STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Livonia	29270 Morlock Livonia, MI 48152

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 This citation pertains to Intakes MI00146343, MI00146953, and MI00146881. Based on interview and record review, the facility failed to provide treatments, medications, and blood sugar monitoring as ordered for two (Resident #2 and Resident #1) of four reviewed. Findings include: Resident #2 (R2) Review of the medical record revealed R2 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included multiple sclerosis, type 2 diabetes, and dysphagia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/24 revealed R2 scored 4 out of 5 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R2 was hospitalized from 8/22/24 until 8/31/24 at which point they were readmitted to the facility with a new PEG (Percutaneous endoscopic gastrostomy/feeding tube). R2 transferred back to the hospital on 9/5/24 and did not return to the facility. Review of the Physician's Order dated 8/31/24 revealed an order for insulin lispro (Humalog/fast acting insulin), inject 6 units before meals. Review of the Medication Administration Record (MAR) revealed lispro was administered on 9/1/24 at 7:00 AM and 11:30 AM. The order was discontinued on 9/1/24. Review of a Physician's Order dated 9/1/24 at 1:35 PM and entered by the pharmacy, revealed insulin lispro was changed to Lyumjev (fast acting insulin) 6 units before meals. The order was scheduled to begin on 9/2/24 at 7:00 AM, therefore, R2 did not receive any fast acting insulin on 9/1/24 at 5:00 PM as scheduled. The pharmacy did not add supplementary documentation of blood sugar checks with the insulin administration order. There was no documentation of blood sugar checks on 9/2/24 at 7:00 AM, 11:30 AM, 5:00 PM or 9/3/24 at 7:00 AM and 11:30 AM. The Lyumjev order was discontinued on 9/2/24 at 1:36 PM. Review of the Medical Practitioner Progress note dated 9/1/24 at 9:20 PM revealed Glucose labile. Start sliding scale insulin. (continued on next page)

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.

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

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of a Physician's Order dated 9/2/24 at 1:36 PM and entered by Unit Manager (UM) C revealed an order for Lyumjev 6 units before meals in addition to a sliding scale. The order was scheduled to start on 9/2/24 at 5:00 PM. The order was discontinued on 9/2/24 at 3:18 PM due to a therapeutic interchange.

Review of the Physician's Order dated 9/2/24 at 3:20 PM and entered by pharmacy, revealed an order for Fiasp (fast acting insulin) sliding scale. The pharmacy did not include the 6 units before each meal with the order. The supply directions indicated both 6 units before meals in addition to the sliding scale, however the 6 units before meals did not transcribe to the MAR. The order was scheduled to start on 9/3/24 at 5:00 PM; therefore, R2 did not receive any fast acting insulin on 9/2/24 at 5:00 PM, 9/3/24 at 7:00 AM, and 9/3/24 at 11:30 AM. R2 also did not receive 6 units of Fiasp before meals from 9/3/24 to 9/5/24

Review of the MAR revealed Fiasp sliding scale was not administered on 9/4/24 at 7:00 AM for a blood sugar of 370 milligrams/deciliter (mg/dL). R2 should have received 10 units sliding scale. The progress notes revealed the Fiasp was not administered because it was on order and pharmacy was notified. On 9/5/24 at 5:00 PM, R2's blood sugar was 389 mg/dL, but R2 did not receive the 10 units per sliding scale as ordered. The progress notes did not state why R2 did not receive sliding scale insulin at that time.

In a telephone interview on 9/19/24 at 9:14 AM, Pharmacy Technician (PT) E reported Fiasp and Lyumjev were interchangeable. PT E reported four pens, containing 100 units each, of Lyumjev were delivered to the facility on [DATE]. PT E reported they did not have note that the facility contacted them on 9/4/24.

In a telephone interview on 9/19/24 at 12:39 PM, Pharmacy [NAME] President of Quality Assurance (VPQA) D reported Lyumjev and Fiasp were part of the pharmacy's therapeutic interchange program; therefore either could be used.

