STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305060	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Hills Center	30 Colby Court Bedford, NH 03110

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43408 Based on interview and record review, it was determined that the facility failed to ensure residents remain free from significant medication errors, which resulted in a resident needing interventions for hypoglycemia, including hospital observation for one of three residents reviewed for insulin use. (Resident Identifier #1). Findings include: Interview on 5/22/24 at approximately 10:00 a.m. with Resident #1 revealed he/she had received too much insulin a little while ago and ended up going to the hospital as a result. Review on 5/22/24 of Resident #1's March 2024 Medication Administration Record revealed the following Humulin R U-500 (Insulin) orders: Humulin R U-500 kwik pen 12 units one time only for CBG= 507 mg/dl, with a start date and time of 3/31/24 at 12:15 p.m.; Humulin R U-500 kwik pen 12 units one time only for CBG= 487 mg/dl, Administer in addition to scheduled 45 units for a total of 57 units, with a start date and time of 3/31/24 at 4:30 p.m. Interview on 5/22/24 at approximately 11:20 a.m. with Staff B (Registered Nurse) revealed that at approximatley 12:15 p.m., they used a U-100 insulin syringe instead of a U-500 syringe to withdraw 12 units of Humulin U-500 from the resident's insulin pen (total concentration administerd was equal to 60 units, not the ordered 12 units). Staff B revealed that at approximatley 4:30 p.m., they used a U-100 insulin syringe instead of a U-500 syringe to withdraw 12 units of Humulin U-500 from the resident's insulin pen (total concentration administered equal to 60 units, not the ordered 12 units). Review on 5/22/24 of the manufacturers' instructions for Humulin R U-500 kwik pen revealed, .HUMULIN R U-500 is a concentrated insulin. Do not transfer HUMULIN R U-500 insulin from your Pen into a syringe. A severe overdose can happen, causing very low blood sugar, which may put your life in danger . Interview on 5/22/24 at approximately 11:20 a.m. with Staff B revealed that the Humlim R U-500 Kwik pen only allows administration in 5 unit increments. Staff B used a syringe in order administer be able to administer 12 units because the pen could only deliver 10 or 15 units. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/22/24 at approximately 11:00 a.m. with Staff A (Director of Nursing) revealed that Resident #1 had received the wrong dose of Humulin R U-500 twice on 3/31/24. Staff A confirmed that Staff B used the wrong syringe to administer the above insulin and therefore the resident recieved five times the dose ordered. Review on 5/22/24 of Resident #1's medical record revealed a nurses note dated 4/1/24, entered at 9:50 p.m. , Resident returned from hospital s/p [status post] accidental insulin overdose . Further review of Resident #1's medical record revealed an eInteract Transfer Form V5, dated 4/1/24, that revealed .5. Additional Relevant Information: notified by previous nurse during report that resident had several episodes of hypoglycemia overnight. Upon assessment resident had CBG [Capillary Blood Glucose] of 42 [mg/dl (milligrams per deciliter)]. Resident lethargic, only arousable with repeated stimuli, insta glucose gel administered, per orders to send to ED [Emergency Department] for eval [evaluation] and tx [treatment]. CBG rechecked and increased to 56 [mg/dl]. Transferred to [Hospital name omitted] ED via [by way of] EMS [Emergency Medical Services] @ [at] 0755 [7:55 a.m.]. Review on 5/22/24 of Resident #1's recorded blood sugars for 3/31/24-4/1/24 revealed the following: 3/31/24 at 9:36 a.m. 375 mg/dl; 3/31/24 at 11:55 a.m. 507 mg/dl; 3/31/24 at 4:21 p.m. 487 mg/dl; 3/31/24 at 7:00 p.m. 291 mg/dl; 3/31/24 8:39 p.m. 168 mg/dl; 4/1/24 at 12:51 a.m. 115 mg/dl; 4/1/24 at 3:30 a.m. 97 mg/dl; 4/1/24 at 5:33 a.m. 57 mg/dl; 4/1/24 at 6:12 a.m. 94 mg/dl; 4/1/24 at 7:38 a.m. 42 mg/dl;4/1/24 at 7:39 a.m. 40 mg/dl. Review of glucose references rangs, retrieved from: https://emedicine.medscape.com/article/2087913-overview?form=fpf revealed the following: Normal glucose, for elderly patients: 82-115 mg/dL Review on 5/22/24 of The American Diabetes Association website article, Using U-500 Insulin, found at diabetesjournals.org/clinical/article/30/2/86/31636/Using-U-500-Insulin, updated on April 1,2012, revealed: . U-500 is 5 times more concentrated than U-100 insulin. This means that every 1 unit of U-500 is the same as 5 units of your usual insulin. This makes it a more powerful medicine. It also means that you need to be careful about giving yourself the right amount of U-500 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review on 5/22/24 of the facility's documentation of corrective action for the above insulin error revealed the facility updated the policy titled: Insulin [NAME] 4/2/24, completed in-service education to all nurses on the administration of insulin with an insulin pen specific to Humulin R U-500 on 4/2/24, conducted competencies with all nurses on the administration of insulin with an insulin pen from 4/4/24-4/15/24, are monitoring insulin administration through weekly audits and are reviewing these audits at quarterly Quality Assurance and Performance Improvement meetings.