STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305078	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Hill Center, Genesis Healthcare	20 Maitland Street Concord, NH 03301

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 1 of 4 residents reviewed for insulin was free from exposure to bloodborne and bacterial pathogen transmission when staff administered the resident insulin from another resident's used insulin pen (Resident Identifier #1). Findings include: Interview on 6/4/24 at 9:30 a.m. with Staff C (Registered Nurse) revealed that he/she was Resident #1's evening nurse on 5/28/24 and that he/she was not able to locate Resident #1's Humalog 75/25 insulin or any back-up/emergency stock in the medication room for the 6:00 p.m. ordered dose. Staff C confirmed that he/she went to another medication cart to use another resident's (Resident #2) Humalog 75/25 insulin pen. Staff C revealed that he/she drew up 10 units of the insulin with a syringe and administered it to Resident #1. Staff C confirmed that the insulin pen was opened and had already been used for Resident #2. Interview on 6/03/24 at 9:30 a.m. with Staff A (Licensed Practical Nurse (LPN)) confirmed that Staff C used Resident #2's Humalog 75/25 insulin pen to draw up the 10 units of insulin for Resident #1 on 5/28/24. Staff A revealed that the insulin pen had already been used for Resident #2. Interview on 6/4/24 at 10:25 a.m. with Staff B (Director of Nursing) confirmed that it was not the facility's policy to borrow medication from another resident. Review on 6/4/24 of Resident #1's May Medication Administration Record (MAR) revealed a physician's order for Humalog Mix 75/25 for 10 units subcutaneously before dinner for diabetes mellitus. Review on 6/4/24 of the Humalog Mix 75/25 KwikPen insert, provided by the facility, revealed, .Do Not share your Humalog Mix75/25 KwikPen or needles with anyone else. You may give an infection to them or get an infection from them . Review on 6/4/24 of the facility's pharmacy policy titled Appropriate Use of Prefilled Insulin Pen Devices, provided by the facility revealed, .Insulin pens include a number of manufacturer-unique administrative devices designed for accurate and simple insulin administration. These benefits are only realized if prefilled pen devices are used appropriately .Never access the rubber seal of the cartridge containing insulin with a syringe and needle. Never use the same pen for more than one resident . (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
	305078	A. Building B. Wing	06/04/2024

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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	Review on 6/4/24 of the facility's policy Medication Shortages/Unavailable Medications revealed, .If a medication is unavailable during normal Pharmacy hours . A Facility nurse should call Pharmacy to determine the status of the order . If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery, if medically necessary . If a medication is unavailable is discovered after normal Pharmacy hours . If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to mange the plan of action. Action may include . Emergency delivery; or . Use of an emergency (back-up) Third Party Pharmacy . If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions . Review on 6/4/24 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 . Interview on 6/4/24 at 2:00 p.m. with Staff B revealed that on 5/29/24 she had worked late to audit and in-service staff working the 3:00 p.m. to 11:00 p.m. and the 11:00 p.m. to 7:00 a.m. shift regarding administration of insulin pens and not using another residents' insulin. Staff B stated that on 5/30/24 audits had been conducted for all residents to be sure that there was no additional missing insulin with no additional concerns found. Review on 6/4/24 of the facility's in-service training record for insulin pen administration, medications not available, abuse/misappropriation revealed it was started on 5/29/24. Review on 6/4/24 of the facility's competencies for medication not being available, abuse, insulin pens, following physician's orders and insulin replacement revealed it was started on 5/29/24 and all staff had been trained prior to working their first shift. Review on 6/4/24 of the facility's Ad Hoc Quality Assurance and Performance Improvement meeting held on 5/30/24 at 10:00 a.m. revealed the facility had reviewed the above incident which included a root cause analysis, review of audits and plan for auditing. Review on 6/4/24 of the facility's Public Health Communication Timeline revealed that the facility had notified New Hampshire Public Health on 5/30/24 regarding the above incident and had followed up on 5/31/24. 45419