

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER MT Alverna Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 6765 State Road Parma, OH 44134	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure blood glucose testing (BGT) was completed per the physician's order. This finding affected one (Resident #150) of three residents reviewed for BGT. The facility census was 140.</p> <p>Findings include:</p> <p>Review of Resident #150's medical record revealed the resident was admitted on [DATE] with diagnoses including encephalopathy, type two diabetes, and dementia. Resident #150 was discharged on 03/27/25.</p> <p>Review of Resident #150's physician orders revealed an order dated 03/11/25 (discontinued 03/22/25) for a general diet, soft and bite sized texture, thin liquid consistency; and an order dated 03/23/25 for a consistent carbohydrate diet, regular texture, thin liquid consistency (CCD).</p> <p>Review of Resident #150's physician orders revealed an order dated 03/11/25 (discontinued 03/15/25) for sliding scale insulin coverage. The order listed Humalog (fast acting insulin) and provided the following additional parameters: if the blood sugar was zero to 180 inject no insulin; 181 to 200 inject two units; 201 to 250 inject four units; 251 to 300 inject six units; 301 to 350 inject eight units; 351 to 400 inject 10 units; and call provider above 400 before meals and at bedtime.</p> <p>Review of Resident #150's progress note dated 03/14/25 at 12:36 P.M. revealed the power-of-attorney (POA) contacted the facility with concerns/requests. The POA was concerned that staff were waking the resident up during the night for care and medications. The resident requested medication administration times be changed to during the day while the resident was awake. The Nurse Practitioner (NP) was updated and agreeable with the time change. The POA also requested the resident should not be woken up for check and changes during the night as well as not be woken up for breakfast. Per the POA, the family was always in the building around breakfast time and would help the resident with meals if needed. The POA requested for the door to the room to be shut half way due to the light in the hallway.</p> <p>Review of Resident #150's physician orders revealed an order dated 03/15/25 (discontinued 03/21/25) for sliding scale insulin coverage. The order listed Humalog and provided the following additional parameters per sliding scale: if the blood sugar was zero to 180 inject no insulin; 181 to 200 inject two units; 201 to 250 inject four units; 251 to 300 inject six units; 301 to 350 inject eight units, 351 to 400 inject ten units and call provider if above 400 before meals and at bedtime.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #150's Medication Administration Record (MAR) for March 2025 revealed the resident's blood sugar level was obtained on 03/17/25 at 9:06 A.M. with a result of 177. The Documentation Survey Report form revealed on 03/17/25 at 8:00 A.M. the resident consumed 75% to 100% of the breakfast meal. The BGT was obtained after the breakfast meal was completed.</p> <p>Review of Resident #150's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.</p> <p>Review of Resident #150's physician orders revealed an order dated 03/21/25 (discontinued 03/25/25) for sliding scale insulin coverage. The order listed Humalog and provided the following additional parameters per sliding scale: zero to 180 no insulin; 181 to 200 inject two units; 201 to 250 inject four units; 251 to 300 inject six units; 301 to 350 inject eight units; 351 to 400 inject 10 units; and above four units call the provider two times a day before meals for morning and evening meals.</p> <p>Review of Resident #150's MAR for March 2025 revealed the blood sugar was completed on 03/21/25 at 10:10 A.M. with a result of 174. The Documentation Survey Report form dated 03/21/25 at 9:04 A.M. revealed the resident consumed 75% to 100% of the breakfast meal. The BGT was obtained after the breakfast meal was completed.</p> <p>Telephone interview on 07/02/25 at 1:53 P.M. with Licensed Practical Nurse (LPN) #828 confirmed the staff placed Resident #150's tray on her overbed table for the breakfast meal but did not wake the resident up. LPN #828 revealed she probably completed the BGT after the breakfast meal on 03/21/25 because the resident either woke up early or the resident's family woke up the resident and the resident started eating the breakfast meal and the staff did not realize it. LPN #828 confirmed she completed the BGT as soon as she realized the resident was eating the breakfast meal.</p> <p>Interview on 07/02/25 at 1:58 P.M. with the Director of Nursing (DON) confirmed staff completed Resident #150's BGTs on 03/17/25 and 03/21/25 after the breakfast meals were completed.</p> <p>Review of the Medication Administration policy dated 06/01/23 revealed medications were administered only by licensed nursing, medical, pharmacy or other personnel authored by state laws and regulations to administer medications. Medications were administered in accordance with written orders of the prescriber.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164078.</p>		