STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225376	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penacook Place, Inc	150 Water Street Haverhill, MA 01830

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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37342 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was free from a significant medication error, when on 03/18/25 he/she was administered the incorrect dose of long acting insulin. Resident #1 experienced an adverse reaction, including lethargy and malaise, for which he/she required treatment and increased monitoring by nursing until his/her blood sugar level stabilized. Findings include: The Facility Policy, titled Insulin Administration, dated revised 09/2014, indicated nursing would verify the type of insulin, dosage requirements, strength, and method of administration before administration, to confirm it corresponds with the physician's orders. The Facility Policy, titled Adverse Consequences and Medication Errors, dated revised 02/2023, indicated that a medication error was defined as the preparation or administration of drugs or biologicals which was not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principals of the professional providing the services. Review of the Facility's Incident Report Form, dated 03/18/25, indicated that at 11:30 A.M., Resident #1's routine blood sugar check indicated his/her blood sugar was 52 milligrams per deciliter (mg/dL) (indicative of hypoglycemia, low blood sugar defined by a blood glucose level below 70 mg/dL), he/she was asymptomatic at that time, ate some fig newtons and juice, and went to the main dining room for lunch. The Incident Report indicated Resident #1 later became symptomatic, was pale, sweating, cool and clammy, and said he/she did not feel well. The Incident Report indicated the Facility discovered that Nurse #1 had administered Resident #1's Toujeo (long acting insulin) 300 units/mL using a standard 100 unit/ml insulin syringe, and had therefore administered three times the prescribed dose of insulin, in error. Review of Resident #1's Nurse Practitioner Note, dated 03/18/25, indicated he/she was given Toujeo 108 units that morning instead of the prescribed dose of 36 units. Resident #1 was admitted to the Facility in August 2021, diagnoses included diabetes which was managed with insulin. (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

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Order Summary Report for March 2025 indicated he/she had a physician's orders for Toujeo Max Solostar Subcutaneous (under the skin) Solution Pen-Injector 300 unit/mL, inject 36 units subcutaneously one time a day. Review of the Highlights for Prescription Information Insert for Toujeo (long acting insulin) Unit 300 Insulin Glargine pre-filled subcutaneous pen, dated revised 08/2024, indicated: -Toujeo was supplied in multi-dose pre-filled pens, and doses were injected using single use needles which attached to the pen. -Do not use a syringe to remove Toujeo from the Toujeo pre-filled pen, as it could cause you to give yourself too much insulin. Toujeo has three times as much insulin (300 units/mL) in one mL as compared to other insulin glargine products (100 units/mL) pens. According to the American Diabetes Association, people with diabetes should have blood sugar levels of 80-130 milligrams per deciliter (mg/dL) before eating a meal (fasting), and less than 180 mg/dL about 1-2 hours after eating a meal, however these ranges varied per individual. Review of Resident #1's Blood Sugar Summary from 03/01/25 to 03/17/25 indicated his/her capillary blood sugar ranged between 88 mg/dL to 290 mg/dL, and was monitored by nursing four times daily. Review of Resident #1's Nurse Progress Note, dated 03/18/25, indicated during his/her routine blood sugar check at 11:30 A.M., his/her blood sugar level was 52 mg/dL (low), he/she was not symptomatic at the time, he/she ate two fig newtons, 16 ounces of cranberry juice and left his/her unit to go to the main dining room. The Note indicated that once Resident #1 was in the main dining room, he/she told the Director of Nurses (DON) about the low blood sugar level, said he/she was feeling sweaty and looking forward to eating lunch so he/she could feel better. The Note indicated Resident #1 said he/she had received his/her normal insulin injection between 08:00 A.M. and 09:00 A.M., that morning, that he/she had eaten a large lunch, continued to complain of feeling