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	04/24/2026

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 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, interview, and record review, the facility failed to ensure that the water management plan accurately described the facility's water system, failed to identify all specific areas where Legionella and other opportunistic waterborne pathogens may grow, failed to outline control measures to prevent such growth, and failed to establish monitoring procedures with defined acceptable ranges that had the potential to affect the facility with a census of 62 residents.Findings include: Review on 4/22/26 of the facility's water management plan, review date of 3/25/26, revealed the following: The water management plan description and flow diagram section identified that water flowed through the boilers and heat up to 142 plus degrees (it did not specify Fahrenheit or Celsius). Further review revealed that on the domestic side, water was delivered at 142 plus degrees (it did not specify Fahrenheit or Celsius) to a mixing valve, where hot water is balance with cold water to a temperature of 105 to 120 degrees (it did not specify Fahrenheit or Celsius). All hot water is delivered to faucets and showers throughout the building. It did not describe how many boilers and where the water flows from which boilers. The water management plan revealed the areas subject to Legionella included dead legs and hot water holding tanks. The plan did not describe the locations of dead legs in the facility, and the number of hot water holding tanks and where water flows from which hot water holding tanks. The water management plan revealed the following section of the control measures: Hot water temperatures were monitored weekly at point of delivery, on the commercial side, washing machine, dish machine, and three bay sinks. On the domestic side, random faucets and showers. The control measure for monitoring hot water temperatures did not specify acceptable ranges for temperatures and did not indicate to monitor temperature of the water holding tanks. There were no control measures for dead legs. The control measures for HVAC (Heating, Ventilation, and Air Conditioning)/PTAC (Packaged Terminal Air Conditioner) was to inspect and change filter every three months. The control measure for hot water holding tanks was to flush the tanks monthly, it did not indicate to monitor temperatures, and it did not specify acceptable ranges for temperatures. Interview on 4/23/26 at approximately 9:51 a.m. with Staff D (Infection Preventionist) revealed that that he/she was not involved in reviewing the control measures outlined in the water management plan. Further interview revealed that Staff E (Maintenance Director) was responsible for implementing the control measures outlined in the facility's water management plan. Interview on 4/23/26 at approximately 9:51 a.m. and approximately 11:30 a.m. with Staff E (Maintenance Director) revealed that the boilers were operating at 180 degrees Fahrenheit and the water holding tanks were at 160 degrees Fahrenheit. Interview with Staff E revealed that he/she initially stated there were no dead legs in the facility, then later clarified that the facility has six dead legs. Staff E reported that he/she flushes the water holding tanks weekly but does not document this activity. Staff E also stated that he/she flushes the six dead legs weekly and does not document this activity. Further interview with Staff E revealed that the facility utilizes an HVAC (Heating, Ventilation, and Air Conditioning) system and PTAC (Packaged Terminal Air Conditioner) units. The PTAC units are located in the [NAME] unit, are used during the summer, and Staff E cleans and washes the filters weekly on Fridays and does not document this activity. