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SKYLAND TERRACE AND REHABILITATION	516 WALL STREET WAYNESVILLE, NC 28786

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F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted 7/11/23 through 7/14/23. The following intakes were investigated: NC00196377, NC00196817, NC00199143, NC00199576, NC201016. Event ID# VZZ211. Event ID# VZZ211. 6 of 6 complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) regarding smoking for 1 of 1 resident reviewed for smoking (Resident #58). Findings included: Resident #58 was admitted to the facility on 12/28/22. The smoking care plan initiated on 01/31/23 for Resident #58 revealed she was an unsafe smoker. The goal was to remain free of injury from unsafe smoking practices through the review date. Interventions included instructing Resident #58 about smoking risks and policy of smoking, monitoring for unsafe smoking with oxygen, and providing supervision when while smoking.	F 641	1. Resident # 58's comprehensive admission Minimum Data Set "MDS", section J1300 "Tobacco Use" was answered "no". This resident is a smoker and should have been coded "yes". This was an oversight by the MDS nurse. Resident # 58 was care planned and the smoking assessment was completed timely. The MDS Coordinator corrected the assessment on 7/14/2023 and answered "yes" to section J1300 indicating that resident #58 was a smoker. 2. All comprehensive assessments for all current residents were audited to ensure section J1300 was coded accurately on the MDS. MDS nurses were educated by the Administrator on 7/31/2023 on the importance of assessment accuracy and instructed to review coding prior to	7/31/23

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

Electronically Signed | 07/31/2023

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F 641	Continued From page 1 Review the smoking assessment for Resident #58 on 04/28/23 revealed she was assessed as an unsafe smoker and required direct supervision during smoking. Review of the admission MDS dated 05/03/23 revealed Resident #58 was coded as a non-tobacco user under Section J 1300. During an interview conducted on 07/11/23 at 3:03 PM, Resident #58 stated she had smoked cigarettes from the day she had been admitted to the facility. During an observation conducted on 07/12/23 at 1:27 PM, Resident #58 was seen smoking in the courtyard with 3 other residents under the supervision of 1 facility staff. During an interview conducted on 07/14/23 at 9:45 AM, the MDS Coordinator stated Resident #58 had been a tobacco user since she admitted to the facility late last year. He confirmed he was responsible for Resident #58's MDS and it was an error to code her as a non-tobacco user due to his oversight. He added the error would be corrected and the MDS re-submitted as soon as possible. During a joint interview conducted on 07/14/23 at 10:59 AM, the Director of Nursing and the Administrator expected all the MDS assessments to be coded accurately.	F 641	submission. 3. In reviewing this deficiency, we do not feel that systemic change is needed. The facilities policy is that the MDS will be coded accurately. The MDS nurses were educated by the Administrator on 7/31/2023 on the importance of assessment accuracy and instructed to review coding of each MDS assessment prior to state submission. 4. The MDS nurses along with the Director of Nursing will audit all assessments completed during the month to assure J1300 is accurately coded. The clinical team will also review the previous weeks MDS assessments to ensure J1300 is coded accurately. These audits will be completed weekly for three months to ensure accuracy, and then monthly for three months. If discrepancies are found, the audits will continue until compliance is achieved. The audit will be turned into the administrator to review in the monthly Quality Assurance Performance Improvement QAPI meeting to ensure complete accuracy. The POC was completed on 7/31/2023.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		7/21/23

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F 756	Continued From page 2 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and	F 756	1. The consultant pharmacist notified the physician on 7/13/2023 that she	

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F 756	Continued From page 3 Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 2 of 7 residents reviewed for unnecessary medications (Residents #24 and Resident #38). The findings included: 1.Resident #24 was admitted to the facility on 06/11/20 with diagnoses that included hyperlipidemia. Review of the medical record for Resident #24 revealed a lipid panel had not been completed since she was admitted to the facility on 06/11/20. Review of the physician orders dated 11/12/21 revealed an order for Resident #24 to receive 1 tablet of atorvastatin 20 milligrams (mg) by mouth once daily at bedtime for hyperlipidemia. A review of medication administration records (MARs) indicated Resident #24 had received atorvastatin as ordered for the past 12 months. Review of Resident #24's vital signs revealed her blood pressure was stable and within the normal limits for the past 6 months. The quarterly Minimum Data Set (MDS) dated 06/30/23 assessed Resident #24 with intact cognition. A further review of medical records revealed the Consultant Pharmacist had completed medication regimen reviews for Resident #24 on the following dates in the past 12 months: 07/11/22, 08/05/22, 09/11/22, 10/19/22, 11/20/22, 12/17/22, 01/31/23, 02/20/23, 03/19/23, 04/20/23, 05/19/23,	F 756	recommended a lipid panel be ordered to check the need for continuing medications for hyperlipidemia on resident #24. The physician ordered a lipid panel on 7/14/2023 for resident # 24. The consultant pharmacist reviewed the sliding scale insulin order for resident # 24 & 38, the order was updated in the Medication Administration Record MAR to alert staff if the residents blood glucose is outside of the parameters on the sliding scale order. 2. The consultant pharmacist audited all residents on 7/20/2023 to assure that all recommended labs for medication monitoring are up to date. The consultant pharmacist was educated by the Director of Clinical Consultants on 7/20/2023 on appropriate medication management monitoring. All residents with sliding scale insulin were audited on 7/13/2023 and the orders were corrected to attach the parameters to the actual order in the MAR. Upon admission, each resident's medication list will be reviewed for any medications that require routine lab monitoring. All new medication orders will also be reviewed for appropriate lab monitoring. These recommendations will be sent to the prescriber in the monthly Medication Record Review "MRR" report prepared by the consultant pharmacist. The consultant pharmacist along with the Director of Clinical Consultants will review each sliding scale insulin dose to ensure insulin was given within the prescribed parameters and will immediately notify the facility of any discrepancies.	

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F 756	Continued From page 4 and 06/20/23. The Consultant Pharmacist had made several recommendations to the physician in the past 12 months. However, none of the recommendations were related to cholesterol level monitoring. During an interview conducted on 07/13/23 at 9:37 AM, Resident #24 stated she had been taking atorvastatin for more than 2 years in the facility. However, she could not recall the facility had ever checked her cholesterol level so far. She added her blood pressure in the past 6 months was stable and within the normal limits. An interview was conducted with the Medical Record Coordinator on 07/13/23 at 11:11 AM. She confirmed she could not find any records related to lipid panel for Resident #24 since her admission. 2. Resident #38 was admitted to the facility on 06/15/22 with diagnoses included diabetes mellitus. The diabetic care plan initiated on 06/18/22 for Resident #38 revealed she was diagnosed with diabetes mellitus with risk for complications. The goal was to remain free from signs and symptoms of hypoglycemia through the next review period. Intervention included administering insulin as ordered by the physician. Review of the physician's orders dated 03/27/23 revealed Resident #38 had an order to receive 3 units of Novolog insulin subcutaneously before meals for diabetes. The order specified to hold the insulin when Resident #38's CBG was lower than 150 mg/dL.	F 756	3. There are no systemic changes required in reference to lab monitoring as the consultant pharmacist already reviews each medication upon admission and new orders that require lab monitoring and recommends labs to be ordered to the prescriber each month. The consultant pharmacist changed her monthly process to review every sliding scale insulin order to ensure the prescribed parameters are being followed. The audit will be completed by the consultant pharmacist along with the Director of Clinical Consultants, the audit will be included in the pharmacist monthly report. The Consultant Pharmacist will immediatley notify the Administrator and Director of Nursing if discrepancies are found. 4. The Consultant Pharmacist and Director of Clinical Consultants will turn their completed audit into the Administrator each month for the next 6 months showing all new admissions and new orders were reviewed for routine lab monitoring. They will also turn in an audit of all sliding scale insulin orders reviewed each month. These audits will be reviewed each month by the Quality Assurance Performance Improvement "QAPI" committee to ensure overall compliance. If labs are found to be missing, the Director of Clinical Consultants will provide further education to the consultant pharmacist. This POC was completed on 7/21/2023.	

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F 756	Continued From page 5	F 756		

The quarterly Minimum Data Set (MDS) dated 06/21/23 assessed Resident #38 with intact cognition.

A review of the MARs for June and July 2023 revealed Resident #38 had received 3 units of Novolog insulin subcutaneously outside of the perimeter 34 times in June 2023 and 13 times in July 2023 when her CBGs were less than 150 mg/dL prior to insulin administration on the following occasions:

- 06/01/23 in the evening when CBG = 111 mg/dL
- 06/02/23 in the evening when CBG = 133 mg/dL
- 06/04/23 in the morning when CBG = 137 mg/dL
- 06/05/23 in the evening when CBG = 108 mg/dL
- 06/06/23 in the morning when CBG = 128 mg/dL
- 06/06/23 in the evening when CBG = 145 mg/dL
- 06/08/23 in the morning when CBG = 114 mg/dL
- 06/09/23 in the morning when CBG = 119 mg/dL
- 06/10/23 in the morning when CBG = 133 mg/dL
- 06/10/23 in the evening when CBG = 110 mg/dL
- 06/11/23 in the morning when CBG = 107 mg/dL
- 06/11/23 in the evening when CBG = 123 mg/dL
- 06/12/23 in the morning when CBG = 106 mg/dL
- 06/12/23 in the evening when CBG = 149

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F 756	Continued From page 6	F 756		

mg/dL
- 06/13/23 in the evening when CBG = 139 mg/dL
- 06/14/23 in the morning when CBG = 145 mg/dL
- 06/15/23 in the morning when CBG = 141 mg/dL
- 06/16/23 in the evening when CBG = 113 mg/dL
- 06/18/23 in the morning when CBG = 117 mg/dL
- 06/19/23 in the evening when CBG = 111 mg/dL
- 06/20/23 in the morning when CBG = 137 mg/dL
- 06/20/23 in the evening when CBG = 120 mg/dL
- 06/21/23 in the morning when CBG = 107 mg/dL
- 06/21/23 in the evening when CBG = 129 mg/dL
- 06/22/23 in the evening when CBG = 144 mg/dL
- 06/24/23 in the morning when CBG = 127 mg/dL
- 06/24/23 in the evening when CBG = 106 mg/dL
- 06/25/23 in the morning when CBG = 121 mg/dL
- 06/25/23 in the evening when CBG = 108 mg/dL
- 06/27/23 in the morning when CBG = 122 mg/dL
- 06/27/23 in the evening when CBG = 134 mg/dL
- 06/28/23 in the morning when CBG = 122 mg/dL
- 06/29/23 in the evening when CBG = 117 mg/dL

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F 756	Continued From page 7	F 756		

- 06/30/23 in the morning when CBG = 122 mg/dL

- 07/01/23 in the morning when CBG = 99 mg/dL
- 07/03/23 in the morning when CBG = 116 mg/dL
- 07/03/23 in the evening when CBG = 117 mg/dL
- 07/04/23 in the morning when CBG = 129 mg/dL
- 07/05/23 in the morning when CBG = 124 mg/dL
- 07/05/23 in the midday when CBG = 101 mg/dL
- 07/06/23 in the morning when CBG = 114 mg/dL
- 07/09/23 in the morning when CBG = 119 mg/dL
- 07/09/23 in the midday when CBG = 139 mg/dL
- 07/10/23 in the morning when CBG = 132 mg/dL
- 07/11/23 in the morning when CBG = 94 mg/dL
- 07/11/23 in the midday when CBG = 112 mg/dL
- 07/12/23 in the morning when CBG = 116 mg/dL

Review of medical records revealed the Consultant Pharmacist had completed medication regimen reviews for Resident #38 on the following dates in the past 12 months: 07/13/22, 08/13/22, 09/07/22, 10/20/22, 11/23/22, 12/18/22, 01/31/23, 02/21/23, 03/20/23, 04/23/23, 05/21/23, and 06/22/23.

The Consultant Pharmacist had made several recommendations to the physician in the past 12 months. However, none of the recommendations

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F 756	Continued From page 8 were related to concerns over administering Novolog without following the perimeter. During an interview conducted on 07/13/23 at 1:35 PM, the Consultant Pharmacist explained the facility did not have an electronic lab protocol that would trigger lab orders automatically as indicated at certain time interval on regular basis. She added she had alerted the physician to order lipid panel for other residents as indicated but she did not know why Resident #24 was excluded. The Consultant Pharmacist stated she did not notice that nurses had been administering Novolog to Resident #38 without following the physician's perimeter repeatedly when she performed the monthly medication regimen reviews. A phone interview was conducted with the MD on 07/13/23 at 2:01 PM. She expected the Consultant Pharmacist to identify and report all drug irregularities related to Novolog and recommend lipid panel when it had not been in place for more than 1 year. During a joint interview conducted on 07/14/23 at 10:59 AM, the Director of Nursing and the Administrator expected the Consultant Pharmacist to identify and report all drug irregularities as indicated and provide recommendations to the physician in timely manner.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		7/21/23

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F 757	Continued From page 9 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with Resident, staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to monitor cholesterol level for 1 of 7 residents reviewed for unnecessary medications (Resident #24). The findings included: Review of lipid guidelines published in 2019 by American College of Cardiology and American Heart Association indicated a lipid panel should be conducted at baseline, then 4 to 12 weeks after statin therapy was started or when a dosage was adjusted. Afterwards, a lipid panel test should be repeated once every 3 to 12 months or as needed.	F 757	1. The Consultant Pharmacist notified the Physician on 7/13/2023 that she recommended a lipid panel be ordered to check the need for continuing medications for hyperlipidemia on resident #24. The Physician ordered a lipid panel on 7/14/2023 for resident # 24. 2. The Consultant Pharmacist audited all residents on 7/20/2023 to assure that all recommended labs for medication monitoring are up to date. The Consultant Pharmacist was educated by the Director of Clinical Consultants on 7/20/2023 on appropriate medication management monitoring. Upon admission, each resident's medication list will be reviewed for any	

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F 757	Continued From page 10 Resident #24 was admitted to the facility on 06/11/20 with diagnoses that included hyperlipidemia. Review of medical records for Resident #24 revealed a lipid panel had not been completed since she was admitted to the facility on 06/11/20. Review of physician's orders dated 11/12/21 revealed an order for Resident #24 to receive 1 tablet of atorvastatin 20 milligrams (mg) by mouth once daily at bedtime for hyperlipidemia. A review of the medication administration record (MARs) indicated Resident #24 had received atorvastatin as ordered for the past 12 months. The quarterly Minimum Data Set (MDS) dated 06/30/23 assessed Resident #24 with intact cognition. During an interview conducted on 07/13/23 at 9:37 AM, Resident #24 stated she had been taking atorvastatin for more than 2 years in the facility. However, she could not recall the facility had ever checked her cholesterol level. An interview was conducted with the Medical Record Coordinator on 07/13/23 at 11:11 AM. She confirmed she could not find any records of lipid panel being completed for Resident #24 since her admission. During an interview conducted on 07/13/23 at 1:35 PM, the Consultant Pharmacist explained the facility did not have an electronic lab protocol that would trigger lab orders automatically as indicated at certain time interval on a regular basis. She added she had alerted the physician to	F 757	medications that require routine lab monitoring. All new medication orders will also be reviewed for appropriate lab monitoring. These recommendations will be sent to the prescriber in the monthly Medication Record Review "MRR" report prepared by the Consultant Pharmacist. 3. There are no systemic changes required as it is the facilities policy that the Consultant Pharmacist reviews each medication upon admission and new orders written during the month that may require lab monitoring and the make recommendations to the prescriber for labs that need to be ordered. 4. The Consultant Pharmacist along with the Director of Clinical Consultants will turn an audit into the Administrator each month for the next 6 months showing all new admissions and new orders written during the month were reviewed for routine lab monitoring. This audit will be reviewed each month by the Quality Assurance Performance Improvement "QAPI" committee to ensure overall compliance. If labs are found to be missing, the Director of Clinical Consultants will provide further education including disciplinary action if warranted to the Consultant Pharmacist. This POC was completed on 7/21/2023.	

