STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305038	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hackett Hill Healthcare Center	191 Hackett Hill Road Manchester, NH 03102

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38218 Based on interviews and record reviews, it was determined that the hospice agency and the facility failed to provide collaborative services for 1 of 1 resident reviewed for hospice services in a final sample of 18 residents (Resident Identifier #44). Findings include: Review on 4/2/24 of Resident #44's care plan for hospice revealed the following: Hospice Nursing 2-3x (times) a week and PRN (as needed) to assess and manage symptoms, comfort/pain, and bowel function, date initiated: 2/26/24 Hospice Nursing Assistant 1-2x a week to complement ADL (activities of daily living) care and provide comfort, date initiated: 2/26/24 Hospice Social Work 1x month and PRN to provide psychosocial support related to end of life care, date initiated: 2/20/24 Hospice Volunteer 1x month and PRN for companionship, date initiated 2/20/24 Review on 4/2/24 of Resident #44's Hospice Certification and Plan of Care (POC) dated 2/19/24 - 5/18/24, revealed: Frequency/Duration of Visits: SN 7x week x1, 3x week x12; Master of Social Work (MSW) 1x month x1; and Chaplain (CH) 1x month x1 Review on 4/2/24 of Resident #44's medical record revealed the following Communication/Continuation Notes from hospice: On 2/19/24 SN visit (medication recommendations), on 3/1/24 SN visit (medication recommendations), on 3/18/24 SN visit (medication recommendations), and on 4/1/24 SN visit (medication recommendations). Interview on 4/2/24 at approximately 12:00 p.m. with Staff C (Unit Manager) revealed there were no other notes from hospice visits than the above Communication/Continuation Notes. Staff C also revealed that he/she was only aware of SN from hospice coming in on Mondays. Staff C also confirmed that Resident #44's care plans and Hospice POC did not match. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/2/24 at approximately 1:20 p.m. with Staff D (Administrator), who is the acting Hospice Liason, revealed that there was no communication between the hospice agency and the facility as to when visits would occur. Staff D also revealed that the hospice did not have any nursing assistants or volunteers available to visit with Resident #44. Review on 4/3/24 of the facility's policy titled OPS118 Hospice revision date 3/1/18 revealed: .5. The Center: .5.2 is responsible for ensuring that the hospice services provided meet professional standards and principles for the timeliness of those services. 6. The hospice and center must communicate, establish, and agree upon a coordinated plan of care which reflects the hospice philosophy and is based on an assessment of the patient's needs. The plan of care must include: . 6.2 The most recent hospice plan of care; .7.2.1.5 Obtaining the following information from the hospice; 7.2.1.5.1 Most recent hospice plan of care .

