STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305057	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courville at Manchester	44 West Webster Street Manchester, NH 03104

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents are free from significant medication errors which resulted in a resident requiring intervention and hospitalization for multiple nights for 1 of 3 medication errors reviewed. (Resident identifier is #1.)Findings include:Interview on 5/1/26 at approximately 11:30 a.m. with Resident #1 revealed he/she had received someone else's insulin a week or two ago and was admitted to the hospital.Review on 5/1/26 of Resident #1's medical record revealed a hospital history and physical, dated 4/20/26, that stated .CHIEF COMPLAINT: Accidental medication overdose, nausea and vomiting .- Aspirin 81 mg The patient was found to be hypoglycemic over here with blood sugars in the low 60s. [Pronoun omitted] was symptomatic with nausea and vomiting . Further review of Resident #1's medical record revealed a hospital Discharge summary, dated [DATE], that stated .ASSESSMENT AND PLAN: .Monitor on telemetry overnight .Antiemetics . Blood glucose every 2 hours overnight, D5WNS [Dextrose 5 percent with Normal Saline] overnight, Aspiration and seizure precautions . Interview on 5/1/26 at approximately 10:00 a.m. with Staff B (Unit Manager) revealed that on 4/20/26 Resident #1 had received multiple medications that were intended for Resident #2 in error during the morning medication pass.Review on 5/1/26 of Resident #2's April 2026 Medication Administration Record revealed the following medications were dispensed for Resident #2 with the morning medication pass:Atenolol (antihypertensive) 25 mg (milligrams), Insulin Lispro 19 units, Trulicity (GLP-1)1.5 mg, Allergy relief nasal suspension, Omeprazole 40 mg, Jardiance 25 mg, Furosemide (diuretic) 20 mg, Donapezil 10 mg, Namenda 10 mg, buspirone (anxiolytic)10 mg, metformin (antihyperglycemic) 1000 mg, Gabapentin (anticonvulsant) 300 mg, Norco (Opioid analgesic) 5-325 mg, Biofreeze Gel 5 % (percent), Visine Dry eye ophthalmic solution, Vitamin C 500 mg, Lactaid 3000 Unit, Calcium Carbonate- Vit D 600-400 mg-unit, Aspirin 81 mg.Interview on 5/1/26 at approximately 10:45 a.m. with Staff C (Director of Nursing) confirmed the above medications intended for Resident #2 were given to Resident #1 in error on the morning of 4/20/26 which resulted in Resident #1 being admitted to the hospital.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure resident medications were labeled in accordance with currently accepted professional principles, medications were not removed from use after expiration, and failed to keep medications stored securely for 2 of 3 medication carts observed. (Resident identifiers are #3 and #6.)Findings include:Observation on 5/1/26 with Staff A (Licensed Practical Nurse) of the first floor medication cart revealed Resident #3's open Glargine (Lantus) insulin pen with no open date or open use by date. Further observation revealed Resident #3's Lispro insulin Kwikpen with an open date of 4/1/26 and a discard date of 4/29/26. Both insulin pens had a pharmacy sticker that read discard 28 days after opening. Review on 5/1/26 of the Lantus (insulin glargine) pen manufacturer instructions for use revealed .After 28 days throw your open Lantus pen away- even if it still has insulin in it. Review on 5/1/26 of the Lispro Kwikpen manufacturer instructions for use revealed .Do not use your pen past the expiration date printed on the label or for more than 28 days after you first start using the pen. Interview on 5/1/26 at approximately 8:30 a.m. with Staff A confirmed the above findings. Observation on 5/1/26 at approximately 8:15 a.m. revealed a second floor medication cart with a clear plastic medicine cup containing pills on top of the cart. There were no nurses in view of the medication cart. Further observation revealed Licensed Nursing Assistants pushing residents by the cart and visitors walking down the hall. Interview on 5/1/26 at approximately 8:15 a.m. with Staff E (Registered Nurse) confirmed that they left the medications unattended on the medication cart and revealed that they were for Resident #6. Review on 5/1/26 of Resident #6's April 20, 2026 Medication Administration Record revealed the following signed morning medications: furosemide (diuretic) 40mg (milligrams),Lisinopril (antihypertensive) 20mg,metoprolol succinate (beta blocker) extended release 100mg, metoprolol succinate extended release 25mg, Pepcid (proton pump inhibitor) 20mg, Risperdal 0.25mg (antipsychotic), sertraline (antidepressant) 150mg, Eliquis (anticoagulant) 5mg, and senna plus 8.6-50mg. Interview on 5/1/26 at approximately 8:30 a.m. with Staff E (Registered Nurse) confirmed the above listed medications were the medications that were left unintended on the medication cart. Review on 5/1/26 of facility policy titled Medication Administration and Storage, effective date 9/8/2022, revealed .Medications are locked in a clean cart, medication room, or refrigerator.Confirm medications are labeled, dated and expired medications are removed.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from exposure to bloodborne pathogen transmission when staff used a resident's insulin pen to administer insulin to another resident. (Resident identifier is #1.)Findings include:Interview on 5/1/26 at approximately 11:30 a.m. with Resident #1 revealed he/she received someone else's insulin a week or two ago and was admitted to the hospital. Review on 5/1/26 of Resident #1's medical record revealed a hospital Discharge summary, dated [DATE], that stated .Accidentally Received Lispro 19 units and Trulicity 1.5 mg. Further review of the hospital discharge summary revealed no lab results for bloodborne pathogens. Further review of Resident #1's medical record revealed no orders for blood borne pathogen lab work before or after hospitalization.Interview on 5/5/26 at 2:30 p.m. with Staff F (Licensed Practical Nurse) confirmed that on 4/20/26 they had administered to Resident #1 insulin from another resident's open Lispro pen. Interview on 5/1/26 at approximately 10:45 a.m. with Staff C (Director of Nursing) confirmed that Resident #1 received Resident #2's used Lispro insulin via multidose pen on 4/20/26. Staff C revealed that no bloodwork for bloodborne pathogens had been performed on Resident #1 or Resident #2. Resident #1's Durable Power of Attorney for Health Care had not been notified of the risk for transmission of bloodborne pathogens as a result of receiving insulin from another resident's used insulin pen.Review on 5/1/26 of the Lispro pen manufacturer's instructions revealed .Do not share your needles or syringes with other people, even if the needle is changed. You may give other people a serious infection or get a serious infection from them.Review on 5/1/26 of the facility policy titled Medication Administration and Storage, effective 9/8/2022, revealed .Use needles, cannulas and syringes for only one resident.Multidose insulin pens are to be clearly labeled for the resident and used only for the resident ordered. Review on 5/1/26 of the Centers for Disease Control and Prevention (CDC) website titled, Considerations for Blood Glucose Monitoring and Insulin Administration, dated 8/7/24, retrieved 5/1/26, from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=medications%20in%20pockets.-,I revealed: .Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices permit self-injection, but healthcare providers may also use them to administer insulin. Each pen is designed to be safe for just one patient to use multiple times with a new, fresh needle for each injection. Pens must never be used for more than one patient because blood may be present in the pen after use