

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Harbor House Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11 Condito Road Hingham, MA 02043	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>15203</p> <p>Based on interviews and records reviewed, for one of three sampled residents (Resident #2), who was severely cognitively impaired and dependent upon staff for care, the Facility failed to ensure that staff implemented and followed the Facility Abuse Prohibition Policy when on 8/24/24 around 12:30 A.M., Nurse #1 was made aware of an allegation of abuse of Resident #2, that the door to his/her room was tied so that he/she could not exit if desired, and although Nurse #1 said he reported the allegation to Nurse #2, neither of them reported the allegation to facility Administration and, as a result, they were not aware of the allegation until more than 8 hours later, when Nurse #3 became aware and reported it, as required.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Prevention of Abuse and Neglect, effective 10/22, indicated that all employees of the Facility are mandated to report incidents of suspected resident abuse, neglect, mistreatment, exploitation or misappropriation to their immediate supervisor, nursing supervisor, Director of Nursing Services or the Executive Director. The Policy defines exploitation to include involuntary seclusion or restraint not required to treat a resident's medical symptoms.</p> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 8/24/24, indicated that at 9:00 A.M., Resident #1 reported to the nurse (later identified as Nurse #3) that during the previous shift, he/she took photographs of a resident's door (Resident #2) with a towel tied to the railing and the door handle, keeping the door closed and the resident from exiting the room. The Report indicated that Resident #1 told the nurse that he/she had reported that the door was tied closed to the nurse (later identified as Nurse #1) during the previous shift.</p> <p>Review of Resident #2's clinical record indicated that he/she was admitted to the Facility during August of 2024 and his/her diagnoses included unspecified dementia.</p> <p>Review of Resident #2's MDS Assessment, dated 8/28/24, indicated that his/her cognitive patterns were severely impaired.</p> <p>Review of Resident #1's clinical record indicated that he/she was admitted to the Facility during June of 2024 and his/her diagnoses included aftercare following shoulder joint prosthesis.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 6/20/24, indicated that his/her cognitive patterns were intact.</p> <p>(continued on next page)</p>

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
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 9/30/24 at 1:50 P.M., Resident #1 said that on 8/24/24 during the overnight shift he/she saw Resident #2's door held closed with a towel tied from the chair rail to the door knob and took photographs of the door. Resident #1 said that he/she reported his/her observation of Resident #2's door to one of the nurse aides and said the nurse aide reported it to the nurse.</p> <p>During telephone interviews on 9/30/24 at 2:15 P.M. with Resident Care Aide #1 and 10/02/24 at 1:45 P.M. with Nurse #1, they said that during the 11:00 P.M. into 7:00 A.M. from 8/23/24 to 8/24/24, Resident #1 alleged that Resident #2's door was tied closed with a towel. Resident Care Aide #1 and Nurse #1 said that Nurse #2, who was the nurse supervisor, heard Resident #1 yelling about the incident and asked them why he/she was yelling.</p> <p>Nurse #1 said that Nurse #2 called him on the phone and asked why Resident #1 was yelling and said he told her that Resident #1 was yelling about a towel being used to tie another resident's door closed.</p> <p>Nurse #1 and Resident Care Aide #1 said Nurse #2 came to Resident #1's Unit and asked who had tied the door closed and they said Nurse #2 told them that tying doors closed could get the Facility in a lot of trouble.</p> <p>During an interview on 9/30/24 at 2:00 P.M. Nurse #2 said that she was nurse supervisor during the 11:00 P.M. to 7:00 A.M. from 8/23/24 into 8/24/24. Nurse #2 said that she was not aware that Resident #1 alleged that a staff member tied Resident #2's door closed. Nurse #2 said that although she had spoken to Nurse #1 about a resident being loud on the Unit and said that she told Nurse #1 to tell the resident (later identified as Resident #1) to quiet down, she said Nurse #1 had not told her that there had been an allegation that Resident #2's door was tied closed.</p> <p>During an interview on 10/02/24 at 2:10 P.M., Nurse #3 said that at 9:00 A.M. on 8/24/24, Resident #1 reported to her that there had been a resident's door tied closed with a towel during the 11:00 P.M. to 7:00 A.M. shift and he/she had taken pictures. Nurse #3 said that she immediately reported Resident #1's allegation to the Director of Nursing and the Administrator.</p> <p>During interviews on 9/30/24 at 9:00 A.M. with the Director of Nursing and on 9/30/24 at 12:30 P.M. with the Administrator, they said that on 8/24/24 around 9:00 A.M., Nurse #3 reported that Resident #1 alleged Resident #2's door was tied closed with a towel during the previous 11:00 P.M. to 7:00 A.M. shift. The Director of Nursing and Administrator said that Nurse #3's report to them was around 8.5 hours after Resident #1 initially reported the allegation to Nurse #1 and Resident Care Aide #1.</p> <p>On 9/30/24 the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction which addressed the concern as evidenced by:</p> <p>A. On 8/24/24, the Facility suspended Resident Care Aide #1 and Nurse #1 pending investigation of the incident.</p> <p>B. On 8/24/24, the Director of Nursing assessed the skin of Resident #2 and all alike residents on his/her Unit.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C. Between 8/24/24 and 9/05/24, all Facility employees were trained by the Director of Nurses or designee on the responsibility to report allegations of abuse, neglect, mistreatment, misappropriation and involuntary seclusion to their immediate supervisor, the nursing supervisor, the Director of Nursing or the Administrator.</p> <p>D. On 8/24/24, the Director of Nursing or designee audited all Units for signs of residents being involuntarily secluded. Observations continued on every shift for 7 days, weekly for 4 weeks and monthly for 3 weeks.</p> <p>E. Since 8/24/24, the Director of Nursing continues to review all reportable incidents for the timeliness of staff members reports to their immediate supervisor, the nursing supervisor, the Director of Nursing or the Administrator.</p> <p>F. On 8/24/24, an emergency, ad hoc QAPI meeting was held to review the correction plan. Further ad hoc meetings will be held weekly for 4 weeks and monthly for 3 months.</p> <p>G. The Administrator and/or designee is responsible for overall compliance.</p>