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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 0685 Level of Harm - Potential for minimal harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. 49819 Based on interviews and record reviews, it was determined that the facility failed to ensure that residents received treatment for hearing loss for 1 of 1 resident reviewed for hearing and vision in a final sample of 18 residents (Resident Identifier #7). Interview on 4/1/24 at approximately 11:00 a.m. with Resident #7 revealed he/she was very hard of hearing. Resident #7 stated he/she had wax in them [their ears]. Review on 4/1/24 of Resident #7's diagnosis list revealed a medical diagnosis of Bilateral Hearing Loss. Interview on 4/2/24 at approximately 9:30 a.m. with Staff E (Recreation Assistant) regarding Resident #7 revealed, communication is difficult, does not engage in conversations or attend group activities. Review on 4/2/24 of Resident #7's Audiology visit dated 1/29/24 revealed that the degree of hearing loss could not be determined. He/she had too much wax in bilateral ear canals to complete a hearing evaluation. A large amount of wax was removed, but the resident could not tolerate further cleaning. Medical consult is needed for wax removal orders. Re-evaluate resident after wax removal. Interview on 4/2/24 at approximately 12:15 p.m. with Staff C (Unit Manager) confirmed the above findings. Staff C revealed that Resident #7 had not received any treatment after the Audiology consult on 1/29/24.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38218 Based on observations, interviews, and record reviews it was determined that the facility failed to ensure the medication error rate was not 5 percent (%) or greater for 2 out of 4 residents observed for medication administration (Resident Identifiers #24 and #41). Findings include: Resident #24 Observation on 4/2/24 at approximately 7:30 a.m. of Staff A (Licensed Practical Nurse (LPN)) preparing medication for Resident #24 revealed Staff A was going to administer Aspirin 81 milligrams (mg). Further observation revealed Staff A removed Resident #24's Novolin N Insulin Pen and placed it on the medication cart. Staff A dialed the pen to 16 units. Staff A proceeded to administer the 16 units of insulin without rolling the pen (to ensure that the insulin in the pen was the correct dosage). Staff A did not prime the insulin pen and did not wait the 5 seconds prior to removing the insulin pen from Resident #24's abdomen. Review on 4/2/24 of Resident #24's April 2024 Medication Administration Record (MAR) revealed the following physician's orders: Novolin N Subcutaneous Suspension 100 UNIT/ML [milliliters], inject 16 units subcutaneously in the evening for DM [Diabetes Mellitus], start date 3/13/24; Aspirin EC [enteric coated] tablet delayed Release 81 mg, give 1 tablet by mouth one time a day for cardiac health, start date 2/2/24. Interview on 4/2/24 at approximately 7:35 a.m. with Staff A confirmed the above findings. Review on 4/2/24 of the manufacturer's instructions for Novoliln N FlexPen, revision date 6/22, revealed: .To resuspend FlexPen, gently move the pen up and down 20 times so the glass ball moves from one end of the cartridge to the other until the suspension appears uniformly white and cloudy. Inject immediately. Mixing by rolling and inverting the Pen is important to make sure you get the right dose .Priming your Pen .Prime before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin .To prime your Pen, turn the dose knob to select 2 units . Slowly push the plunger of the syringe all the way in, and then leave the needle in the skin for 10 seconds. If you are using a pen, while holding the base against the skin, push down on the injection button. You will hear a loud click. This will insert the needle and start the injection. Keep holding the pen against your skin until you hear a second click in about 5 to 10 seconds . Review on 4/2/24 of the facility's procedure titled Skills Checklist 8: Insulin Medication Administration, undated, revealed: .8 .c. Dial up 2 units of insulin (or per manufacturer's recommendations); hold pen upright and perform an air shot to prime the pen .18. During injection with a pen, push the plunger and slowly inject the insulin; hold the pen in place for 5-10 seconds per manufacturer's instructions . Resident #41 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/2/24 at approximately 9:00 a.m. of Staff B's (LPN) medication administration with Resident #41 revealed: Staff B administered Resident #41's Miralax Oral Powder through his/her Jejunostomy tube. Review on 4/2/24 of Resident #41's April 2024 MAR revealed the following physician's order: Miralax Oral Powder 17 gm [grams]/scoop, give 1 scoop by mouth one time a day for bowel management, order date 3/29/24. Interview on 4/2/24 at approximately 9:00 a.m. with Staff B confirmed the above findings. There were 3 medication errors out of a total of 29 medication administration opportunities resulting in a 10. 34% error rate.

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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. 49819 Based on observations, interviews, and record reviews, it was determined that the facility failed to ensure open injectable medications were labeled in accordance with the manufacturer's instructions in 1 out of 2 medication carts and in 1 of 1 medication rooms observed and refrigeration temperatures were not monitored daily for medications storage in 1 out of 1 medication rooms observed. Findings include: Observation on 4/1/24 at approximately 8:10 a.m. of Webster Street Medication Cart revealed an open Lantus Insulin Pen without an open or open expiration date. Interview on 4/1/24 with Staff F (Registered Nurse) confirmed the above finding. Review on 4/2/24 of the Lantus Insulin Pen manufacturer's instructions revealed After 28 days, throw your opened Lantus pen away - even if it still has insulin in it. Observation on 4/1/24 at approximately 8:20 a.m. of the Derryfield Medication Room revealed an open vial of Tuberculin Purified Derivative without an open or open expiration date. Interview on 4/1/24 at approximately 8:20 a.m. with Staff G (Registered Nurse) confirmed the above finding. Review on 4/2/24 of the Tuberculin Purified Derivative manufacturer's instructions revealed: .Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency . Review on 4/2/24 of the facility's policy titled 5.3 Storage and Expiration Dating of Medications, Biologicals dated January 2022 revealed: .5.3 If a multi-dose vial of injectable medication has been opened or accessed (e.g. needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . Review on 4/1/24 of the medication refrigerator logs for March 2024 revealed missing temperatures on 3/2, 3/4, 3/8, 3/22, 3/29, and 3/30. Interview on 4/1/24 at approximately 8:20 a.m. with Staff G confirmed the above findings. Review on 4/2/24 of the facility's policy titled 5.3 Storage and Expiration Dating of Medications, Biologicals dated January 2022 revealed: .10.3.1 Facility should monitor the temperature of medication storage areas at least once a day .