PRINTED: 08/18/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SKYLAND TERRACE AND REHABILITATION    SUMMARY STATEMENT OF DEFICIENCIES   STREET ADDRESS, CITY, STATE, ZIP CODE   STR WALL STREET   WAYNESVILLE, NC 2878		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
SKYLAND TERRACE AND REHABILITATION    CAMPIE   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   PROPRIET   CROSS-REFERENCED TO THE APPROPRIATE   DAME   DAME   CROSS-REFERENCED TO THE APPROPRIATE   DAME   DA			345411	B. WING _		07/14/2023
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD  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 641  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.  EACH COMMENT  TAG  CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERINCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPER TO THE APPROPRIATE TO THE APPROPER TO TH			BILITATION		516 WALL STREET	ODE
An unannounced recertification survey and complaint investigation was conducted 7/11/23 through 7/14/23. The following intakes were investigated: NC00196377, NC00199817, NC00199143, NC00199576, NC201016. Event ID# VZZ211.  6 of 6 complaint allegations did not result in deficiency. 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.  An unannounced recertification survey and complaint investigation was conducted 7/11/23 throughly 11/23. The following intakes were investigation was conducted 7/11/23 throughly 11/23. The following intakes were investigated:  F 641  F 641	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE COMPLETI HE APPROPRIATE DATE
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 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 MDS coordinator corrected investigation was completed timely. The MDS Coordinator corrected	F 000	INITIAL COMMENTS	3	F 0	00	
§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.  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	-	complaint investigation through 7/14/23. The investigated: NC0019 NC00199143, NC001 ID# VZZ211. Event I G of 6 complaint alleg deficiency. Accuracy of Assessm	on was conducted 7/11/23 following intakes were 96377, NC00196817, 199576, NC201016. Event D# VZZ211. gations did not result in	F 6	41	7/31/23
the assessment on 7/14/2023 and 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.  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	SS=D	§483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) rega resident reviewed for Findings included: Resident #58 was ad 12/28/22. The smoking care pla Resident #58 reveale smoker. The goal wa from unsafe smoking review date. Interven Resident #58 about s smoking, monitoring oxygen, and providin	is not met as evidenced iew and staff interviews, the ately code the Minimum rding smoking for 1 of 1 smoking (Resident #58).  mitted to the facility on  an initiated on 01/31/23 for ed she was an unsafe sto remain free of injury practices through the tions included instructing smoking risks and policy of for unsafe smoking with		admission Minimum Data S section J1300 "Tobacco Us answered "no". This reside and should have been code was an oversight by the ME Resident # 58 was care pla smoking assessment was of timely. The MDS Coordinate the assessment on 7/14/20 answered "yes" to section of indicating that resident #58 2. All comprehensive asses current residents were audi section J1300 was coded at the MDS. MDS nurses were educated Administrator on 7/31/2023 importance of assessment	Set "MDS", se" was Int is a smoker sed "yes". This DS nurse. Inned and the completed or corrected 23 and J1300 was a smoker. Issments for all sited to ensure accurately on Intel by the on the accuracy and
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE	LABORATORY	DIDECTORIS OF PROVINCES	CLIDDLIED DEDDECENTATIVEIC CLOSSATUS	) )	TITLE	(VC) DATE

Electronically Signed 07/31/2023

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING			07/14/2023	
	ROVIDER OR SUPPLIER  TERRACE AND REHAE	ILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 516 WALL STREET WAYNESVILLE, NC 28786	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From page	÷ 1	F 64	41			
	#58 on 04/28/23 reveran unsafe smoker and uring smoking.  Review of the admiss revealed Resident #5 non-tobacco user und During an interview of 3:03 PM, Resident #5 cigarettes from the datter facility.  During an observation 1:27 PM, Resident #5 courtyard with 3 other supervision of 1 facility.  During an interview of 9:45 AM, the MDS Courtyard with 3 other supervision of 1 facility.	der Section J 1300.  conducted on 07/11/23 at 68 stated she had smoked ay she had been admitted to a conducted on 07/12/23 at 68 was seen smoking in the residents under the		submission.  3. In reviewing this deficience feel that systemic change is facilities policy is that the MD coded accurately. The MDS educated by the Administrate 7/31/2023 on the importance assessment accuracy and in review coding of each MDS prior to state submission.  4. The MDS nurses along will audit assessments completed durit to assure J1300 is accurately clinical team will also review weeks MDS assessments to J1300 is coded accurately. Twill be completed weekly for to ensure accuracy, and there three months. If discrepancies the audits will continue until achieved. The audit will be to administrator to review in the Quality Assurance Performal Improvement QAPI meeting complete accuracy.  The POC was completed on	needed. The DS will be nurses were or on e of istructed to assessment the the all ing the month y coded. The the previous ensure These audits three months in monthly for es are found, compliance is urned into the emonthly ince to ensure		
F 756 SS=E	10:59 AM, the Director Administrator expected to be coded accurate Drug Regimen Reviet CFR(s): 483.45(c)(1)(s)483.45(c) Drug Reg	ed all the MDS assessments ly. w, Report Irregular, Act On (2)(4)(5)	F 7	56		7/21/23	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 756	Continued From pag	ge 2	F 756	3		
	must be reviewed at licensed pharmacist	least once a month by a				
	§483.45(c)(2) This re of the resident's med	eview must include a review dical chart.				
	irregularities to the a facility's medical dire and these reports m (i) Irregularities including that meets the (d) of this section for (ii) Any irregularities during this review m separate, written regattending physician director and director minimum, the reside and the irregularity t (iii) The attending phresident's medical reirregularity has been action has been take be no change in the	ude, but are not limited to, any criteria set forth in paragraph an unnecessary drug. noted by the pharmacist ust be documented on a port that is sent to the and the facility's medical of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. In the ecord that the identified areviewed and what, if any, cen to address it. If there is to medication, the attending cument his or her rationale in				
	maintain policies and drug regimen review limited to, time frame the process and step when he or she iden requires urgent action. This REQUIREMEN by:	acility must develop and d procedures for the monthly that include, but are not es for the different steps in the pharmacist must take tifies an irregularity that on to protect the resident.  T is not met as evidenced				
	Based on record re	view and interviews with the ultant Pharmacist, and		1. The consultant pharmacist notified physician on 7/13/2023 that she	I the	