Review of the Therapeutic Interchange (TI) Formulary provided by Pharmacy VPQA D revealed insulin lispro (humalog), Lyumjev, and Fiasp were all interchangeable unit to unit and same frequency. The document also revealed Following any insulin product interchange, close blood glucose monitoring is recommended, with possible insulin dosage titration based on follow-up blood glucose values.

In a telephone interview on 9/19/24 at 12:13 PM, Physician M reported they could not recall the specifics of R2's insulin orders. Physician M reported R2 should have had their blood sugar checked three to four times a day. Physician M reported they were not made aware that R2 did not receive insulin and that Fiasp was not available. Physician M reported they would expect to be notified and that there were alternative insulins available for use.

In an interview on 9/19/24 at 1:06 PM, UM C reported the facility had an arrangement with the pharmacy for therapeutic interchanges and that each physician was required to review and sign the interchange. UM C reported that occasionally, pharmacy entered orders and that nursing would confirm the orders. UM C agreed R2 did not receive any fast-acting insulin and blood sugars checked as ordered. UM C agreed when the order was changed from Lyumjev to Fiasp, the 6 units before meals was dropped off the order and therefore the order was transcribed as only a sliding scale.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/19/24 at 2:52 PM, Director of Nursing (DON) B reported the physicians signed a pharmacy therapeutic interchange which allowed the pharmacy to make changes. DON B reported pharmacy could write the order in the electronic medical record and that the pharmacy would contact the physician if they had any questions or concerns. DON B agreed the pharmacy's Therapeutic Interchange (TI) Formulary listed Lyumjev, Fiasp, and lispro/Humalog as being interchangeable. DON B reported R2's blood sugar would normally be monitored three times a day and reported they were not sure why R2 missed doses of fast acting insulin. 38383 Resident #1 (R1): Review of the medical record reflected R1 admitted to the facility on [DATE], with diagnoses that included local infection of the skin and subcutaneous tissue. The admission/5-day Medicare Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/7/24, reflected R1 was coded for infection of the foot, open lesion(s) on the foot and application of dressings to the feet. R1 discharged from the facility on 8/16/24 and did not reside in the facility at the time of the survey. A Progress Note for 8/4/24 reflected R1 admitted to the facility with ulcers (wounds) on both great (big) toes and the second toe of the right foot. A Physician visit note for 8/7/24 reflected R1 had the following wounds: -An abrasion to the left great toe, measuring 3 centimeters (cm) in length by (x) 0.8 cm in width. -An abrasion to the right great toe, measuring 3 cm in length x 1.5 cm in width -An abrasion to the second toe of the right foot, measuring 0.5 cm in length x 0.5 cm in width -A right calf avulsion (skin torn away) trauma wound, measuring 2 cm in length x 2 cm in width x 0.3 cm in depth -A right anterior (front) shin trauma wound, measuring 1.8 cm in length x 1.3 cm in width x 0.3 cm in depth The same Physician visit note reflected wound care orders for the left great toe, right great toe and second toe of the right foot, which included cleansing with normal saline, application of triple antibiotic ointment and application of an ABD pad and kling wrap/kerlix to secure the dressing. The dressings were to be changed daily and as needed. Additionally, the Physician visit note reflected recommendations for the right calf and right anterior shin wounds, which included cleansing with normal saline and the application of Xeroform (type of wound dressing), an ABD pad and kling wrap/kerlix to secure the dressing. The dressings were to be changed daily and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Treatment Administration Record (TAR) for 8/2024 reflected an order to cleanse the left and right great toes with betadine and apply triple antibiotic ointment. The dressing was to be wrapped with kerlix and changed every Monday, Wednesday and Friday on day shift. The treatments began on 8/7/24, which was three days after R1 admitted to the facility. No further wound treatment orders were noted in R1's medical record. In an interview on 9/19/24 at 2:30 PM, Licensed Practical Nurse (LPN) P reported being the Wound Nurse for the facility. After reviewing R1's medical record, LPN P acknowledged she did not see treatment orders for R1's second toe on the right foot, right shin or right calf and could not explain why.