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F 757	Continued From page 11 order a lipid panel for other residents as indicated but she did not know why Resident #24 was excluded. A phone interview was conducted with the MD on 07/13/23 at 2:01 PM. She stated she expected the facility to conduct a lipid panel for Resident #24 at least once per year or as needed according to the published lipid guidelines. During a joint interview conducted on 07/14/23 at 10:59 AM, the Director of Nursing and the Administrator expected the facility to conduct lipid panels as indicated per the published lipid guidelines for all the residents with statin therapy for cholesterol monitoring.	F 757		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and the Medical Director (MD), the facility failed to prevent a significant medication error when nurses failed to follow physician's perimeter setting as ordered during insulin administration. As a result, Resident #24 received 2 doses of unnecessary Novolog insulin within 1 day, and Resident #38 had received 34 doses of unnecessary Novolog insulin in June 2023, 13 doses of unnecessary Novolog insulin in July 2023. This affected 2 of 7 residents reviewed for significant medication errors (Resident #24 and Resident #38).	F 760	1. Resident # 24 & 38's insulin orders were reviewed, and the order was changed in our electronic medical record system to link the sliding scale insulin parameters to the order. The nurse will enter the blood glucose result into the Medication Administration Record "MAR", if the result is outside of the ordered parameters the system will alert the nurse and will not let them record that it was administered. 2. All residents with sliding scale insulin were audited on 7/13/2023 and the orders	7/15/23

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F 760	Continued From page 12 The findings included: 1.Resident #24 was admitted to the facility on 06/11/20 with diagnoses included diabetes mellitus. The diabetic care plan initiated on 05/24/21 for Resident #24 revealed she was diagnosed with diabetes mellitus. The goal was to remain free of complications related to diabetes through the next review period. Intervention included to administer diabetes medications as ordered by the physician. The quarterly Minimum Data Set (MDS) dated 06/30/23 assessed Resident #24 with intact cognition. Review of the physician's orders dated 07/10/23 revealed Resident #24 had an order to receive 4 units of Novolog insulin subcutaneously before meals and at bedtime for diabetes. The order specified to hold the insulin when Resident #24's capillary blood glucose (CBG) was lower than 150 milligrams per deciliter (mg/dL). A review of the medication administration records (MARs) for July 2023 revealed Resident #24 had received 4 units of Novolog insulin subcutaneously 2 times outside of the perimeter within 1 day in July 2023 when her CBGs were less than 150 mg/dL prior to insulin administration on the following occasions: - 07/11/23 in the morning when CBG = 130 mg/dL - 07/11/23 at bedtime when CBG = 110 mg/dL 2. Resident #38 was admitted to the facility on	F 760	were corrected to attach the sliding scale insulin parameters to the actual order in the MAR. The nurse will enter the blood glucose result into the Medication Administration Record "MAR", if the result is outside of the ordered parameters the system will alert the nurse and will not let them record that it was administered. Education was started by the Director of Nursing "DON" on 7/13/2023 and will be ongoing with all current nurses, agency nurses, and new nurses onboarding to check medication orders and read the entire order before administering the medication. No nurse will be allowed to work until they have been educated. 3. A systemic change was implemented. All sliding scale insulin orders will be entered into our electronic medical record with the prescribed sliding scale insulin parameters attached to the insulin order. The nurse will enter the blood glucose result into the Medication Administration Record "MAR", if the result is outside of the ordered parameters the system will alert the nurse and will not let them record that it was administered. 4. The DON or designee will audit all sliding scale insulin administration each day x 1 month, then one time per week for 1 month, and then every 2 weeks for 1 month. If at any time during these audits, if we find discrepancies, we will start back over in the audit process and immediately provide re-education and/or disciplinary	