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		-		516 WALL STREET		
SKYLAND	TERRACE AND REHAE	BILITATION		WAYNESVILLE, NC 28786		
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F 756	Continued From page	e 3	F 75	6		
	failed to identify drug recommendations for for unnecessary med Resident #38).  The findings included			recommended a lipid panel be or check the need for continuing me for hyperlipidemia on resident #2 physician ordered a lipid panel or 7/14/2023 for resident # 24.  The consultant pharmacist review sliding scale insulin order for resi & 38, the order was updated in the	edications 4. The n wed the ident # 24	
	06/11/20 with diagnos hyperlipidemia.			Medication Administration Record alert staff if the residents blood goutside of the parameters on the scale order.	lucose is sliding	
	revealed a lipid pane	al record for Resident #24 I had not been completed ed to the facility on 06/11/20.		2. The consultant pharmacist aud residents on 7/20/2023 to assure recommended labs for medicatio monitoring are up to date.	that all	
	revealed an order for tablet of atorvastatin once daily at bedtime A review of medication	Resident #24 to receive 1 20 milligrams (mg) by mouth for hyperlipidemia.  In administration records sident #24 had received		The consultant pharmacist was e by the Director of Clinical Consul 7/20/2023 on appropriate medica management monitoring.  All residents with sliding scale insaudited on 7/13/2023 and the order corrected to attach the paramete	Itants on ation sulin were ders were	
	atorvastatin as ordere Review of Resident #	ed for the past 12 months. 24's vital signs revealed her stable and within the normal		actual order in the MAR.  Upon admission, each resident's medication list will be reviewed for medications that require routine I monitoring. All new medication or also be reviewed for appropriate	or any lab rders will	
		m Data Set (MDS) dated esident #24 with intact		monitoring. These recommendat be sent to the prescriber in the m Medication Record Review "MRF prepared by the consultant pharr	ions will nonthly R" report nacist.	
	Consultant Pharmaci regimen reviews for F following dates in the 08/05/22, 09/11/22, 1	edical records revealed the st had completed medication Resident #24 on the past 12 months: 07/11/22, 0/19/22, 11/20/22, 12/17/22, 13/19/23, 04/20/23, 05/19/23.		The consultant pharmacist along Director of Clinical Consultants we each sliding scale insulin dose to insulin was given within the presuparameters and will immediately facility of any discrepancies.	vill review ensure cribed	

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F 756	made several recommendations were level monitoring.  During an interview of 9:37 AM, Resident #2 taking atorvastatin for facility. However, she had ever checked her She added her blood months was stable and An interview was con Record Coordinator of She confirmed she confirmed she confirmed to lipid panel that admission.  2. Resident #38 was 06/15/22 with diagnosmellitus.  The diabetic care plant Resident #38 revealed diabetes mellitus with goal was to remain frosymptoms of hypogly review period. Intervenius lin as ordered by Review of the physici revealed Resident #3 units of Novolog insulmeals for diabetes. T	ensultant Pharmacist had mendations to the physician is. However, none of the cre related to cholesterol conducted on 07/13/23 at 24 stated she had been is more than 2 years in the could not recall the facility is cholesterol level so far. pressure in the past 6 and within the normal limits.  Inducted with the Medical on 07/13/23 at 11:11 AM. bould not find any records for Resident #24 since her admitted to the facility on sees included diabetes  In initiated on 06/18/22 for dishe was diagnosed with a risk for complications. The see from signs and cemia through the next ention included administering	F	756	3. There are no systemic changes required in reference to lab monitoring the consultant pharmacist already revie each medication upon admission and rorders that require lab monitoring and recommends labs to be ordered to the prescriber each month.  The consultant pharmacist changed he monthly process to review every sliding scale insulin order to ensure the prescribed parameters are being follow. The audit will be completed by the consultant pharmacist along with the Director of Clinical Consultants, the aud will be included in the pharmacist mont report. The Consultant Pharmacist will immediatley notify the Administrator an 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 an new orders were reviewed for routine lamonitoring. They will also turn in an audit all sliding scale insulin orders review 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	ews new er det dit chly de	

Facility ID: 923009

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	06/21/23 assessed cognition.  A review of the MAF revealed Resident ** Novolog insulin sub perimeter 34 times July 2023 when her mg/dL prior to insuli following occasions  - 06/01/23 in the mg/dL - 06/02/23 in the mg/dL - 06/05/23 in the mg/dL - 06/06/23 in the mg/dL - 06/06/23 in the mg/dL - 06/08/23 in the mg/dL - 06/08/23 in the mg/dL - 06/09/23 in the mg/dL - 06/09/23 in the mg/dL - 06/09/23 in the mg/dL - 06/10/23 in the mg/dL - 06/10/23 in the mg/dL	Resident #38 with intact  Rs for June and July 2023  #38 had received 3 units of ocutaneously outside of the in June 2023 and 13 times in CBGs were less than 150 in administration on the	F 750	,	
	mg/dL - 06/11/23 in the mg/dL - 06/12/23 in the mg/dL	morning when CBG = 107 evening when CBG = 123 morning when CBG = 106 evening when CBG = 149			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 756	mg/dL - 06/14/23 in the mg/dL - 06/15/23 in the mg/dL - 06/16/23 in the mg/dL - 06/18/23 in the mg/dL - 06/18/23 in the mg/dL - 06/20/23 in the mg/dL - 06/20/23 in the mg/dL - 06/21/23 in the mg/dL - 06/21/23 in the mg/dL - 06/21/23 in the mg/dL - 06/24/23 in the mg/dL - 06/24/23 in the mg/dL - 06/25/23 in the mg/dL - 06/25/23 in the mg/dL - 06/25/23 in the mg/dL - 06/27/23 in the mg/dL	evening when CBG = 139 morning when CBG = 145 morning when CBG = 141 evening when CBG = 113 morning when CBG = 117 evening when CBG = 111 morning when CBG = 137 evening when CBG = 120 morning when CBG = 120 morning when CBG = 129 evening when CBG = 129 evening when CBG = 127 evening when CBG = 127 evening when CBG = 121 evening when CBG = 121 evening when CBG = 122 evening when CBG = 134 morning when CBG = 134 morning when CBG = 122 evening when CBG = 122 evening when CBG = 117	F7	756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 756	mg/dL  - 07/01/23 in the nmg/dL  - 07/03/23 in the nmg/dL  - 07/03/23 in the nmg/dL  - 07/04/23 in the nmg/dL  - 07/05/23 in the nmg/dL  - 07/05/23 in the nmg/dL  - 07/06/23 in the nmg/dL  - 07/09/23 in the nmg/dL  - 07/09/23 in the nmg/dL  - 07/10/23 in the nmg/dL  - 07/11/23 in the nmg/dL  - 07/12/23 in the nmg/dL	norning when CBG = 122  norning when CBG = 99  norning when CBG = 116  evening when CBG = 117  norning when CBG = 129  norning when CBG = 124  nidday when CBG = 101  norning when CBG = 114  norning when CBG = 119  nidday when CBG = 119  nidday when CBG = 139  norning when CBG = 132  norning when CBG = 132  norning when CBG = 116  cords revealed the st had completed medication Resident #38 on the	F	756	DEFICIENCY)		
	07/13/22, 08/13/22, 0 12/18/22, 01/31/23, 0 05/21/23, and 06/22/2 The Consultant Phart recommendations to	.9/07/22, 10/20/22, 11/23/22, 12/21/23, 03/20/23, 04/23/23,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 756	During an interview of 1:35 PM, the Consultative facility did not have that would trigger lab indicated at certain tire. She added she had a lipid panel for other redid not know why Rest The Consultant Pharmotice that nurses had Novolog to Resident aphysician's perimeter performed the monthly reviews.  A phone interview wa 07/13/23 at 2:01 PM. Consultant Pharmacist drug irregularities related recommend lipid panel place for more than 1.  During a joint interview 10:59 AM, the Director Administrator expected Pharmacist to identify irregularities as indicate recommendations to manner.	erns over administering wing the perimeter.  Conducted on 07/13/23 at ant Pharmacist explained are an electronic lab protocol orders automatically as the interval on regular basis. Itered the physician to order esidents as indicated but she sident #24 was excluded. In the interval on regular basis. Itered the physician to order esident #24 was excluded. In the interval on 07/14/23 at or of Nursing and the interval on the interval on the interval on the interval on on interval on the interval on on interval on the interval on on interval on on interval on interval on interval on on interval		756			
F 757 SS=D	CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug		F	757			7/21/23

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F 757	duplicate drug therap §483.45(d)(2) For ex §483.45(d)(3) Withou se; or §483.45(d)(4) Withou use; or §483.45(d)(5) In the consequences which reduced or discontinu §483.45(d)(6) Any co stated in paragraphs section. This REQUIREMENT by: Based on record rev Resident, staff, Cons Medical Director (ME monitor cholesterol le reviewed for unneces #24). The findings included Review of lipid guide American College of Heart Association inc be conducted at base after statin therapy w	essive dose (including by); or cessive duration; or ut adequate monitoring; or ut adequate indications for its presence of adverse indicate the dose should be ued; or ombinations of the reasons (d)(1) through (5) of this  I is not met as evidenced views and interviews with sultant Pharmacist, and 0), the facility failed to evel for 1 of 7 residents essary medications (Resident d: lines published in 2019 by Cardiology and American dicated a lipid panel should eline, then 4 to 12 weeks was started or when a dosage	F 7	1. The Consultant Pharma Physician on 7/13/2023 tha recommended a lipid panel check the need for continui for hyperlipidemia on reside Physician ordered a lipid pa 7/14/2023 for resident # 24  2. The Consultant Pharmac residents on 7/20/2023 to a recommended labs for med monitoring are up to date. The Consultant Pharmacist by the Director of Clinical Consultant Pharmacist Director Director of Clinical Consultant Pharmacist Director Direc	t she be ordered to ng medications ent #24. The anel on . cist audited all assure that all dication t was educated consultants on
		rards, a lipid panel test once every 3 to 12 months or		7/20/2023 on appropriate n management monitoring. Upon admission, each resid medication list will be revie	dent's

Facility ID: 923009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,	E SURVEY PLETED
		345411	B. WING _	<del></del>	07	//14/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				516 WALL STREET		
SKYLAND	TERRACE AND REI	HABILITATION		WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From p	age 10	F 7	57		
	06/11/20 with diag hyperlipidemia. Review of medica revealed a lipid pa	admitted to the facility on inoses that included  I records for Resident #24 anel had not been completed		medications that require roumonitoring. All new medicated also be reviewed for appropriate monitoring. These recommended be sent to the prescriber in Medication Record Review	tion orders will oriate lab endations will the monthly "MRR" report	
		mitted to the facility on 06/11/20.		prepared by the Consultant		
	revealed an order tablet of atorvasta once daily at bedti A review of the me	an's orders dated 11/12/21 for Resident #24 to receive 1 tin 20 milligrams (mg) by mouth ime for hyperlipidemia.  edication administration record Resident #24 had received		There are no systemic characteristics of required as it is the facilities Consultant Pharmacist review medication upon admission orders written during the marequire lab monitoring and the recommendations to the present the recommendations.	s policy that the ews each and new onth that may the make	
	, ,	dered for the past 12 months.		labs that need to be ordered		
	06/30/23 assessed cognition.	mum Data Set (MDS) dated d Resident #24 with intact		4. The Consultant Pharmac the Director of Clinical Cons turn an audit into the Admin month for the next 6 months	sultants will nistrator each	
	9:37 AM, Residen taking atorvastatir facility. However, had ever checked	w conducted on 07/13/23 at t #24 stated she had been for more than 2 years in the she could not recall the facility her cholesterol level.		new admissions and new of during the month were reviewed lab monitoring. This reviewed each month by the Assurance Performance Im "QAPI" committee to ensure	ewed for audit will be e Quality provement	
	Record Coordinate She confirmed she	conducted with the Medical or on 07/13/23 at 11:11 AM. e could not find any records of completed for Resident #24 on.		compliance. If labs are foun missing, the Director of Clin Consultants will provide furl including disciplinary action the Consultant Pharmacist.	nical ther education if warranted to	
	1:35 PM, the Cons the facility did not that would trigger indicated at certain	w conducted on 07/13/23 at sultant Pharmacist explained have an electronic lab protocol lab orders automatically as n time interval on a regular she had alerted the physician to		This POC was completed o	n 7/21/2023.	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		07/14/2023	
	ROVIDER OR SUPPLIER  TERRACE AND REHAE	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 760 SS=E	but she did not know excluded.  A phone interview wa 07/13/23 at 2:01 PM. the facility to conduct #24 at least once per according to the publication of the publicati	s conducted with the MD on She stated she expected a lipid panel for Resident year or as needed ished lipid guidelines.  w conducted on 07/14/23 at or of Nursing and the ed the facility to conduct lipid er the published lipid residents with statin therapy oring.  f Significant Med Errors  are that itsnets are free of any significant is not met as evidenced iew and interviews with the altant Pharmacist, and the hyte facility failed to prevent on error when nurses failed perimeter setting as ordered stration. As a result, d 2 doses of unnecessary in 1 day, and Resident #38 as of unnecessary Novolog 13 doses of unnecessary y 2023. This affected 2 of 7 or significant medication	F 75		ord I kR", urse	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVE' COMPLETED	Y
		345411	B. WING		07/14/202	23
	ROVIDER OR SUPPLIER  TERRACE AND REHA	ABILITATION	,	STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP	K5) LETION ATE
F 760	06/11/20 with diagram ellitus.  The diabetic care properly Resident #24 reveal diabetes mellitus. To complications relatively period. Interdiabetes medication physician.  The quarterly Minim 06/30/23 assessed cognition.  Review of the physic revealed Resident units of Novolog insime als and at bedtir specified to hold the capillary blood glucomilligrams per decimal period on the following occurred 4 units of subcutaneously 2 to within 1 day in July less than 150 mg/d on the following occurred of the medical period of the medical period of the following occurred of the medical period of the following occurred of the medical period of the following occurred o	ed:  s admitted to the facility on loses included diabetes  lan initiated on 05/24/21 for aled she was diagnosed with The goal was to remain free of ed to diabetes through the next evention included to administer in as ordered by the  num Data Set (MDS) dated Resident #24 with intact  ician's orders dated 07/10/23 #24 had an order to receive 4 sulin subcutaneously before the insulin when Resident #24's lose (CBG) was lower than 150 liter (mg/dL).  dication administration records 23 revealed Resident #24 had Novolog insulin times outside of the perimeter 2023 when her CBGs were L prior to insulin administration casions:  e morning when CBG = 130 dtime when CBG = 110 mg/dL	F 76	were corrected to attach the sinsulin parameters to the acture the MAR.  The nurse will enter the blood result into the Medication Adn Record "MAR", if the result is the ordered parameters the stalert the nurse and will not let that it was administered.  Education was started by the Nursing "DON" on 7/13/2023 ongoing with all current nurse nurses, and new nurses onboth check medication orders and entire order before administer medication. No nurse will be a work until they have been education as work until they have been educated into our electronic medication with the prescribed sliding scale insulin orders entered into our electronic medication attached to the inthe nurse will enter the blood result into the Medication Administration and will not let that it was administered.  4. The DON or designee will a sliding scale insulin administration and then every 2 we month. If at any time during the first we find discrepancies, we wore in the audit process and	glucose ininistration outside of ystem will them record  Director of and will be s, agency arding to read the ing the allowed to ucated.  Dlemented. will be edical record ale insulin sulin order. glucose ininistration outside of ystem will them record  audit all action each per week for eeks for 1 leese audits, i'll start back immediately	
ORM CMS-256	2. Resident #38 wa 7(02-99) Previous Versions 0	s admitted to the facility on  Dissolete Event ID: VZZ2:	 11	provide re-education and/or d	If continuation sheet Page	13 of 21

