STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305061	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Center	40 Crosby Street Milford, NH 03055

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. 43002 Based on interview and record review, it was determined that the facility failed to ensure that 2 of 4 residents reviewed for insulin were free from potential exposure to bloodborne pathogen transmission when staff administered insulin to two residents using the same insulin pen (Resident Identifiers are #1 and #2). Findings include: Interview on 6/26/24 at 10:45 a.m. with Staff B (Licensed Practical Nurse) revealed that on 6/13/24 at around 9:00 a.m. he/she administered Resident #2's used Aspart insulin pen to Resident #1 by mistake. Resident #2's insulin pen was labeled for Resident #2. Staff B stated that he/she did not discard the insulin pen and used it shortly after on Resident #2 and then placed it back in the medication cart for continued use. Staff B stated that they thought that since the needle had been changed, there was no infection control concerns. Interview on 6/26/24 at approximately 9:15 a.m. with Staff A (Unit Manager) confirmed that Resident #1 had received Resident #2's Aspart insulin in error on 6/13/24 and that the insulin pen was returned to the medication cart for use for Resident #2 after it was used on Resident #1. Review on 6/26/24 of Resident #2's June Medication Administration Record (MAR) revealed the following orders for Aspart insulin: Aspart insulin 12 units two times a day, with a start date of 6/11/12 and an end date of 6/12/24; Aspart Insulin 12 units with meals, with a start date of 6/12/24 and an end date of 6/19/24. Further review of the June MAR revealed that Resident #2 received the following administrations of Aspart insulin from 6/13/24 through 6/17/24: 6/13/24- 3 doses administered; 6/14/24- 3 doses administered; 6/15/24- 3 doses administered; 6/16/24- 3 doses administered; and 6/17/24- 1 dose administered. Interview on 6/26/24 at approximately 1:00 p.m. with Staff C (Previous Director of Nursing) confirmed that Resident #2 had continued to receive Aspart insulin with the same insulin pen that was used on Resident #1 from 6/13/24 until 6/17/24. Staff C notified Public Health because the pen had been used on two different residents potentially exposing both residents to blood borne pathogens. (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
	305061	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/26/24 at 10:05 a.m. with Staff C revealed that he/she did not realize that there was an infection control concern with the above medication error until Monday 6/17/24. Staff C stated that he/she discarded Resident #2 Aspart insulin pen on 6/17/24 that had been in use. Interview on 6/26/24 at 11:40 a.m. with Staff D (Administrator) confirmed that he/she had been made aware of the medication error on 6/14/24; however, was not made aware of the infection control issue until 6/17/24 when the insulin pen was removed from the medication cart by Staff C. 43408 Interview on 6/26/24 at 1:15 p.m. with Staff D revealed that education regarding insulin pens was started for all staff on duty who administer insulin on 6/17/24 and all other staff received education prior to working their next shift. Review on 6/26/24 of the manufacturers' instructions for Insulin Aspart, provided by the facility, revealed: .Do Not share your Insulin Apart FlexPen or needles with anyone else. You may give an infection to them or get an infection from them . Review on 6/26/24 of the facility policy titled Insulin Pens revised on 2/28/21, revealed: .Insulin pens containing multiple doses of insulin are meant for single patient use only and must never be used for more than one person, even when the needle is changed . Review on 6/26/24 of the Centers for Disease Control and Prevention (CDC) handout, retrieved 6/4/24, from https://www.cdc.gov/injection-safety/media/pdfs/Insulin-Pen-Safety-Handout-P.pdf revealed: .Injection equipment (e.g., insulin pens, needles and syringes) should never be used for more than one person . It is critical to remember that insulin pens are meant for only one person .Although invisible to the eye, back flow of blood into the insulin pen can happen during an injection. This creates a risk of bloodborne and bacterial pathogen transmission to patients if the pen is used for more than one person, even when the needle is changed . Review on 6/26/24 of the facility's documentation of education for medication administration and insulin pen safety to staff who administer medications was initiated on 6/17/24. This included the risk of bloodborne pathogens. Review on 6/26/24 of the facility's Quality Assurance and Performance Improvement (QAPI) meeting held on 6/18/24 revealed the facility reviewed the above incident which included a root cause analysis and plan for auditing. Review on 6/26/24 of the facility competencies revealed that they were started on 6/20/24 for staff insulin medication competencies.