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F 760	Continued From page 13 06/15/22 with diagnoses included diabetes mellitus. The diabetic care plan initiated on 06/18/22 for Resident #38 revealed she was diagnosed with diabetes mellitus with risk for complications. The goal was to remain free from signs and symptoms of hypoglycemia through the next review period. Intervention included administering insulin as ordered by the physician. Review of the physician's orders dated 03/27/23 revealed Resident #38 had an order to receive 3 units of Novolog insulin subcutaneously before meals for diabetes. The order specified to hold the insulin when Resident #38's CBG was lower than 150 mg/dL. The quarterly MDS dated 06/21/23 assessed Resident #38 with intact cognition. A review of the MARs for June and July 2023 revealed Resident #38 had received 3 units of Novolog insulin subcutaneously outside of the perimeter 34 times in June 2023 and 13 times in July 2023 when her CBGs were less than 150 mg/dL prior to insulin administration on the following occasions: - 06/01/23 in the evening when CBG = 111 mg/dL - 06/02/23 in the evening when CBG = 133 mg/dL - 06/04/23 in the morning when CBG = 137 mg/dL - 06/05/23 in the evening when CBG = 108 mg/dL - 06/06/23 in the morning when CBG = 128 mg/dL	F 760	action including up to termination if warranted. These audits will be turned in to the Administrator to review and discuss in our monthly Quality Assurance Performance Improvement meeting to ensure complete compliance. This POC was completed on 7/15/2023	

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F 760	Continued From page 14 - 06/06/23 in the evening when CBG = 145 mg/dL - 06/08/23 in the morning when CBG = 114 mg/dL - 06/09/23 in the morning when CBG = 119 mg/dL - 06/10/23 in the morning when CBG = 133 mg/dL - 06/10/23 in the evening when CBG = 110 mg/dL - 06/11/23 in the morning when CBG = 107 mg/dL - 06/11/23 in the evening when CBG = 123 mg/dL - 06/12/23 in the morning when CBG = 106 mg/dL - 06/12/23 in the evening when CBG = 149 mg/dL - 06/13/23 in the evening when CBG = 139 mg/dL - 06/14/23 in the morning when CBG = 145 mg/dL - 06/15/23 in the morning when CBG = 141 mg/dL - 06/16/23 in the evening when CBG = 113 mg/dL - 06/18/23 in the morning when CBG = 117 mg/dL - 06/19/23 in the evening when CBG = 111 mg/dL - 06/20/23 in the morning when CBG = 137 mg/dL - 06/20/23 in the evening when CBG = 120 mg/dL - 06/21/23 in the morning when CBG = 107 mg/dL - 06/21/23 in the evening when CBG = 129 mg/dL - 06/22/23 in the evening when CBG = 144	F 760		

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F 760	Continued From page 15	F 760		

mg/dL
- 06/24/23 in the morning when CBG = 127 mg/dL
- 06/24/23 in the evening when CBG = 106 mg/dL
- 06/25/23 in the morning when CBG = 121 mg/dL
- 06/25/23 in the evening when CBG = 108 mg/dL
- 06/27/23 in the morning when CBG = 122 mg/dL
- 06/27/23 in the evening when CBG = 134 mg/dL
- 06/28/23 in the morning when CBG = 122 mg/dL
- 06/29/23 in the evening when CBG = 117 mg/dL
- 06/30/23 in the morning when CBG = 122 mg/dL