PRINTED: 08/18/2023 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			07/	14/2023
	ROVIDER OR SUPPLIER  TERRACE AND REHAB	ILITATION	•	5′	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	mellitus.  The diabetic care plat Resident #38 revealed diabetes mellitus with goal was to remain fir symptoms of hypogly review period. Interveinsulin as ordered by Review of the physici revealed Resident #3 units of Novolog insulmeals for diabetes. The insulin when Resithan 150 mg/dL.	n initiated on 06/18/22 for d she was diagnosed with risk for complications. The ee from signs and cemia through the next ention included administering the physician.  an's orders dated 03/27/23 8 had an order to receive 3 lin subcutaneously before the order specified to hold dent #38's CBG was lower	F 7	760	action including up to termination if warranted. These audits will be turned to the Administrator to review and discrin our monthly Quality Assurance Performance Improvement meeting to ensure complete compliance.  This POC was completed on 7/15/2023	ssı	
	revealed Resident #3 Novolog insulin subcuperimeter 34 times in July 2023 when her C mg/dL prior to insulin following occasions:  - 06/01/23 in the e mg/dL - 06/02/23 in the e mg/dL - 06/04/23 in the n mg/dL - 06/05/23 in the e mg/dL	s for June and July 2023 8 had received 3 units of utaneously outside of the June 2023 and 13 times in CBGs were less than 150 administration on the  vening when CBG = 111  vening when CBG = 137  vening when CBG = 108  norning when CBG = 128					

Facility ID: 923009

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345411	B. WING		07/14/2023
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	, 0
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 760	mg/dL - 06/08/23 in the mg/dL - 06/09/23 in the mg/dL - 06/10/23 in the mg/dL - 06/10/23 in the mg/dL - 06/11/23 in the mg/dL - 06/11/23 in the mg/dL - 06/12/23 in the mg/dL - 06/12/23 in the mg/dL - 06/13/23 in the mg/dL - 06/15/23 in the mg/dL - 06/16/23 in the mg/dL - 06/18/23 in the mg/dL - 06/18/23 in the mg/dL - 06/18/23 in the mg/dL - 06/19/23 in the mg/dL - 06/20/23 in the mg/dL - 06/21/23 in the mg/dL	ge 14 evening when CBG = 145 morning when CBG = 114 morning when CBG = 119 morning when CBG = 133 evening when CBG = 110 morning when CBG = 107 evening when CBG = 107 evening when CBG = 123 morning when CBG = 149 evening when CBG = 149 evening when CBG = 145 morning when CBG = 145 morning when CBG = 141 evening when CBG = 111 morning when CBG = 117 evening when CBG = 117 evening when CBG = 120 morning when CBG = 120 morning when CBG = 129	F 70	60	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
	345411	B. WING _			07/	14/2023
	BILITATION		510	6 WALL STREET		
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mg/dL - 06/24/23 in the mg/dL - 06/25/23 in the mg/dL - 06/25/23 in the mg/dL - 06/25/23 in the mg/dL - 06/27/23 in the mg/dL - 06/27/23 in the mg/dL - 06/27/23 in the mg/dL - 06/28/23 in the mg/dL - 06/29/23 in the mg/dL - 06/30/23 in the mg/dL - 07/01/23 in the mg/dL - 07/03/23 in the mg/dL - 07/03/23 in the mg/dL - 07/03/23 in the mg/dL - 07/05/23 in the mg/dL - 07/05/23 in the mg/dL - 07/05/23 in the mg/dL - 07/06/23 in the mg/dL - 07/06/23 in the mg/dL - 07/09/23 in the mg/dL	evening when CBG = 127 evening when CBG = 106 morning when CBG = 121 evening when CBG = 108 morning when CBG = 108 morning when CBG = 122 evening when CBG = 134 morning when CBG = 122 evening when CBG = 122 evening when CBG = 117 morning when CBG = 117 morning when CBG = 116 evening when CBG = 116 evening when CBG = 117 morning when CBG = 117 morning when CBG = 110 morning when CBG = 101 morning when CBG = 114 morning when CBG = 119 midday when CBG = 119 midday when CBG = 139	F	760			
	morning when CBG = 132					
	SUMMARY S (EACH DEFICIENCE REGULATORY OR  Continued From page mg/dL - 06/24/23 in the emg/dL - 06/25/23 in the emg/dL - 06/25/23 in the emg/dL - 06/27/23 in the emg/dL - 06/27/23 in the emg/dL - 06/27/23 in the emg/dL - 06/28/23 in the emg/dL - 06/29/23 in the emg/dL - 06/30/23 in the emg/dL - 07/03/23 in the emg/dL - 07/05/23 in the emg/dL - 07/06/23 in the emg/dL - 07/09/23 in the emg/dL	TERRACE AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15 mg/dL  - 06/24/23 in the morning when CBG = 127 mg/dL  - 06/25/23 in the evening when CBG = 121 mg/dL  - 06/25/23 in the evening when CBG = 121 mg/dL  - 06/25/23 in the evening when CBG = 122 mg/dL  - 06/27/23 in the evening when CBG = 122 mg/dL  - 06/27/23 in the evening when CBG = 122 mg/dL  - 06/28/23 in the evening when CBG = 122 mg/dL  - 06/28/23 in the evening when CBG = 122 mg/dL  - 06/28/23 in the evening 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 = 116 mg/dL  - 07/03/23 in the evening when CBG = 117 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 morning when CBG = 101 mg/dL  - 07/05/23 in the morning when CBG = 114 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 morning when CBG = 139	ROVIDER OR SUPPLIER  TERRACE AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  mg/dL  06/24/23 in the morning when CBG = 127  mg/dL  06/25/23 in the evening when CBG = 121  mg/dL  06/25/23 in the evening when CBG = 122  mg/dL  06/27/23 in the evening when CBG = 122  mg/dL  06/27/23 in the evening when CBG = 122  mg/dL  06/28/23 in the evening when CBG = 122  mg/dL  06/29/23 in the evening when CBG = 122  mg/dL  06/29/23 in the evening when CBG = 122  mg/dL  06/29/23 in the evening when CBG = 122  mg/dL  06/30/23 in the morning when CBG = 122  mg/dL  07/03/23 in the morning when CBG = 117  mg/dL  07/03/23 in the morning when CBG = 117  mg/dL  07/03/23 in the morning when CBG = 129  mg/dL  07/05/23 in the morning when CBG = 124  mg/dL  07/05/23 in the morning when CBG = 124  mg/dL  07/05/23 in the morning when CBG = 114  mg/dL  07/05/23 in the morning when CBG = 114  mg/dL  07/06/23 in the morning when CBG = 119  mg/dL  07/09/23 in the morning when CBG = 119  mg/dL  07/09/23 in the morning when CBG = 139  mg/dL	TORRECTION  IDENTIFICATION NUMBER:  345411  B. 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WING  STREET ADDRESS, CITY, STATE, 2IP CODE 516 WALL STREET WAYNESVILLE, NC 28786  SUMMARY STATEMENT OF DEFICIENCES (EGAL DEFICIENCY) WIST OF PRECIDENCY (EGAL DEFICIENCY) WIST OF PRECIDENCY (EGAL DEFICIENCY)  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 760  Continued From page 15  mg/dL  06/24/23 in the morning when CBG = 127  mg/dL  06/25/23 in the evening when CBG = 128  mg/dL  06/28/23 in the evening when CBG = 122  mg/dL  06/28/23 in the evening when CBG = 122  mg/dL  06/29/23 in the evening when CBG = 114  mg/dL  06/29/23 in the evening when CBG = 122  mg/dL  07/03/23 in the morning when CBG = 116  mg/dL  07/03/23 in the morning when CBG = 116  mg/dL  07/03/23 in the morning when CBG = 129  mg/dL  07/03/23 in the evening when CBG = 129  mg/dL  07/03/23 in the morning when CBG = 129  mg/dL  07/03/23 in the morning when CBG = 124  mg/dL  07/03/23 in the morning when CBG = 129  mg/dL  07/05/23 in the morning when CBG = 124  mg/dL  07/05/23 in the morning when CBG = 124  mg/dL  07/05/23 in the morning when CBG = 114  mg/dL  07/05/23 in the morning when CBG = 114  mg/dL  07/05/23 in the morning when CBG = 114  mg/dL  07/05/23 in the morning when CBG = 114  mg/dL  07/05/23 in the morning when CBG = 119  mg/dL  07/05/23 in the morning when CBG = 119  mg/dL  07/09/23 in the morning when CBG = 119  mg/dL  07/09/23 in the morning when CBG = 119  mg/dL  07/09/23 in the morning when CBG = 119  mg/dL

STATEMENT ( AND PLAN OF	CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		07/14/2023		
	ROVIDER OR SUPPLIER  TERRACE AND REHA	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 760	mg/dL - 07/11/23 in the mg/dL - 07/12/23 in the mg/dL - 07/12/23 in the mg/dL During an interview 9:07 AM, Nurse #1 working on 06/01/2 06/16/23, 06/19/23 and 07/03/23 and 07/03/23 and 07/03/23 and odministered Novo when her CBGs we was aware of the p to hold the Novolog mg/dL. She explair she told Resident # request to have the have some snacks Resident #38 had the added she did not of administering Novo An interview was comply a minister of the properties o	e morning when CBG = 94 e midday when CBG = 112 e morning when CBG = 116 e conducted on 07/13/23 at acknowledged that she was 3, 06/05/23, 06/11/23, 06/24/23, 06/25/23, 06/29/23,	F 76				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
		345411	B. WING		0	7/14/2023
	ROVIDER OR SUPPLIER  TERRACE AND REHAE	ILITATION	•	STREET ADDRESS, CITY, STATE, ZIP CO 516 WALL STREET WAYNESVILLE, NC 28786	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	o6/21/23, 07/05/23, a she had administered and Resident #38 rep were less than 150 m perimeter attached to #2 explained both Re #38 would request to were notified of CBG planned to have some period of time. She st consulted the physician Novolog outside of the During an interview of 11:29 AM, Resident #1:29 AM, Resident #1:29 AM, Resident #1:29 AM, Resident #1:29 AM, Resident #1:35 PM, the Consulted the nurse of the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the Consulted in the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM, the CBG checks During an interview of 1:35 PM,	23. 06/08/23, 06/12/23, nd 07/11/23 and confirmed I Novolog to Resident #24 reatedly when their CBGs g/dL. She was aware of the the Novolog order. Nurse sident #24 and Resident have the Novolog when they below 150 mg/dL as they e snacks within a short ated she should have an before administering the e perimeter.  Onducted on 07/13/23 at 38 confirmed she had o give her Novolog CBG was below 150 mg/dL we some snacks very soon onducted on 07/13/23 at ant Pharmacist stated she reses had been administering #38 repeatedly without perimeter when she y medication regimen the incident was a significant	F 76			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345411	B. WING		07/14/2023
	ROVIDER OR SUPPLIER  TERRACE AND REHAL	BILITATION	5	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 812 SS=E	10:59 AM, the Direct Administrator acknown a significant medicat with the potential of the level. Both expected physician's order and when administering in Food Procurement, SCFR(s): 483.60(i)(1) (1) (2) (3) (4) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	ew conducted on 07/14/23 at or of Nursing and the viedged that the incident was ion error as it involved insulin riggering low blood glucose all nursing staff to follow d the set perimeters fully medications.  tore/Prepare/Serve-Sanitary (2)  Ity requirements.  The food from sources are satisfactory by federal, ties.  Food items obtained directly a subject to applicable State and ulations.  The ses not prohibit or prevent broduce grown in facility compliance with applicable and handling practices.  The ses not procured by the facility.  The prepare, distribute and ance with professional	F 760		oler

