STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305093	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Health Care	5 Nursing Home Drive Unity, NH 03743

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. Based on interview and record review, it was determined that 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 identifiers are #1 and #2.) Findings include: Interview on 6/6/25 at approximately 10:03 a.m. with Staff A (Licensed Practical Nurse (LPN)) revealed that on 6/3/25 he/she administered insulin to Resident #2 using Resident #1's used insulin pen. Interview on 6/6/25 at approximately 10:09 a.m. with Staff C (LPN) revealed that on 6/3/25 he/she received shift report from Staff A that Resident #2 ran out of insulin and Staff A used Resident #1's insulin pen to administer insulin to Resident #2. Staff C stated that he/she reported to the night supervisor and both resident's providers about the above mentioned incident on 6/3/25. Resident #1's insulin pen was discarded on 6/3/25. Review on 6/6/25 of Resident #1's June 2025's Electronic Medication Administration Record (EMAR) revealed an active physician's order for Basaglar Kwikpen (insulin glargine) and was signed as given on 6/3/25. Review on 6/6/25 of Resident #2's June 2025 EMAR revealed an active physician's order for Semeglee (insulin glargine) one time a day and was signed as given on 6/3/25. Interview on 6/6/25 at approximately 10:30 a.m. with Staff B (Director of Nursing) revealed that he/she was made aware of the above mentioned incident on 6/4/25. An Adhoc Quality Assurance meeting was held by Staff B, Assistant Director of Nursing, and Administrator about the incident and developed a corrective action plan on 6/4/25. Staff B stated that corrective actions taken included staff interviews on safe insulin administration and facility policy for unavailable medication and found no deviation to facility policy, education was provided to Staff A on safe insulin administration and facility policy on unavailable medications on 6/4/25 and 6/5/25, Staff B assigned online education to Staff A on understanding blood-borne pathogen and avoiding common medication errors before returning to work, and Staff A will have random insulin administration observations during the next 2 weeks. Further interview with Staff B also revealed that both resident's providers were notified on 6/3/25 and blood-borne pathogen testing was ordered on 6/5/25 for Resident #1 and Resident #2. Review on 6/6/25 of the Basaglar (insulin glargine) manufacturer's instruction dated 2015, revealed: . Instructions for use .Do not share your BASAGLAR KwikPen with other people, even if the needle has been changed. You may give other people a serious infection or get a serious infection from them . (continued on next page)

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review on 6/6/25 of the facility's policy titled, Medication Administration-General Guidelines, effective date of May 2018, revealed .Medications supplied for one resident are never to be administered to another resident . Review on 6/6/25 of the Centers for Disease Control and Prevention (CDC) website titled, Considerations for Blood Glucose Monitoring and Insulin Administration, dated 8/7/24, retrieved 6/6/25, from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=medications%20in%20pockets.-,Insulin%20administration,Training%20and%20oversight 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 . Review on 6/6/25 of the facility's documentation of corrective action revealed the following: Staff A was educated on safe insulin administration on 6/4/25; all staff were interviewed to ensure staff had knowledge of safe insuling administration; blood-borne pathogen testing was performed on 6/5/25 for Resident #1 and Resident #2, and an ad hoc Quality Assurance meeting was held on 6/4/24 to initiate a Quality Assurance Performance Imporvement plan that included monitoring.