STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366457	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Gahanna	5151 North Hamiliton Road Columbus, 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)
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** 49794 Based on observation, record review, policy review, review of manufacturer instructions, review of Medscape guidance on intermittent insulin injections, and pharmacy and staff interviews, the facility failed to prime an insulin pen per manufacturer instructions prior to administration, resulting in a significant medication error. This affected one (Resident #75) of one resident observed for insulin administration. The facility identified 19 residents who receive insulin. The facility census was 98. Findings include: Review of the medical record for Resident #75 revealed an admitted [DATE]. Diagnoses include diabetes mellitus (DM) type two. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 was cognitively impaired. Review of the physician orders for Resident #75 revealed an order dated 04/14/24 for Insulin Glargine subcutaneous solution 100 unit/milliliter (ml) inject 26 units subcutaneously one time a day for DM. Observation of medication administration on 07/10/24 at 9:10 A.M. with Licensed Practical Nurse (LPN) #204 and Assistant Director of Nursing (ADON) #231 revealed LPN #204 administered medications to Resident #75. LPN #204 turned the dial to 26 units on the insulin pen. LPN #204 did not expel insulin from pen to prime prior to dialing 26 units. LPN #204 then administered the insulin to Resident #75. Interview on 7/10/24 at 9:18 A.M. with LPN #204 stated she turned the dial on the insulin pen to 28 units then turned the insulin dial to 26 units to prime the insulin pen before administering. LPN #204 confirmed she did not expel any insulin prior to administering the 26 units of insulin to Resident #75. Interview on 7/10/24 at 9:25 A.M. with ADON #231 stated nursing staff were taught to prime insulin pens by turning the dial two to three units past the ordered dose to get rid of the bubbles and then to flip it to the administration dose. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Interview on 07/10/24 at 1:10 P.M. with the Director of Nursing (DON) stated when priming an insulin pen, two to three units of insulin should be expelled from the pen to prime it. The DON stated insulin pen can be primed by dialing past two to three units past the prescribed units and pressing the button to expel the additional units, making sure the correct dose was left, or dialing to the two mark and pressing the button. The DON stated that was how they were taught to do it in nursing school. The DON stated the facility received instructions for administration from Pharmacy #500 and did not go by the manufacturer's instructions. Interview on 07/10/24 at 1:50 P.M. and 4:26 P.M. with Pharmacist #600 from Pharmacy #500 confirmed two units of insulin needs to be expelled from insulin pens to prime them prior to administration. Pharmacist #600 confirmed the correct way to prime the insulin pen prior to administration is to turn the dial to two units, hold pen upright, tap the top to remove air bubbles, then press the button to expel the two units to complete priming of the insulin pen. Pharmacist confirmed after the pen has been primed the dial should be turned to the correct dose for administration. Pharmacist #600 confirmed turning the dial to 28 and then dialing it to 26 would not be considered priming the pen. Review of the facility's Safe Insulin Pen Practices from [Pharmacy #500] dated 2023 revealed Prime and Dial and always prime then dial to ensure correct dosage. Review of the facility policy titled [Pharmacy #500] Injectable Medications, dated March 2022, revealed staff should prime (air shot) insulin pens prior to each administration with two units or manufacturer's recommendations. Hold the pen with the needle up, tap to move any air bubbles to the top. Dial correct dose of insulin from, or draw up correct dose from vial. Review of the facility policy titled Medication Administration, dated 10/17/23, revealed resident medications administered in an accurate, safe, timely, and sanitary manner. Review of Medscape guidance titled Intermittent Insulin Injections Insulin Overview dated 11/05/20 and located at https://emedicine.medscape.com/article/2049311-overview#a1 revealed to avoid air and to ensure proper dose, you will need to prime the syringe each time; to do this, dial two units; hold the pen with the needle pointing up and tap the cartridge gently a few times to get rid of any air bubble; press the push button all the way in until the dose selector returns to zero; a drop of insulin must appear at the needle tip; if not, change the needle and repeat the procedure. Review of the administration instructions for Insulin Glargine-yfgn pen located at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3ac85ebb-5594-59c8-77fd-df254329d151 revealed insulin pen should be primed and tested for safety prior to administration to make sure they were working properly using the following method: select two units by turning the dose selector until the dose pointer is at the two mark, then press the injection button all the way in. When insulin comes out of the needle tip, the pen was working correctly. Turn the dose selector until the dose pointer lines up with your dose. This instruction for Use has been approved by the U.S. Food and Drug Administration. This deficiency represents noncompliance investigated under Complaint Number OH00154908. This is an example of continued non-compliance from the survey dated 06/03/24.