STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____ FEB 14 2012	C 01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on record review, interview with the attending physician, and staff interviews, the facility failed to administer the correct sliding scale insulin coverage for 1 of 2 Residents (Res. #2) receiving sliding scale insulin. Findings include:

Record review indicated Resident #2 was admitted to the facility on 11/09/11 from the hospital with diagnoses of Diabetes Mellitus.

Review of the Laboratory studies dated 11/10/11 indicated Resident #2 had a high Glucose level of 167 mg/dl (milligrams per deciliter) with a Reference Range of 70 mg/dl - 99 mg/dl. The Hemoglobin A1C (estimated average glucose) was high at 6.7 with a Reference Range of less than 5.7%.

A Physician's Progress Note dated 11/15/11 read in part, "Diabetes- blood sugars have been poorly controlled since admission. Range 174 -270 mg/dl. Continue to check BS (blood sugar) BID (2 times per day). Recent HGB (Hemoglobin) A1C 6.7. Will adjust med (medications) accordingly."

Review of the Physician's Telephone orders dated 11/30/11 at 9:00 PM read, FSBS (Fasting Blood Sugars) BID (2 times per day) with Sliding Scale Insulin Novolog (200-250 mg/dl = 2 units,

This plan of correction is submitted as required under state and federal law. The facility's submission of this Plan of Correction does not constitute any admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the plan of correction cannot be used against the facility in any subsequent administrative or civil proceedings.

1. Resident # 2 was assessed by the Director of Nursing on 01/20/2012. The attending physician and the Responsible Party was notified by the Director of Nursing on 01/23/2012. No adverse outcomes were noted. An order was received on 01/23/2012 by the Director of Nursing to discontinue the order for sliding scale insulin. 2/10/12

2. A 100% audit was conducted on 02/09/12 and 02/10/12 by the Director of Nursing, Assistant Directors of Nursing, and Minimum Data Set Coordinators of all residents to determine if sliding scale insulin was ordered and given as ordered. Any resident found to be affected had their responsible party and attending physician notified.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Raymond Cooper	Administrator	2/10/12

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 1 251-300 mg/dl = 4 units, 301 -350 mg/dl = 6 units, 351 - 400 mg/dl = 8 units, and 400 mg/dl = 10 units." Review of the Medication Administration Record (MAR) for December 2011 was transcribed as, Novolog S/S (Sliding Scale) 201 - 200) mg/dl =2 u (units), 251 - 300 mg/dl = 4 u, 301 - 350 mg/dl =6 u, 351 - 400 mg/dl = 8 u, > (greater than) 400 mg/dl = 10 u, and call MD (Physician). A staff interview was conducted with the DON (Director of Nurses) on 01/20/12 at 5:30 PM. The DON indicated, " I think it was a transcription error where the order for the sliding scale insulin was not carried over from the November (2011) MAR." A interview was conducted by phone with the facility Physician on 01/20/12 at 5:00 PM regarding the sliding scale blood sugar ranges ordered for Resident #2. The Physician indicated, "It has to be 201 - 250 mg/dl. It's always in 50 point increments. I believe it ' s a transcription error." Review of the December 2011 Medication Administration Record (MAR) from 12/01/11 - 12/31/11 indicated on 12/03/11 at 4:30 PM the blood sugar readings were noted at 256 mg/dl. No insulin coverage was given according to the Physician's orders. On 12/5/11 at 4:30 PM the blood sugar readings were noted at 220 mg/dl. No insulin coverage was given. On 12/6/11 at 4:30 PM the blood sugar readings were 281 mg/dl. No insulin coverage was given. On 12/07/11 at 4:30 PM the blood sugar readings were 368 mg/dl. No insulin coverage was given.	F 333	3. All licensed nurses were inserviced by the Staff Development Coordinator from 02/08/2012 through 02/10/2012 regarding obtaining, transcribing, and administering insulin orders. 4. An audit of all resident Medication Administration Records who have sliding scale insulin ordered will be reviewed by the Director of Nursing and/or the Assistant Directors of Nursing to ensure that sliding scale insulin is given as ordered. This audit will take place five days per week for four weeks then weekly for two months and/or 100% compliance. Results of this audit will be brought to and reviewed in the monthly Quality Assurance / Performance Improvement Committee Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance/Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

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F 333	Continued From page 2	F 333		

On 12/09/11 at 8:00 AM the blood sugar levels were 213 mg/dl. The Physician orders read Sliding Scale 201 -250 give 2 units Insulin. The MAR indicated the resident was given 4 units of insulin instead of 2 units. On 12/10/11 at 8:00 AM the blood sugar levels were at 325 mg/dl. No insulin coverage was given. On 12/10/11 at 4:30 PM the blood sugar levels were 210 mg/dl. No insulin coverage was given.

Interview with Nurse #1 was conducted on 01/20/12 at 4:45 PM, regarding the reason why the sliding scale insulin coverage was not given as ordered on 11/30/11. Nurse #1 indicated, " I started giving the coverage when I did the finger stick. I started giving coverage on the December 14, 2011. I gave coverage for the first time on December 14. The sliding scale wasn't on there (referring to the written entry on the MAR) before the 14th. It wasn't on there (referring to the written entry on the MAR) and then all of a sudden it was. On 12/5/11, 12/06/11, 12/07/11, and 12/10/11, I did not give coverage because there wasn't a sliding scale on the MAR."

Interview with MDS Coordinator #1 on 01/20/12 at 4:20 PM indicated, "We did an audit in the last week of the year (December 2011), we were participating in our MAR audits to see if medications were being given as ordered. We found enough omissions on the MAR's to implement it in our QA(Quality Assurance) in January. What we were doing was monitoring documentation at the end of the shift and asking our Nurses to check for holes on our MAR'S. We concentrated on insulin injections the last week of December. For (Resident #2), we found out there were days the medication had not been given."

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F 333	Continued From page 3	F 333		

Interview with the DON on 01/20/12 at 4:30 PM regarding the lack of insulin coverage for Resident #2 in December of 2011. The DON indicated, " When there were instances where the resident did not receive the medication as ordered, the Physician was notified and the family was notified. It is considered a drug error. "

Interview with the DON on 1/20/12 at 5:30 PM revealed, "If the order is for the resident to receive the insulin sliding scale coverage, the Nurse is supposed to give it according to the range."