- 07/01/23 in the morning when CBG = 99 mg/dL
- 07/03/23 in the morning when CBG = 116 mg/dL
- 07/03/23 in the evening when CBG = 117 mg/dL
- 07/04/23 in the morning when CBG = 129 mg/dL
- 07/05/23 in the morning when CBG = 124 mg/dL
- 07/05/23 in the midday when CBG = 101 mg/dL
- 07/06/23 in the morning when CBG = 114 mg/dL
- 07/09/23 in the morning when CBG = 119 mg/dL
- 07/09/23 in the midday when CBG = 139 mg/dL
- 07/10/23 in the morning when CBG = 132

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F 760	Continued From page 16	F 760		

mg/dL
- 07/11/23 in the morning when CBG = 94 mg/dL
- 07/11/23 in the midday when CBG = 112 mg/dL
- 07/12/23 in the morning when CBG = 116 mg/dL

During an interview conducted on 07/13/23 at 9:07 AM, Nurse #1 acknowledged that she was working on 06/01/23, 06/05/23, 06/11/23, 06/16/23, 06/19/23, 06/24/23, 06/25/23, 06/29/23, and 07/03/23 and confirmed she had administered Novolog to Resident #38 repeatedly when her CBGs were less than 150 mg/dL. She was aware of the perimeter set by the physician to hold the Novolog if the CBG was less than 150 mg/dL. She explained most of the times when she told Resident #38 her CBG level, she would request to have the Novolog as she planned to have some snacks soon. Nurse #1 stated Resident #38 had the right to have the insulin and added she did not consult the physician prior to administering Novolog outside of the perimeter.

An interview was conducted with the Unit Manager on 07/13/23 at 9:34 AM. She expected the nurse to consult the physician to obtain order to administer Novolog outside of the perimeter. It was her expectation all the nurses to follow physician's order and the perimeter all the time.

During an interview conducted on 07/13/23 at 9:37 AM, Resident #24 could not recall if she had ever requested to have Novolog from the nurse when her glucose level was less than 150 mg/dL.

An interview was conducted with Nurse #2 on 07/13/23 at 10:06 AM. She acknowledged that

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F 760	Continued From page 17	F 760		

she worked on 06/06/23. 06/08/23, 06/12/23, 06/21/23, 07/05/23, and 07/11/23 and confirmed she had administered Novolog to Resident #24 and Resident #38 repeatedly when their CBGs were less than 150 mg/dL. She was aware of the perimeter attached to the Novolog order. Nurse #2 explained both Resident #24 and Resident #38 would request to have the Novolog when they were notified of CBG below 150 mg/dL as they planned to have some snacks within a short period of time. She stated she should have consulted the physician before administering the Novolog outside of the perimeter.

During an interview conducted on 07/13/23 at 11:29 AM, Resident #38 confirmed she had requested the nurse to give her Novolog frequently when her CBG was below 150 mg/dL as she planned to have some snacks very soon after the CBG checks.

During an interview conducted on 07/13/23 at 1:35 PM, the Consultant Pharmacist stated she did not notice that nurses had been administering Novolog to Resident #38 repeatedly without following physician's perimeter when she performed the monthly medication regimen reviews. She added the incident was a significant medication error as it involved insulin.

A phone interview was conducted with the MD on 07/13/23 at 2:01 PM. She stated the nurse should not administer the Novolog when the CBGs were less than 150 mg/dL. It was her expectation for all nurses to follow the physician's order and its perimeter all the time. She was not sure if the incident would be considered as a significant medication error.

