)." Nurse #2 confirmed there were no notations made on the MAR to indicate a dose of Levemir insulin was administered to the resident on 3/16/15 at 9:00 PM. Nurse #2 indicated further review of the MAR revealed the	F 333	6) Inservice education provided to all nursing staff (this included all CNA's and all licensed nurses) on state and federal requirements for minimizing significant medication errors. Training emphasized the importance of using facility procedures for proper administration of insulin and other medications for the safety of all residents in this facility and followed up on staff questions. 7) Monitoring Plan and Quality Expectation that each oncoming nurse will review the off going nurse's MAR and Nursing Task List prior to accepting the medication cart to ensure all medications have been administered or accounted for was reviewed with all nurses. 8) Further continuing education will be provided to nurses by Lantus Drug Representative to discuss proper insulin administration and diabetes education and monthly staff meeting.	3/25/15 Implemented on 3/25/15 and Ongoing Planned for 4/15/15 and Ongoing

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F 333	Continued From page 3 computerized system had generated a pop-up alert of "Medium Importance" on 3/17/15 at 8:30 AM. Nurse #2 reported a response would have been required to acknowledge and continue past the electronic alert on the MAR. The MAR records indicated Nurse #1 had input an "Early/Late Reason" for administering the Levemir insulin on 3/17/15 at 8:30 AM, with the reason noted as, "Nursing Judgment." An interview was conducted with the Director of Nursing (DON) on 3/17/15 at 3:04 PM. The DON acknowledged the 8:30 AM dose of Levemir insulin administered to Resident #173 on 3/17/15 was an unscheduled dose. The DON reported the physician had been contacted, informed of the unscheduled administration of Levemir insulin to Resident #173 at 8:30 AM, and new orders were received for the resident. A follow-up interview was conducted with the facility's Administrator and DON on 3/17/15 at 5:13 PM. During the interview, the situation involving Resident #173's unscheduled Levemir insulin administration was discussed. The DON indicated Nurse #3 (the 2nd shift nurse assigned to care for the resident on 3/16/15), "did not follow the process in place." Both the Administrator and DON reported corrective measures had been initiated to prevent similar occurrences in the future.	F 333	Monitoring Plan: 1) The Director of Nursing will monitor medication records to ensure accurate administration of insulin with rounds and through chart audits 3 times per week for the first 30 days or until 100% compliance is achieved for 30 consecutive days. 2) Ongoing audits will be conducted monthly with 70 insulin administrations reviewed each month for two months, then 70 insulin administrations per quarter for 3 quarters. 3) Any deficiencies will be corrected and reported in a timely manner according to facility policy. 4) Quality monitoring findings, including any correction actions taken in response to deficiencies, will be reported to the Quality Assurance Committee and the organization-wide Quality Coordinating Council.	Implemented on 3/18/15 and Ongoing