STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075335	A. Building B. Wing	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beechwood	31 Vauxhall Street New London, CT 06320

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on clinical record review, facility documentation review, facility policy review, and interviews for two of two residents (Resident's #1 and #2) reviewed for medication administration errors, the facility failed to ensure licensed staff followed professional standards including following the 5 rights of medication administration and following facility established policy for Insulin pen use. The findings include: a. Resident #1 was admitted to the facility during May 2022 with diagnoses that included periprosthetic fracture around an internal prosthetic of left hip joint. The Resident Care Plan (RCP) plan dated 6/10/2022 identified a self-care deficit. Interventions directed to provide extensive assistance for ADLs as needed. The Medicare 5-day MDS dated [DATE] identified Resident #1 was alert and oriented, and required extensive assistance with personal hygiene. b. Resident #2 was admitted to the facility in July 2022 with the diagnoses that included type 1 diabetes mellitus. The Nursing Admission assessment dated [DATE] identified Resident #2 was alert and oriented, and required use of Insulin. The RCP dated 7/27/2022 identified diabetes. Interventions directed to administer diabetes medication as ordered. A physician's order for Resident #2, dated 7/27/2022 directed to administer Humalog Kwik Pen (Insulin used to treat high blood sugar) 4 units subcutaneously (SQ) before meals and add per sliding scale: if blood sugar is 0-150 give 0 units, if blood sugar is 151-200 give 1 unit, if blood sugar is 201-250 give 2 units, if blood sugar is 251-300 give 3 units, if blood sugar is 301-350 give 4 units, if blood sugar is 351-400 give 5 units, if blood sugar is over 400 to call the MD. 1. Review of the facility incident report dated 8/9/2022 at 8:30 AM identified Resident #1 was administered 8 units of Humalog in error; Resident #1 did not have a physician's order for Insulin administration. A nurse's note dated 8/9/2022 at 9:37 AM identified Resident #1 was inadvertently given Humalog insulin, 8 units subcutaneously (SQ). The physician and family were notified with new orders to check blood glucose (BG) every 30 minutes on 8/9/2022, and to check Resident #1 every 15-minute checks for signs/symptoms of hypoglycemia. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with LPN #1 on 8/10/2022 at 11:39 AM identified while performing the morning medication pass with RN #1 oversight, LPN #1 prepared insulin for another resident (Resident #2). LPN #1 indicated she was interrupted to provide assistance to Resident #1, and she was distracted when RN #1 was called away. LPN #1 indicated that once she had finished helping Resident #1, she administered the Insulin to Resident #1 using the Insulin pen belonging to Resident #2. She identified the Insulin had been administered to the wrong resident. LPN #1 further indicated that she did not check Resident #1's identification (ID) bracelet prior to administering the Insulin, and she should have checked the ID bracelet; she should have verified Resident #1's identity prior to administering the Insulin. Interview, clinical record review and facility documentation review with RN #1 on 8/10/2022 at 12:00 PM identified she was observing LPN #1 during the medication pass on 8/9/2022 when LPN #1 prepared the Insulin dose for Resident #2. RN #1 indicated she was called away and when she returned to the medication cart, LPN #1 informed her that she had administered the insulin to the wrong resident. RN #1 identified that LPN #1 should have verified Resident #1's identity prior to administering the insulin, and she should not have left LPN #1 alone when administering medications. Interview with RN #3 (Regional Clinical Specialist) and the DNS on 8/9/22 at 1:08 PM identified the facility policy for medication administration is to identify the correct resident, medication, route, time, dose; know what you are giving and who you are giving it to, and LPN #1 should have verified Resident #1's identity prior to administering any medication. 2. Review of Resident #2's Medication Administration Record (MAR) dated 8/9/2022 identified Resident #2 was scheduled to receive four (4) units of Humalog Insulin via Kwik-pen, and had a blood sugar before the breakfast meal of 303 that required four (4) additional units of Humalog Insulin. Review of facility incident report dated 8/9/2022 at 8:45 AM identified Resident #2 was administered 8 units of Humalog Insulin using Resident #2 ' s Insulin pen which was previously used (in error) to administer Insulin to Resident #1. The physician was notified and directed lab work for blood borne pathogens for both Resident #1 and #2. Review of Resident #2's clinical record identified a nurse's note dated 8/10/2022 at 10:19 AM (late entry for 8/9/2022) indicated Resident #2 was administered Insulin using his/her Insulin pen after the pen had been used to administer Insulin to another resident (Resident #1 on 8/9/2022). The note indicated new needle caps were used for each resident. An assessment was performed, and the physician and family were notified, with new orders obtained to obtain a complete blood count, comprehensive metabolic panel, hepatitis panel and HIV panel. Resident #2 was discharged from the facility and provided with information for follow up related to the incident. Interview, clinical record review, and facility documentation review with LPN #1 on 8/10/2022 at 11:39 AM identified she was newly hired and was still on orientation on 8/9/2022. LPN #1 indicated on 8/9/2022, with RN #1 oversight, after she administer the Insulin to Resident #1 in error, she used the same