STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366229	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Villa	7040 Hepburn Road Middleburg Heights, OH 44130

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** 35768 Based on record review, observation, interview, policy review, and review of the Centers for Disease Control and Prevention guidance, the facility failed to test blood glucose levels appropriately. This affected two (#12 and #23) of six residents reviewed for blood glucose testing. Findings include: 1. Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included type two diabetes, joint replacement surgery, and peripheral vascular disease. Review of the Minimum Data Set (MDS) assessment, dated 04/23/24, revealed Resident #12 had intact cognition. Review of the physician order dated 04/17/24 revealed an order to administer insulin with meals and at bedtime per sliding scale based on blood glucose levels. Observations of medication administration on 04/29/24 at 8:37 A.M. revealed Licensed Practical Nurse (LPN) #200 checking a blood glucose level for Resident #12. Resident #12 had already consumed breakfast. Resident #12's blood sugar level was 206 which indicated the resident was to receive four units of insulin per sliding scale. LPN #200 confirmed the blood glucose was obtained after Resident #12 consumed his breakfast; she stated she was late getting to the floor. LPN #200 stated blood glucose levels were to be obtained before meals. Interview on 04/30/24 at 4:16 P.M. with the Director of Nursing confirmed blood glucose levels were to be obtained before meals were consumed. Review of the facility policy titled Blood Glucose Testing, dated 2023, revealed to test glucose levels as ordered. The policy did not indicate to check blood glucose levels before meals. Review of the CDC guidance obtained from https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html revealed how often you check your blood sugar depends on the type of diabetes you have and if you take any diabetes medicines. Typical times to check your blood sugar included: When you first wake up, before you eat or drink anything. Before a meal. Two hours after a meal. (continued on next page)

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At bedtime. 2. Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included type two diabetes. Review of the Minimum Data Set (MDS) assessment, dated 01/19/24, revealed Resident #23 had intact cognition. Review of the physician order dated 04/26/24 revealed an order to administer insulin before meals and at bedtime. Observations of medication administration on 04/29/24 at 10:32 A.M. revealed Licensed Practical Nurse (LPN) #208 checking a blood glucose level for Resident #23. Resident #23 had already consumed breakfast. Resident #23's blood glucose level was 100 which indicated the resident was not to receive additional insulin per the sliding scale. LPN #208 stated blood glucose levels should be tested before meals. Interview on 04/30/24 at 4:16 P.M. with the Director of Nursing confirmed blood glucose levels were to be obtained before meals were consumed. Review of the facility policy titled Blood Glucose Testing, dated 2023, revealed to test glucose levels as ordered. The policy did not indicate to check blood glucose levels before meals. Review of the CDC guidance obtained from https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html revealed how often you check your blood sugar depends on the type of diabetes you have and if you take any diabetes medicines. Typical times to check your blood sugar included: When you first wake up, before you eat or drink anything. Before a meal. Two hours after a meal. At bedtime This deficiency represents non-compliance investigated under Complaint Number OH00152656.

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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** 35768 Based on record review, observation, interview, and review of manufacturer guidelines for use of KwikPen, the facility failed to residents were free of significant medication errors. This affected one (#12) of one resident observed for insulin administration. Findings include: Review of the medical record for Resident #12 revealed an admitted [DATE]. Diagnoses included type two diabetes, aftercare following joint replacement surgery, peripheral vascular disease, and need for assistance with personal care. Review of the comprehensive Minimum Data Set (MDS) assessment, dated 04/23/24, revealed Resident #12 had intact cognition, required maximal assistance for toileting and showering, and was occasionally incontinent of bladder and frequently incontinent of bowel. Review of Resident #12's plan of care dated 04/17/24 revealed plans to monitor and provide care for hyper/hypoglycemia. Observations of medication administration on 04/29/24 at 8:37 A.M. revealed Licensed Practical Nurse (LPN) #200 checking blood glucose levels for Resident #12. Resident #12 had already consumed breakfast. Resident #12's blood sugar level was 206 which indicated the resident was to receive four units of insulin per sliding scale. LPN #200 drew up the insulin using a clean syringe and a KwikPen. LPN #200 inserted the syringe into the top of the KwikPen to extract the insulin. LPN#200 stated the facility had no needles for the KwikPens so she used a syringe. Observation of the general supply room on 04/29/24 at 2:30 P.M. revealed a box filled with needles to use with the Kwikpens. Interview during the observation with the supply clerk revealed the facility had a sufficient amount of needles and staff needed to ask or come and get them when they ran out. Review of the manufacturer safety summary for use of KwikPens revised July 2023 revealed Do not use a syringe to remove Humalog from your prefilled pen. This can cause you to take too much insulin. Taking too much insulin can lead to severe low blood sugar. This may result in seizures or death. This deficiency represents non-compliance investigated under Complaint Number OH00152893 and OH00152656.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35768 Based on observations and interviews the facility failed to name and date open insulin and discard expired and unused insulin from the medication cart. This affected five (#18, #27, #85, #105, and #115) of 21 residents that required insulin. Findings include: Observation on [DATE] at 9:29 A.M. of Medication cart #1 revealed an open vial of insulin for Resident #105, the vial was not dated as to when it was opened; an open vial of insulin with no name or date as to when the insulin vial had been opened, and six additional opened insulin vials for residents that were either discharged or moved to another unit. Interview during the observation with Licensed Practical Nurse (LPN) #200 revealed staff were to write the resident's name and date the insulin vial was opened and remove all insulin vials non longer in use from the cart. Observation on [DATE] at 9:51 A.M. of Medication cart #2 revealed open vials of insulin that were not dated as to when opened for Resident #18 and Resident #27, and one opened vial of insulin for a resident that was moved to another unit. Interview during the observation with LPN #201 revealed staff were to write the resident's name and date the insulin vials were opened on the insulin vials and remove all vials no currently in use from the cart. Observation on [DATE] at 10:20 A.M. of Medication cart #3 revealed three open vials of insulin that were not dated as to when opened for Resident #85; one opened vial for Resident #115 that was not dated as to when opened, and opened vials of insulin for a resident that was moved to another unit and one resident who was discharged . Interview during the observation with LPN #206 revealed staff were to write the resident's name and date the insulin was opened on the vials and remove all unused vials from the cart. Observation on [DATE] at 10:50 A.M. of Medication cart #4 revealed two opened vials of insulin for two residents who were discharged . Interview during the observation with LPN #214 revealed staff were to remove all unused insulin vials from the cart. Review of the facility policy titled Medication Storage in the Facility, dated 2018 revealed staff were to place the date opened sticker on the vial when initially opened. This deficiency represents non-compliance investigated under Complaint Number OH00152893.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35768 Based on observation and interview the facility failed to ensure appropriate infection control standards were maintained during medication administration. This affected one (Resident #23) of three residents observed for medication administration. Findings include: Observations of medication administration on 04/29/24 at 10:32 A.M. revealed Licensed Practical Nurse (LPN) #208 sanitizing hands, opening the drawers in the medication cart, and removing the bubble packs of medications. LPN #208 popped seven medications for Resident #23 into a bare hand. Interview immediately after observation with LPN #208 revealed the pills should have been popped into the medication cup or a gloved hand. The facility did not provide a policy regarding hand hygiene during medication administration as requested. This deficiency represents non-compliance investigated under Complaint Number OH00152656.