PRINTED: 08/18/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		07/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	1	'	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0111111111111111111111111111111111111
				516 WALL STREET	
SKYLAND	TERRACE AND REHAE	BILITATION		WAYNESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 812	Continued From pag	e 19	F 81:	2	
		oaves of expired bread. This ential to affect foods served		washed. The cooler floor was cleaned before replacing mats. The cooler factor were cleaned by the Maintenance D on 7/11/2023.	ins
	Findings included:	2 AM an observation of the		The expired loaves of bread were immediately discarded, and all other	
	kitchen prep table re- bread sitting next to t used. The label on th sandwich bread indic 07/08/23 and the who was expired on 07/08 revealed half of both used.	vealed 2 opened loaves of the toaster and ready to be the plastic wrap of the white wrap wrap wrap wrap wrap wrap wrap wrap		loaves were audited to ensure they within date.  All other foods in the dry storage are coolers were audited to ensure no o expired food was present.  Cooler mats were taken out of the conthe evening of 7/11/2023 and prewashed. The cooler floor was cleane before replacing mats. The cooler fawere cleaned by the Maintenance D on 7/11/2023.	were ea and ther cooler essure ed
	of bread from both lo to make toasts for re- her oversight as she expiration dates of th She acknowledged the should be discarded	aves of bread this morning sidents. She explained it was did not pay attention to the e breads prior to using it. nat both loaves of bread as they were expired.		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 maintained going forward to include walk-in refrigerator floor and fans.	w ne s are the
	of the two walk-in ref floor was covered wit 1 inch in thickness. F the floor had an accu darkish matter under addition, the air vents refrigerator were obs clumpy grayish matter	and an observation of one rigerators revealed the entire th rubber mat approximately further observation revealed imulation of thick, clumpy, neath the rubber mat. In is in the same walk-in erved with a buildup of thick, er on the circulatory fan ht, and electrical cords.		All kitchen staff were educated by the Administrator and Director of Food Services by 7/24/2023 about FIFO (in First Out) to ensure older food is brought to the front to use first and reproducts are placed in the back to ulast.  All new kitchen staff will be educated regarding the cleaning schedule and as part of their orientation training.	First new se
		conducted on 07/11/23 at on Manager stated she did #1 did not check the		A new cleaning schedule that inclead the circulatory fan cover and mats here implemented to ensure all area.	as

Facility ID: 923009

ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  2 20 breads before using it. It for the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and itchen staff to clean it. She	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  516 WALL STREET  WAYNESVILLE, NC 28786  PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)  12  the kitchen are cleaned on a routir basis.	TION ULD BE COPRIATE	(X5) COMPLETION DATE
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  2 20 breads before using it. It or the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)  12 the kitchen are cleaned on a routing	TION ULD BE COPRIATE	(X5) COMPLETION
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  2 20 breads before using it. It or the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)  The kitchen are cleaned on a routing the strong provided the control of the control	ULD BE COPRIATE	COMPLETION
which was the preceded by Full (SC IDENTIFYING INFORMATION)  2 20 breads before using it. It for the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)  12 the kitchen are cleaned on a routing	ULD BE COPRIATE	COMPLETION
which was the preceded by Full (SC IDENTIFYING INFORMATION)  2 20 breads before using it. It for the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and	PREFIX TAG	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)  12  the kitchen are cleaned on a routing the kitch	ULD BE COPRIATE	COMPLETION
breads before using it. It for the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and	F 81	the kitchen are cleaned on a routir	ne	
or the kitchen staff to check each food items before are of the dirty floor and dirty walk-in refrigerators and			IE	
are of the dirty floor and dirty walk-in refrigerators and				
		An audit tool was implemented to expiration dates on bread each we when a new bread order is placed	eek	
st started the role as the ut 1 month ago and there o be addressed. It was her for and the air vents in the remain clean all the time.  We conducted on 07/14/23 at or of Nursing and the ed the kitchen to remain ired foods.		4. The Dietary Manager or designer follow-up and sign off cleaning scheduler as completed. If cleaning scheduler not being followed, the Dietary Mawill re-educate staff and use disciplaction including up to termination in warranted. These audits will be confidefinitely. All cleaning schedules bread audits will be turned into the Administrator for six months and refinition our monthly Quality Assurance Performance Improvement QAPI in to ensure total compliance.	ee will nedules es are inager olinary if enducted is and e eviewed	
o co	t started the role as the t 1 month ago and there be addressed. It was her or and the air vents in the remain clean all the time.  v conducted on 07/14/23 at r of Nursing and the d the kitchen to remain	t started the role as the t 1 month ago and there be addressed. It was her or and the air vents in the remain clean all the time.  v conducted on 07/14/23 at or of Nursing and the d the kitchen to remain	t started the role as the It 1 month ago and there be addressed. It was her or and the air vents in the remain clean all the time. It 2 conducted on 07/14/23 at a rof Nursing and the did the kitchen to remain reed foods.  It 3 completed are follow-up and sign off cleaning schedules as completed. If cleaning schedules will re-educate staff and use disciplination in the did the kitchen to remain reed foods.  It 4. The Dietary Manager or designs follow-up and sign off cleaning schedules as completed. If cleaning schedules will re-educate staff and use disciplination in the did the kitchen to remain reed foods.  It 5 completed as the follow-up and sign off cleaning schedules as completed. If cleaning schedules will re-educate staff and use disciplination in the did the kitchen to remain red foods.  It 6 completed as the follow-up and sign off cleaning schedules as completed. If cleaning schedules will re-educate staff and use disciplination in the did the kitchen to remain red foods.	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