Insulin pen with a new needle to administer the prescribed Insulin to Resident #2. LPN #1 indicated she did not know an Insulin pen was for use on one resident only (not to be used for multiple residents). (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 8/10/2022 at 12:00 PM identified that she was observing LPN #1 during the medication pass on 8/9/2022. RN #1 identified after the medication error with Resident #1, RN #1 indicated she instructed LPN #1 to give Resident #2 his/her Insulin. RN #1 identified that she did not direct LPN #1 to use a new Insulin pen prior to administering the Insulin to Resident #2. RN #1 further indicated it is facility policy there are no shared Insulin pens; each Insulin pen is resident specific to be used only for one resident. RN #1 indicated that she should have directed LPN #1 to obtain a new Insulin pen after it was used in error on Resident #1. Interview with RN #3 (Regional Clinical Specialist) and the DNS on 8/9/2022 at 1:08 PM identified Insulin pens are resident specific and not to be shared; LPN #1 should not have used the same Insulin pen to administer Insulin to Resident #2 after using it in error on Resident #1. Review of the Medication Administration Policy dated 3/19/2018, directed in part, the individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include checking the identification band, checking the photograph attached to the medical record; and, if necessary, verifying resident identification with other facility personnel. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Additionally, the policy directed insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make is safe to use insulin pens for more than one resident. Insulin pens will be clearly labeled with the resident's name or other identifying information and prior to administering insulin with an insulin pen, the nurse will verify that the correct pen is used for that resident. Please cross reference F760 and F800.

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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 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** 43184 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1) reviewed for significant medication errors, the facility failed to ensure the resident was free from significant medication errors. The findings include: Resident #1 was admitted to the facility during May 2022 with diagnoses that included periprosthetic fracture around an internal prosthetic of left hip joint. The Resident Care Plan (RCP) plan dated 6/10/2022 identified a self-care deficit. Interventions directed to provide extensive assistance for ADLs as needed. The Medicare 5-day MDS dated [DATE] identified Resident #1 was alert and oriented, and required extensive assistance with personal hygiene. Review of the facility incident report dated 8/9/2022 at 8:30 AM identified Resident #1 was administered 8 units of Humalog in error; Resident #1 did not have a physician's order for Insulin administration. A nurse's note dated 8/9/2022 at 9:37 AM identified Resident #1 was inadvertently given Humalog insulin, 8 units subcutaneously (SQ). The physician and family were notified with new orders to check blood glucose (BG) every 30 minutes on 8/9/2022, and to check Resident #1 every 15-minute checks for signs/symptoms of hypoglycemia. Interview and clinical record review with LPN #1 on 8/10/2022 at 11:39 AM identified while performing the morning medication pass with RN #1 oversight, LPN #1 prepared insulin for another resident (Resident #2). LPN #1 indicated she was interrupted to provide assistance to Resident #1, and she was distracted when RN #1 was called away. LPN #1 indicated that once she had finished helping Resident #1, she returned to the medication cart, picked up the Insulin pen prepared for Resident #2 and went in to Resident #1's room and administered the 8 units of Humalog Insulin to Resident #1 in error, using the Insulin pen belonging to Resident #2. She identified the Insulin had been administered to the wrong resident. LPN #1 further identified that she immediately informed the supervisor and physician with new orders to document vital signs and blood glucose for Resident #1 every 30 minutes, with every 15-minute checks for signs and symptoms of hypoglycemia. LPN #1 identified that when she was in the room with Resident #1 the resident asked what the medication was to which she told the resident It's your insulin and the resident stated ok. LPN #1 further indicated that she did not check Resident #1 ' s identification (ID) bracelet prior to administering the Insulin, and she should have checked the ID bracelet; she should have verified Resident #1's identity prior to administering the Insulin. Please cross reference F658 and F880. Interview, clinical record review and facility documentation review with RN #1 on 8/10/2022 at 12:00 PM identified she was observing LPN #1 during the medication pass on 8/9/2022 when LPN #1 prepared the Insulin dose for Resident #2. RN #1 indicated she was called away and when she returned to the medication cart, LPN #1 informed her that she had administered the insulin to the wrong resident. RN #1 identified that LPN #1 should have verified Resident #1's identity prior to administering the insulin, and she should not have left LPN #1 alone when administering medications. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 (Regional Clinical Specialist) on 8/9/22 at 1:08 PM with DNS present identified the facility policy for medication administration is to identify the correct resident, medication, route, time, dose; know what you are giving and who you are giving it to, and LPN #1 should have verified Resident #1 ' s identity prior to administering any medication. Interview with MD #1 on 8/9/22 at 12:28 PM identified Resident #1 was administered Insulin that was not ordered for Resident #1, and there was a potential for an adverse reaction. Interview with RN #3 (Regional Clinical Specialist) and the DNS on 8/9/22 at 1:08 PM identified the facility policy for medication administration is to identify the correct resident, medication, route, time, dose; know what you are giving and who you are giving it to, and LPN #1 should have verified Resident #1's identity prior to administering any medication. Review of the Medication Administration Policy dated 3/19/2018, directed in part, the individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include checking the identification band, checking the photograph attached to the medical record; and, if necessary, verifying resident identification with other facility personnel. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Additionally, the policy directed insulin pens containing multiple doses of insulin are for single-resident use only. Changing the needle does not make is safe to use insulin pens for more than one resident. Insulin pens will be clearly labeled with the resident's name or other identifying information and prior to administering insulin with an insulin pen, the nurse will verify that the correct pen is used for that resident.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43184 Based on interview and facility policy review, the facility failed to ensure an Insulin pen was stored in a safe manner to ensure only authorized staff had access to the medication. The findings include: Interview with LPN #1 on 8/10/2022 at 11:39 AM identified on 8/9/2022 during the morning medication pass she prepared an Insulin dose for Resident #2 consisting of his/her regular dose of 4 units of Lispro with the addition of 4 units of sliding scale coverage of Lispro using the resident's Insulin pen (device used to deliver Insulin). LPN #1 indicated that prior to administering the Insulin to Resident #2, she was directed to do another task in a different resident's room (Resident #1). LPN #1 identified that she left Resident #2's Insulin pen on top of the medication cart, without the benefit of placing it inside the medication cart and locking the cart when she left to provide assistance to the other resident. When she returned to the medication cart, she picked up the Insulin pen to use it to administer Insulin. Interview with RN #2 on 8/10/2022 at 12:19 PM identified when a licensed nurse must walk away from the medication cart, the medications should be put in the drawer and the medication cart should be locked. Additionally, RN #2 identified if the medication is Insulin, the needle should be capped for safety, not left in the open and when the licensed nurse returns to the cart, they should start from the beginning of the medication administration for Insulin and if the dose had already been dialed up it should be wasted, and the dose preparation should start again from the beginning. Review of the Medication Administration Policy dated 3/19/2018 directed in part, during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse. Additionally, the policy directed no medications are kept on top of the cart, the cart must be clearly visible to the personnel administering medications and all outward sides must be inaccessible to residents or others passing by.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on clinical record review, facility documentation review, facility policy review, and interviews for two of two residents (Resident's #1 and #2) reviewed for infection control, the facility failed to ensure the residents were free from potential exposure to blood borne pathogens. The failures resulted in a finding of Immediate Jeopardy. The findings include: a. Resident #1 was admitted to the facility during May 2022 with diagnoses that included periprosthetic fracture around an internal prosthetic of left hip joint. The Resident Care Plan (RCP) plan dated 6/10/2022 identified a self-care deficit. Interventions directed to provide extensive assistance for ADLs as needed. The Medicare 5-day MDS dated [DATE] identified Resident #1 was alert and oriented, and required extensive assistance with personal hygiene. b. Resident #2 was admitted to the facility in July 2022 with the diagnoses that included type 1 diabetes mellitus. The Nursing Admission assessment dated [DATE] identified Resident #2 was alert and oriented, and required use of Insulin. The RCP dated 7/27/2022 identified diabetes. Interventions directed to administer diabetes medication as ordered. A physician's order for Resident #2, dated 7/27/2022 directed to administer Humalog Kwik Pen (Insulin used to treat high blood sugar) 4 units subcutaneously (SQ) before meals and add per sliding scale: if blood sugar is 0-150 give 0 units, if blood sugar is 151-200 give 1 unit, if blood sugar is 201-250 give 2 units, if blood sugar is 251-300 give 3 units, if blood sugar is 301-350 give 4 units, if blood sugar is 351-400 give 5 units, if blood sugar is over 400 to call the MD. Review of facility incident report dated 8/9/2022 at 8:45 AM identified Resident #2 was administered 8 units of Humalog Insulin using Resident #2's Insulin pen which was previously used (in error) to administer Insulin to Resident #1. The physician was notified and directed lab work for blood borne pathogens for both Resident #1 and #2. Review of Resident #1's clinical record identified a nurse's note dated 8/9/2022 at 9:37 AM indicated Resident #1 was administered Humalog Insulin, 8 units subcutaneously (SQ) in error. Review of Resident #2's clinical record identified a nurse's note dated 8/10/2022 at 10:19 AM (late entry for 8/9/2022) indicated Resident #2 was administered Insulin using his/her Insulin pen after the pen had been used to administer Insulin to another resident (Resident #1 on 8/9/2022). The note indicated new needle caps were used for each resident. An assessment was performed, and the physician and family were notified, with new orders obtained to obtain a complete blood count, comprehensive metabolic panel, hepatitis panel and HIV panel. Resident #2 was discharged from the facility and provided with information for follow up related to the incident. Additional review of Resident #1 and Resident #2's clinical records identified laboratory results, including Hepatitis and a HIV panels, were negative for any blood borne pathogens. (continued on next page)

