

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2024
NAME OF PROVIDER OR SUPPLIER  Oaknoll Retirement Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Oaknoll CT Iowa City, IA 52240	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>44972</p> <p>Based on observation, record review, staff interview, policy review and manufacturer insert review, the facility failed to provide services that met professional standards regarding medication administration for 2 of 2 residents observed (Resident #9 and #25). They did not have their insulin flex pen primed appropriately and the needle was not left under the skin after the insulin was injected for the recommended period of time to ensure the full dose of medication was given. The facility reported a census of 57 residents.</p> <p>Findings include:</p> <p>An observation on 8/26/24 at 7:59 AM, during the Medication Pass Task, revealed Staff A, Registered Nurse, (RN) administered Resident #9's insulin. Staff A, RN obtained the resident's Novolog (insulin) flex pen from the medication cart, put the needle on the tip of the pen and dialed it to 16 units (order was for 14 units plus 2 units of sliding scale for a blood sugar of 175) and proceeded to administer the insulin. Staff A, RN failed to prime the pen with 2 units prior to setting it to 16 units and failed to keep the needle under the skin for a full count of 6 to ensure the full dose was injected before removing.</p> <p>An observation on 8/26/24 at 12:00 PM, during the Medication Pass Task, revealed Staff A, RN administered Resident #25's insulin. Staff A, RN obtained the resident's Novolog (insulin) flex pen from the medication cart, put the needle on the tip of the pen and primed the pen with 1 unit, then dialed it to 3 units as ordered and proceeded to administer the insulin. Staff A, RN failed to prime the pen with 2 units per policy, prior to setting it to 3 units and failed to keep the needle under the skin for a full count of 6 to ensure the full dose was injected before removing.</p> <p>Review of the manufacturer insert for Novolog flex pen revealed the flex pen was to be primed with 2 units of insulin prior to selecting the dose to be administered. It further directed the pen was to be inserted, the dose button pressed down until the dose counter showed 0 and the needle kept in the skin for a slow count to 6 before removing. The insert stated the full dose would not be received unless left in the skin for 6 seconds.</p> <p>(continued on next page)</p>		

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility provided policy titled Insulin Pen dated 11/7/17 and reviewed on 8/26/24, stated when injecting insulin using an insulin pen, the process was to include priming the insulin pen by dialing 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. It further stated when injecting the insulin, inject the needle straight at a 90-degree angle to the skin. Fully depress plunger until the dosing numbers count back to zero. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin.</p> <p>In an interview on 8/27/24 at 1:30 PM, the Director of Nursing (DON) stated it was the expectation staff completing insulin injections using a flex pen, follow the policy and procedure of the facility. The DON stated licensed staff had all been re-educated on the appropriate process for flex pen insulin injections.</p>