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F 760	Continued From page 18 During a joint interview conducted on 07/14/23 at 10:59 AM, the Director of Nursing and the Administrator acknowledged that the incident was a significant medication error as it involved insulin with the potential of triggering low blood glucose level. Both expected all nursing staff to follow physician's order and the set perimeters fully when administering medications.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a walk-in refrigerator from an accumulation of thick, clumpy grayish matter on the circulatory fan cover and thick, clumpy darkish buildup on the floor of 1 of 2 walk-in refrigerators. In addition, the facility failed	F 812	1. The expired loaves of bread were immediately discarded, and all other loaves were audited to ensure they were within date. Cooler mats were taken out of the cooler on the evening of 7/11/2023 and pressure	7/24/23

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F 812	Continued From page 19 to discard 2 opened loaves of expired bread. This practice had the potential to affect foods served to residents. Findings included: 1.On 07/11/23 at 9:32 AM an observation of the kitchen prep table revealed 2 opened loaves of bread sitting next to the toaster and ready to be used. The label on the plastic wrap of the white sandwich bread indicated it was expired on 07/08/23 and the whole wheat bread revealed it was expired on 07/09/23. Further observation revealed half of both loaves of bread had been used. During an interview conducted on 07/11/23 at 9:37 AM, Cook #1 stated she had used one slice of bread from both loaves of bread this morning to make toasts for residents. She explained it was her oversight as she did not pay attention to the expiration dates of the breads prior to using it. She acknowledged that both loaves of bread should be discarded as they were expired. 2. On 07/11/23 at 10:11 AM an observation of one of the two walk-in refrigerators revealed the entire floor was covered with rubber mat approximately 1 inch in thickness. Further observation revealed the floor had an accumulation of thick, clumpy, darkish matter underneath the rubber mat. In addition, the air vents in the same walk-in refrigerator were observed with a buildup of thick, clumpy grayish matter on the circulatory fan cover, around the light, and electrical cords. During an interview conducted on 07/11/23 at 10:20 AM, the Kitchen Manager stated she did not know why Cook #1 did not check the	F 812	washed. The cooler floor was cleaned before replacing mats. The cooler fans were cleaned by the Maintenance Director on 7/11/2023. 2. The expired loaves of bread were immediately discarded, and all other loaves were audited to ensure they were within date. All other foods in the dry storage area and coolers were audited to ensure no other expired food was present. Cooler mats were taken out of the cooler on the evening of 7/11/2023 and pressure washed. The cooler floor was cleaned before replacing mats. The cooler fans were cleaned by the Maintenance Director on 7/11/2023. All kitchen staff were educated by the Administrator and Director of Food Services by 7/24/2023 about the new cleaning schedule implemented in the kitchen to ensure sanitary conditions are maintained going forward to include the walk-in refrigerator floor and fans. All kitchen staff were educated by the Administrator and Director of Food Services by 7/24/2023 about FIFO (First in First Out) to ensure older food is brought to the front to use first and new products are placed in the back to use last. All new kitchen staff will be educated regarding the cleaning schedule and FIFO as part of their orientation training. 3. A new cleaning schedule that included the circulatory fan cover and mats has been implemented to ensure all areas of	

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F 812	Continued From page 20 expiration date of the breads before using it. It was her expectation for the kitchen staff to check the expiration date of each food items before using it. She was aware of the dirty floor and dirty air vents in one of the walk-in refrigerators and planned to assign a kitchen staff to clean it. She explained she had just started the role as the kitchen manager about 1 month ago and there were a lot of issues to be addressed. It was her expectation for the floor and the air vents in the walk-in refrigerator to remain clean all the time. During a joint interview conducted on 07/14/23 at 10:59 AM, the Director of Nursing and the Administrator expected the kitchen to remain clean and free of expired foods.	F 812	the kitchen are cleaned on a routine basis. An audit tool was implemented to monitor expiration dates on bread each week when a new bread order is placed. 4. The Dietary Manager or designee will follow-up and sign off cleaning schedules as completed. If cleaning schedules are not being followed, the Dietary Manager will re-educate staff and use disciplinary action including up to termination if warranted. These audits will be conducted indefinitely. All cleaning schedules and bread audits will be turned into the Administrator for six months and reviewed in our monthly Quality Assurance Performance Improvement QAPI meeting to ensure total compliance. This POC was completed on 7/24/2023.	