unlike him/herself. The Note indicated Resident #1 appeared cool, clammy and was pale. Further review of the Nurse Progress Note indicated his/her blood sugar was 55 mg/dL at 12:15 P.M., and Nurse Practitioner #1 provided new orders for the following: - Glucose Chewable Tablets - Intravenous Dextrose 5% in Water (D5W), 1,000 mL at a rate of 75 ml an hour (times one). - Check his/her blood sugar every 30 minutes for two hours, then every two hours until 07:30 A.M. on 03/19/25. Review of Resident #1's Blood Sugar Summary indicated his/her blood sugars were monitored as ordered, and between 12:30 P.M. on 03/18/25 into 07:38 A.M., on 3/19/25, his/her blood sugars ranged from 94 mg/dL to 389 mg/dl. Review of Resident #1's Nurse Progress Note, dated 03/19/25, timed 07:35 A.M., indicated nursing assessed him/her throughout the night, he/she had no symptoms of hypoglycemia, and he/she received D5W via IV, as ordered. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/29/25 at 11:07 A.M., Nurse #1 said that on 03/18/25, he was Resident #1's assigned nurse, that he was familiar with Resident #1 and was normally assigned as his/her nurse. Nurse #1 said that on 03/18/25 at 08:00 A.M., the needles that attach to Resident #1's Toujeo pre-filled pen were not in the medication cart, that he did not look elsewhere or ask other staff where to find more pen needles, and used an insulin syringe that measured 100 units/ml to draw up 36 units from the pre-filled pen, then injected Resident #1 with that syringe. Nurse #1 said he did not realize that the Toujeo insulin concentration was 300 units/ml, and said since he used a syringe that measured 100 units/ml, he administered Resident #1 three times the physician's ordered dose of Toujeo, in error. During an interview on 04/29/25 at 08:48 A.M., the Director of Nurses (DON) said Nurse #1 should only have injected Resident #1's Toujeo using the pre-filled pen and needle, but had used an insulin syringe, which led to Resident #1 receiving three times the prescribed dose, and experiencing symptoms of low blood sugar. The DON said there were more needles for insulin pens available in the Facility on 03/18/25 in the supply room on the unit. On 04/29/25, the Facility was found to be in Past Non-Compliance and provided the Surveyor with a plan of correction which addressed the area of concern as evidenced by: A. 03/18/25, Resident #1 was administered IV D5W, was monitored by nursing, and recovered from his/her hypoglycemic episode caused by the accidental overdose of insulin. B. 03/18/25, The Sentinel Event Root Cause Analysis Report was created which indicated Facility's Leadership developed a plan to correct the deficient practice to ensure that residents were administered insulin doses as prescribed, and that residents whose insulin was administered via multi-dose pens were only administered doses via the pen/needle set up. C. 03/18/25, The DON completed an audit of all residents with high concentration insulin to ensure nursing was not drawing from high dose insulin pens using a syringe. D. 03/18/25, The DON completed an audit of each unit to ensure there were enough insulin pen needles and that licensed nurses were aware of where to obtained additional needles, if needed. E. 03/18/25, The DON implemented new High-Dose alert labels for insulin with concentrations greater than 100 units/ml. F. 03/18/25, The DON and MDS Nurse discussed with the Medial Director and obtained approval to implement new standing orders for a new protocol specific to hypoglycemia for all residents with diabetes or prediabetes. G. 03/19/25, The DON and MDS Nurse audited all residents with diabetes and prediabetes and the new standing orders for hypoglycemia protocol were implemented. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	H. 03/20/25, The DON and ADON educated licensed nursing staff regarding insulin pen use, verifying insulin dose and concentration, blood glucose testing, hypoglycemia protocol, symptoms of hypoglycemia and hypoglycemic rescue medications. I. 03/18/25, The DON initiated audits for all residents with high-dose insulin pens for four weeks and will continue to do so monthly for two months to ensure that high-dose insulin pens are labeled, that pen needles are well stocked, and that nurses are not drawing from pens with insulin syringes. J. The Facility will monitor compliance at monthly and quarterly Quality Assurance Meetings. K. The Director of Nurses and/or designee is responsible for ongoing compliance.