

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  01/06/2025
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** 49039</b></p> <p>Based on observation, staff interview, medical record review, manufacture's guidelines, and policy review the facility failed to ensure insulin pens were primed before administering insulin to the residents. This affected one resident (#47) of one resident reviewing for insulin pen priming. The facility identified two residents (#47 and #55) in House #1 who received insulin. The facility census was 55.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #47 revealed an admitted [DATE] with diagnoses of transient cerebral ischemic attack, type two diabetes mellitus without complications, anemia, adult failure to thrive, hypertension and dementia.</p> <p>Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 had moderate cognitive impairment.</p> <p>Review of physician orders dated 01/29/24 for Resident #47 revealed the resident was prescribed Insulin Glargine Solution 100 units, with instructions to inject 8 units subcutaneously each morning before breakfast to manage Diabetes Mellitus.</p> <p>Observation of medication administration on 12/18/24 at 8:41 A.M. for Resident #47 indicated the resident was scheduled to receive 8 units of insulin Glargine solution 100 units/ml. Registered Nurse (RN) #113 prepared the medication at the medication cart, first cleansing the tip of the insulin pen, attaching a needle, and placing the pen on a clean tissue. The nurse then grabbed an alcohol wipe, locked the medication, and entered the resident's room. Upon entering, the nurse performed hand hygiene, donned clean gloves, and approached the resident. The nurse wiped the right side of the resident's arm with the alcohol wipe, twisted the insulin pen to prepare 8 units, but failed to prime the insulin pen prior to administration. The nurse quickly showed the pen to the surveyor with 8 units dosed and then administered the medication.</p> <p>Interview on 12/18/24 at 8:46 A.M. with RN #113 confirmed she did not prime the insulin pen before administering the medication. RN #113 was unaware of the required procedure or the proper amount of insulin to use for priming the insulin pen.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy entitled Insulin Pen Quick Reference Guide dated 2021 revealed Lantus insulin pens require two units to be used for priming the needle before an injection is administered, ensuring accurate dosing.</p> <p>Review of the manufacturer's guidelines entitled Drop Safe Safety Pen Needle not dated revealed a priming test is recommended by the pen device manufacturer. A drop of liquid should appear on the needle tip, visible through the viewing window. If priming is unsuccessful, a new safety pen needle should be used.</p> <p>Review of How to use your Lantus SoloStar pen dated 2022 revealed the nurse should dial a test dose of two units, hold the pen with the needle pointing up, and tap the insulin reservoir lightly to move any air bubbles to the top. The nurse should then press the injection button fully to ensure insulin is dispensed from the needle. If no insulin is released, the test should be repeated twice more. If the problem persists, a new needle should be used and the priming test repeated.</p> <p>This deficiency represents non-compliance as an incidental finding during investigation of Complaint Number OH00160045.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49039</p> <p>Based on observation and interview the facility failed to maintain a clean kitchen environment. This had the potential to affect all residents except Resident #1 who does not receive food from the kitchen. The facility census was 55.</p> <p>Findings include:</p> <p>Observation on 12/17/24 at 9:54 A.M. of house number four revealed kitchen cabinets were dirty with a splattered white substance on the island and the cabinet next to the stove.</p> <p>Observation on 12/17/24 at 10:01 A.M. of house number five revealed a broken cabinet hinge facing outward toward the resident care area. The cabinets were observed with yellow, dripping dried substance along the fronts.</p> <p>Observation on 12/18/24 at 8:02 A.M. of house number three revealed the front of the kitchen cabinets were dirty with splatter, and the stainless steel area around the stove looked dirty.</p> <p>Observation on 12/18/24 at 9:17 A.M. of house number four revealed kitchen cabinets were dirty with a splattered white substance on the island and the cabinet next to the stove.</p> <p>Observation on 12/19/24 at 11:15 A.M. of house five revealed the kitchen island with a red plug had food splatters on it, and the cabinet was still off the hinge. The fridge, which was stainless steel, had fingerprints and grime along the door, the cabinet by the hairnet drawer had grime along the front door. The island had a yellow substance dripping along the front of the cabinet.</p> <p>Observation on 12/19/24 at 11:42 A.M. of house three revealed the fridge had fingerprints all over it, and the door had a dried substance along the edge when opening the fridge. The cabinet front specifically had splattered or dripping dried food along the cabinets. When opening the trash can, food and wrappers were present at the bottom around the trash can.</p> <p>Observation on 12/19/24 at 4:30 P.M. of house three revealed the fridge had fingerprints and dried substance along the door, the cabinet fronts were dirty, and the area underneath the pull-out trash cans had not been cleaned.</p> <p>Interview on 12/19/24 at 4:42 P.M. with Certified Nursing Assistant (CNA) #82 stated that she would not want her own home to look like this. However, the aides do not have enough time to clean. She mentioned that the kitchen really needs a deep clean but that there is no housekeeper to do it. The aides prioritize the residents' needs-such as bathing, feeding, restroom assistance, and dressing-over environmental concerns.</p> <p>Observation on 12/19/24 at 4:48 P.M. of house five revealed the cabinet fronts were dirty, the island had splatters along the front, and the area under the trash can had food and wrappers. The fridge had adhesive and fingerprint marks along the front. The hinge to the kitchen island had been hanging off for the past three days.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/19/24 at 4:52 P.M. with Diet Technician #103 confirmed the kitchen was not in satisfactory condition and that all areas of concern were present.</p> <p>Observation on 12/19/24 at 4:59 P.M. of house four revealed the area under the trash can was filthy, filled with food and wrappers. The cabinet fronts were dirty, along with all the cabinet fronts on the island and around the stove.</p> <p>Interview on 12/19/24 at 5:01 P.M. with CNA #99 confirmed that the trash can had food and wrappers at the base of the cabinet. All cabinet fronts were dirty, and the area around the stove was greasy.</p> <p>Interview and observation on 12/19/24 at 5:11 P.M. with the Director of Nursing confirmed the kitchen in house #1 and house #2 were not in clean and sanitary conditions.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00160461.</p>		