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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, clinical record review, and facility documentation review with LPN #1 on 8/10/2022 at 11:39 AM identified she was newly hired and on orientation. LPN #1 indicated on 8/9/2022, with RN #1 oversight, LPN #1 prepared Resident #2's (who has a diagnosis of diabetes) Humalog Insulin 4 units scheduled dose and 4 units of sliding scale coverage (total of 8 units) using Resident #2's Insulin pen device (a device for dialing the dose and administering Insulin). LPN #1 identified RN #1 verified the dose, and she placed the Insulin pen on top of the medication cart and entered Resident #1's room to provide assistance. Upon returning to the medication cart, she picked up the Insulin pen and administered the Insulin to Resident #1 in error (wrong resident). She notified RN #1 and the physician of the error. LPN #1 identified after administering the Insulin to Resident #1, she used the same Insulin pen (with a new needle) to administer Insulin to Resident #2. LPN #1 indicated she did not know an Insulin pen was for use on one resident only (not to be used for multiple residents). LPN #1 indicated she had been oriented to the medication administration task on three (3) different days prior to this incident, with a preceptor demonstrating initially and then performing the task under the guidance of the preceptor. Interview with RN #1 on 8/10/2022 at 12:00 PM identified that she was observing LPN #1 during the medication pass on 8/9/2022. RN #1 identified LPN #1 prepared the Insulin dose for Resident #2 at approximately 8:30 AM. RN #1 indicated that prior to the administration of Insulin, LPN #1 was obtaining a blood glucose for Resident #2 and RN #1 was called away. When she returned LPN #1 informed her that she had administered the Insulin to the wrong resident, and the MD, DNS, APRN, Administrator and Resident #1's family were notified of the error, and new orders obtained to monitor Resident #1 every 15 minutes with blood glucose checks every 30 minutes. RN #1 identified she then instructed LPN #1 to give Resident #2 his/her Insulin. RN #1 identified that she did not direct LPN #1 to use a new Insulin pen prior to administering the Insulin to Resident #2. RN #1 further indicated it is facility policy there are no shared Insulin pens; each Insulin pen is resident specific to be used only for one resident. RN #1 indicated that she should not have left LPN #1 when she was obtaining Resident #2's blood glucose and preparing to administer the Insulin, and she should have directed LPN #1 to obtain a new Insulin pen after it was used in error on Resident #1. Interview with MD #1 on 8/9/2022 at 12:28 PM identified as common practice, one Insulin pen should be used for one resident (not used for multiple residents) and indicated neither Residents #1 or #2 had a history of blood borne pathogens, and they would both be tested to ensure there was no blood borne pathogen. Interview with Regional Nurse/RN #3 on 8/10/2022 at 1:46 PM identified the process should be the nurse would swap out the Insulin pen and not use it for a second resident. Additionally, RN #3 identified RN #1 should have directed LPN #1 not to use the Insulin pen after it was identified it had been used on another resident. RN #3 further identified RN #1 was aware and was able to verbalize facility policy regarding Insulin pen use for one (1) resident only. (continued on next page)

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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 of the facility Medication Administration Policy dated 3/19/2018 directed in part, Insulin pens containing multiple doses of Insulin are for single-resident use only. Changing the needle does not make is safe to use insulin pens for more than one resident. Insulin pens will be clearly labeled with the resident's name or other identifying information. Prior to administering Insulin with an Insulin pen, the nurse will verify that the correct pen is used for that resident. Post exposure follow up procedures will be conducted if an Insulin pen is used for more than one resident. The policy further directed medications ordered for a resident may not be administered to another resident. New personnel authorized to administer medications will not be permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. Review of the facility Infection Control Policy dated July 2014 directed in part, all personnel will be trained on infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infections control. The policy further directed the depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. A review of the facility's removal plan on 8/11/2022 identified all licensed staff will be educated on sharing of insulin pens, newly hired nurses will have medication competencies completed prior to administering medications independently, a system change was implemented to remove all insulin pens from use and change to vials effective 8/9/2022, random audits will be completed weekly for four weeks, monthly for two months, and audits will be summitted to the QA committee for review. As a result of the corrective action that was implemented and verified as complete, the Immediate Jeopardy was identified as removed on 8/11/2022.