

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/04/2024
NAME OF PROVIDER OR SUPPLIER  Otterbein Gahanna		STREET ADDRESS, CITY, STATE, ZIP CODE  402 Liberty Way Gahanna, OH 43230	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34291</p> <p>Based on observation, staff interview, medical record review, and policy review the facility failed to ensure insulin pens were primed before administering insulin to the residents. This affected one resident (#23) of one resident reviewed for insulin pen priming. The facility identified five residents (#14, #15, #18, #19 and #23) in House #2 who received insulin. The facility census was 54.</p> <p>Findings included:</p> <p>Medical record review for Resident #23 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease and diabetes.</p> <p>Review of physician orders dated 11/02/23 revealed Lantus to inject 35 units subcutaneously in the morning. Further review of physician orders dated 01/31/24 for Resident #23 revealed Novolog flex pen subcutaneous solution to inject per sliding scale in the morning and at bedtime.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact.</p> <p>During a medication administration observation on 11/04/24 at 8:21 A.M. for Resident #23 revealed after her blood sugar was taken she required two units of Novolog and she was scheduled for Lantus 35 units. The Registered Nurse (RN) #171 didn't prime either one of the pens before administration.</p> <p>Interview with RN #171 on 11/04/24 at 8:38 A.M. revealed he didn't know anything about an insulin pen needed primed before giving the medication. He confirmed he didn't prime the needles for Novolog or Lantus.</p> <p>Review of policy entitled Insulin Pen Quick Reference Guide dated 2021 revealed Novolog and Lantus require two units to prime the needle before injecting the insulin.</p> <p>Review of the manufacturer's guidelines entitled Drop Safe Safety Pen Needle not dated revealed to perform a priming test recommended by the pen inject device manufacturer. A drop of liquid should appear on the needle tip visible through the viewing window. Use a new safety pen needle if the priming was unsuccessful.</p> <p>This deficiency represents non-compliance as an incidental finding during investigation of Complaint Number OH00159371.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34291</p> <p>Based on medical record review, observations, staff interview and policy review the facility failed to ensure glucometers were sanitized between residents. This affected three (#14, #15, #23) of three residents reviewed for medication administration. The facility identified this had the potential to affect five residents (#14, #15, #18, #19 and #23) who received accuchecks in House #2. The facility census was 54.</p> <p>Findings included:</p> <p>1. Review of the medical record review for Resident #14 revealed an admitted [DATE]. Medical diagnoses included Alzheimer's Disease and diabetes.</p> <p>Review of physician orders dated 11/18/23 revealed to take blood sugars in the morning.</p> <p>Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 was rarely or ever understood.</p> <p>During a medication administration observation on 11/04/24 at 7:38 A.M. for Resident #14 revealed after taking the blood sugar of the resident the Registered Nurse (RN) #171 revealed he didn't wipe the glucometer off with any sanitizing wipes.</p> <p>2. Medical record review for Resident #15 revealed an admitted [DATE]. Medical diagnoses included cerebrovascular attack (CVA) and diabetes.</p> <p>Review of physician orders dated 09/13/23 revealed to take blood sugar three times a day before meals and at bed time.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #15 was moderately cognitively impaired.</p> <p>During a medication administration observation on 11/04/24 at 7:56 A.M. for Resident #15 revealed after taking the blood sugar of the resident the RN #171 revealed he didn't wipe the glucometer off with any sanitizing wipes.</p> <p>3. Medical record review for Resident #23 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease and diabetes.</p> <p>Review of physician orders dated 11/02/23 revealed Lantus to inject 35 units subcutaneously in the morning. Further review of physician orders dated 01/31/24 for Resident #23 revealed Novolog flex pen subcutaneous solution to inject per sliding scale in the morning and at bedtime.</p> <p>Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a medication administration observation on 11/04/24 at 8:21 A.M. for Resident #23 revealed after taking the blood sugar of the resident the RN #171 revealed he didn't wipe the glucometer off with any sanitizing wipes.</p> <p>Interview with RN #171 on 11/04/24 at 8:38 A.M. revealed the facility was using the alcohol swabs to clean off the glucometer's. He confirmed he didn't sanitize the glucometer's in between residents for Resident's #14, #15, and #23.</p> <p>Review of policy entitled Cleaning/Disinfecting Elder Equipment and Medical Devices dated 11/05/21 revealed resident care devices - such as electric thermometers, glucose monitoring devices and coagulation monitoring devices may transmit pathogens if devices contaminated with blood and body fluids are shared without cleaning and disinfecting between uses for different residents. Single use disposable devices and individually assigned equipment should be used whenever possible. If equipment is required to be shared, it will be cleaned or disinfected between elders.</p> <p>This deficiency represents non-compliance as an incidental finding during investigation of Complaint Number OH00159371.</p>		