STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365849	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ayden Healthcare of Toledo	4293 Monroe St Toledo, OH 43606

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** 15816 Based on medical record review, staff interview, and policy review, the facility failed to ensure monitoring of a medication included obtaining blood sugar levels as ordered by the physician. This affected one (#2) of three residents reviewed for administration of medications and associated monitoring. The facility census was 75. Findings include: Review of Resident #2's medical record revealed an admitted [DATE],with the diagnoses including: type 2 diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, schizoaffective disorder, anemia, adjustment disorder with mixed anxiety and depressed mood, hypertension, psychoactive substance abuse and non-pressure chronic ulcer of back. Review of the most current minimum data set assessment, dated 02/01/24, assessed Resident #2 with intact cognition, required supervision/touch assistance with activities of daily living, occasionally incontinent of urine and continent of bowel, received antipsychotic, antidepressant and opioid medications. Review of a nursing plan of care implemented on 03/21/21 to address Resident #2 risk for hyper/hypoglycemic episodes related to non-insulin dependent diabetes mellitus. Interventions included: Be alert to medications that may cause changes in blood sugar, blood sugar as needed for symptoms of hypo/hyperglycemia that is (i.e.) change in hunger, thirst, anxiety, changes in level of consciousness, fruity breath and alterations in urinary patterns. Review of a physician order obtained on 11/15/23, for the administration of Mounjaro to inject 7.5 milligrams (mg) per(/) 0.5 milliliters (ml) subcutaneously once every seven days for Diabetes. On 03/28/24, the diagnosis for Mounjaro was changed to weight loss with the same dosage and once every seven days. According to Medication Administration Records (MAR) between 03/01/24 and 04/08/24, the medication was administered as ordered with the last dose on 04/04/24. Review of the physician order dated 01/16/23, revealed the physician ordered blood sugar monitoring while the resident was receiving the medication Mounjaro every Monday and Thursday. Review of the medical record discovered documentation contained in the MAR revealing nurse initials which indicated Resident #2 blood sugar was obtained twice weekly on every Monday and Thursday between 03/01/24 and 04/08/24. However, no documented evidence was listed indicating the blood sugar result levels. (continued on next page)

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	Interview on 06/05/24 at 2:25 P.M., with the Director of Nursing (DON), during a review of the medical record confirmed Resident #2's MAR noted nurse initials which indicated Resident #2 blood sugar was obtained twice weekly on every Monday and Thursday. However, no documented evidence was provided indicating the blood sugar results were documented in the medical record to monitor blood sugar levels as ordered by the physician. Review of the policy titled, Nursing Care of the Resident with Diabetes Mellitus, dated Revised December 2015, revealed the physician will order the frequency of glucose monitoring. Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. Documentation should reflect the carefully assessed diabetic resident and include the following: blood sugar results and other pertinent laboratory studies. This deficiency represents non-compliance investigated under Complaint Number OH00154139.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, policy review, and manufacturer instructions for use review, the facility failed to ensure medications were administered as ordered by the physician and within prescribed time frames, resulting in delay in administration of insulin, and antidepressant medication. This affected one (#1) of three residents observed during medication administration. The facility census was 75. Findings include: Observation on 06/05/24 at 9:45 A.M., noted Licensed Practical Nurse (LPN) #300 obtain a blood glucose monitor from the medication cart and proceed into Resident #1 room. Upon entry Resident #1 had concluded the breakfast meal consuming between 50-75% of the meal. LPN #300 obtained a blood sample from Resident #1 left index finger which resulted at a blood sugar level of 286. LPN #300 returned back to the medication cart and obtained a Insulin Lispro pen, placed a needle to the pen and returned to the room. At 10:00 A.M., LPN #300 dialed six (6) units to the indicator window and injected the insulin into the resident. No prime of the pen was conducted. Once the needle was injected, LPN #300 pressed the injection button for two (2) seconds and removed the needle. No count for 10 seconds was conducted. LPN #300 then provided Resident #1 with additional morning medications including a dose of Paxil 20 milligrams (mg). Interview on 06/05/24 at 10:11 A.M., Resident #1 stated she frequently receives blood sugar monitoring and associated insulin coverage after meals. The resident also stated she had not received her antidepressant Paxil. The resident indicated she felt a change in mood and lack of tolerance with staff due to not receiving the Paxil 20 mg. Interview on 06/05/24 at 10:19 A.M., with LPN #300 verified Resident #1 blood sugar monitoring and insulin sliding scale administration were past prescribed time frames. LPN #300 confirmed Resident #1 had consumed 50-75% of the breakfast meal before obtaining blood sugar. LPN #300 also confirm she was unaware the Insulin Lispro pen required a prime before administration and stated she was unaware to inject the needle for slow count of ten seconds before removing the injection needle. Review of Resident #1's medical record revealed an admitted [DATE], with the diagnoses including: chronic obstructive pulmonary disease, cerebral infarction, occlusion and stenosis of basilar artery, myocardial infarction, chronic ischemic heart disease, morbid obesity, type 2 diabetes mellitus, polyneuropathy, bipolar personality disorder, borderline personality disorder, and major depression. Review of the most current minimum data set assessment dated [DATE], assessed Resident #1 with moderate cognitive impairment, required substantial/maximal assistance with activities of daily living, utilized a wheelchair and walker for mobility, incontinent of bowel and bladder, received antianxiety, diuretic, opioid, antiplatelet, hypoglycemic medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing plan of care was implemented on 05/18/24 and revised on 05/21/24, to address Resident #1 risk for hyper/hypoglycemic episodes related to diabetes mellitus type II. Interventions included blood sugar testing as ordered/as needed, insulin as ordered, medications as ordered. On 05/21/24, a nursing plan of care was implemented to address Resident #1 mood problem related to bipolar, borderline personality disorder, depression with interventions to administer medications as ordered. Monitor/document for side effects and effectiveness. Review of Hospital Discharge physician orders dated 05/17/24 noted an order Paroxetine (Paxil) 20 milligrams (mg) one tablet at bedtime. Review of the medication administration record (MAR) from 05/17/24 to 05/30/24 was silent to the administration of Paxil 20 mg. On 05/31/24, a physician order was obtained for Paxil 20 mg give one tablet once daily for Major Depressive Disorder scheduled to be given upon rising between 7:00 A.M. and 10:00 A. M. Review of Resident #1 medical record revealed a physician order dated 05/19/24 for the administration of Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 units per (/) milliliter (Insulin Lispro) to Inject as per sliding scale: if blood sugar (BS) level 151 - 200 = 2 units notify physician for BS <70; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; 451 - 500 = 14 units notify physician if BS >451, administer subcutaneously before meals related to type 2 diabetes mellitus. Prescribed administration times were listed for before meals at 7:30 A.M., 11:00 A.M., and 4:00 P.M. Interview on 06/05/24 at 11:45 A.M., with the Administrator and Director of Nursing verified Resident #1 insulin pen is to be primed before administration and Resident #1 blood sugar monitoring and associated insulin coverage was given outside of prescribed timeframe's. Interview on 06/06/24 at 1:55 P.M., with the Director of Nursing revealed no documentation could be provided indicating Resident #1 Paxil 20 mg was administered or discontinued between admission on 05/18/24 and 05/31/24. Review of the Paxil (Paroxetine) manufacturer indications for use revised September 22, 2022 all dose changes should be gradual, including discontinuation. Review of the policy titled, Administering Medications, dated Revised December 2012, revealed medications must be administered in accordance with physician orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified for example before and after meals. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Medication Administration Subcutaneous Insulin, dated January 2022 indicates to prepare syringe/pen and safety needle. (See pen example). Performing the safety test ensures an accurate dose by: ensuring that pen and needle work properly, removing air bubbles. Hold the pen with the needle pointing upwards. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. If no insulin comes out, the needle may be blocked. Change the needle and try again. If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen. Insert the needle into the skin at a 90 degree angle. Deliver the dose by pressing the injection button in all the way. The number in the dose window will return to 0 as you inject. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose was delivered. Review of policy titled, Nursing Care of the Resident with Diabetes Mellitus, policy dated Revised December 2015 revealed the physician will order the frequency of glucose monitoring. Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. Documentation should reflect the carefully assessed diabetic resident and include the following: Blood sugar results and other pertinent laboratory studies. Review of Humalog KwikPen (insulin lispro) instructions for use revised July 2023 priming pen which removes the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly. If pen is not primed before each injection, this may result in the patient receiving too much or too little insulin. To prime pen, turn the dose knob to select 2 units. Hold pen with needle pointing up. Tap cartridge holder gently to collect air bubbles at the top. Continue holding pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. Insulin should be seen at tip of needle. If insulin is not seen, repeat priming no more than four times. If still no insulin is observed, change the needle and repeat priming. This deficiency represents non-compliance investigated under Complaint Number OH00154139.