STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLEASANT VIEW CENTER, GENESIS HEALTHCARE	239 PLEASANT 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 0760 **Level of harm** - Minimal harm or potential for 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 observation, record review and interview, the facility failed to ensure that a resident was free of a significant medication error by administering insulin in excess of the dose ordered by a physician for 1 resident out of 4 residents with diabetes in a survey sample. (Resident identifier is #2.) Findings include: Interview on 7/16/20 at at approximately 11:30 a.m. with Staff C (Administrator) revealed a medication error in which Resident #1's [MEDICATION NAME] Solution Pen Injector was used to administer insulin to Resident #2. This error caused Resident #2 to receive a greater dose of insulin than ordered by Resident #2's physician. Resident #2's blood glucose was monitored with no changes and resident was noted to be asymptomatic and ate dinner. Resident #2 was transferred to the hospital to be monitored. Review on 7/16/20 at approximately 11:45 a.m. of Resident #2's June Medication Administration Record [REDACTED]. Review on 7/16/20 of nursing notes dated 6/30/20 written Staff D (Unit Manager) revealed the following: (Name omitted) (DPOA) (Durable Power of Attorney) was called to notify her that (resident name omitted) is being transferred to (hospital name omitted) due to receiving incorrect insulin. Interview on 7/16/20 at approximately 1:25 p.m. with Staff D confirmed the above finding and revealed that Staff D called the DPOA following the above incident and informed them that Resident #2 received the incorrect dose of insulin and would be transferred to the hospital to be monitored.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement appropriate corrective actions based on an investigation of a facility identified incident for potential exposure to bloodborne pathogens for 1 of 1 facility incidents reviewed. Findings include: Interview on 7/16/20 at approximately 11:30 a.m. with Staff C (Administrator) and Staff G (Center Nurse Executive/Infection Preventionist) reviewed a medication error in which Resident #1's [MEDICATION NAME] Solution Pen Injector was used to administer insulin to Resident #2. This error caused Resident #2 to receive a greater dose of insulin than ordered by Resident#2's a physician. Interview revealed that Resident #1 and Resident #2 had not been tested for bloodborne pathogens following the incident and both had been discharged from the facility. Interview on 7/16/20 at approximately 11:25 a.m. with Staff C revealed that Resident #1's insulin pen was discarded immediately after the incident. Staff were immediately re-educated on medication administration of insulin, a medication review audit was performed on all the units, and a performance improvement plan was implemented for Staff B (Registered Nurse) who was responsible for the above incident. Review on 7/16/20 of the facility's investigation of the above incident revealed that they determined the incident to be a medication error impletement corrective actions regarding medication administration. The facility did not identify or implement corrective actions for potential exposure to bloodborne pathogens. Interview on 7/16/20 at approximately 1:25 p.m. with Staff D (Unit Manager) revealed that Staff D called the DPOA (Durable Power of Attorney) and informed them that Resident #2 received the incorrect dose of insulin and would be transferred to the hospital to be monitored. Staff D revealed that they did not discuss with the DPOA that Resident #2 had a potential exposure from the use of another resident's pen in administering the insulin. Review on 7/16/20 of the re-education materials for the above incident revealed it addressed the medication error but did not contain information about exposure bloodborne pathogens. Review on 7/16/20 of the facility's policy titled: SH308 Post Exposure to Bloodborne Pathogens dated 9/26/19 revealed it was a policy for occupational exposure. Interview on 7/16/20 at approximately 12:30 with Staff C confirmed the above finding and revealed the facility did not have a policy for resident exposure to bloodborne pathogens.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that staff follow the manufacturer's instructions for cleaning glucose meters for 3 of 3 glucose tests observed, failed to ensure medications were labeled with an open expiration date for 1 of 7 insulin pens observed, and failed to address potential cross contamination of bloodborne pathogens for 1 resident out of 4 residents reviewed with diabetes (Resident identifiers is #2.) Findings include: Interview on 7/16/20 at at approximately 11:30 a.m. with Staff C (Administrator) reviewed a medication error in which Resident #1's [MEDICATION NAME] Solution Pen Injector was used to administer insulin to Resident #2. This error caused Resident #2 to receive a greater dose of insulin than ordered by Resident#2's a physician. Interview also revealed that Resident #1 and Resident #2 had not been tested for bloodborne pathogens following the incident and both had been discharged from the facility. Interview on 7/16/20 at approximately 11:25 a.m. with Staff C revealed that Resident #1's insulin pen was discarded immediately after the incident. Interview on 7/16/20 at approximately 1:25 p.m. with Staff D (Unit Manager) revealed that Staff D called the DPOA (Durable Power of Attorney) and informed them that Resident #2 received the incorrect dose of insulin and would be transferred to the hospital to be monitored. Staff D revealed they did not discuss with the DPOA that Resident #2 had a potential exposure from the use of another resident's pen in administering the insulin. Review on 7/17/20 of the CDC Clinical Reminder: Insulin Pens Must Never Be Used for More than One Person recommends Insulin pens containing multiple doses of insulin are meant for use on a single person only, and should never be used for more than one person, even when the needle is changed .If reuse is identified, exposed persons should be promptly notified and offered appropriate follow-up including bloodborne pathogen testing. Data used from https://www.cdc.gov/injectionsafety/clinical-reminders/insulin-pens.html on 7/17/20. Observation on 7/16/20 at approximately 11:35 a.m. during a medication pass revealed an opened [MEDICATION NAME] SolarStar Insulin pen for Resident #3 that was not dated with an open date or an open expiration date. Review of the manufacturer's instructions titled [MEDICATION NAME] (insulin [MEDICATION NAME] injection) revealed Once you take your [MEDICATION NAME] out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86F (30C). Do not use it after this time. Observation on 7/16/20 at approximately 11:30 a.m. to 12:45 p.m. during medication pass revealed that the multiuse glucose meters (Evencare G2 Blood Glucose Monitoring System) were being cleaned with alcohol wipes before and after taking the blood sugars for Residents #3, #4, and #5. Observation further revealed a container of EPA registered disinfecting wipes in the bottom draw in all three medication carts. Interview on 7/16/20 at approximately 11:30 a.m. with Staff E (Licensed Practical Nurse (LPN) confirmed the observation during medication pass and revealed that Staff E had been using the alcohol wipes to clean the glucose meters. Interview on 7/16/20 at approximately 12:40 p.m. with Staff F (LPN) revealed that Staff F confirmed the observation during medication pass and revealed that Staff F had been using the alcohol wipes to clean the glucose meters. Interview on 7/16/20 at approximately 12:40 p.m. with Staff G (Center Nurse Executive) revealed that Staff G was aware that staff were using the alcohol wipes to clean the

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) glucose meters because they thought there was a shortage of disinfecting wipes a couple months ago. Interview on 7/16/20 at approximately 12:30 p.m. with Staff C revealed that they was not currently a shortage of disinfected wipes. Review on 7/16/20 of the facility's policy titled: SH308 Post Exposure to Bloodborne Pathogens dated 9/26/19 revealed it was a policy for occupational exposure. Interview on 7/16/20 at approximately 12:30 with Staff C confirmed the above finding and revealed the facility did not have a policy for resident exposure to bloodborne pathogens. Review on 7/17/20 at approximately 1:30 p.m. of the facility's Glucose Meter policy, dated 11/1/19 revealed that an Environmental Protection Agency (EPA) approved disinfectant against [MEDICAL CONDITIONS] be used to disinfect meters and do NOT use an alcohol prep pad. Review on 7/17/20 of the manufacturer's instructions titled Evencare G2 Blood Glucose Monitoring System, Operator's Manual., dated 2017) under Cleaning and Disinfecting your Evencare G2 Meter (page 13) revealed the meters are to be cleaned with a validated EPA registered disinfecting wipe.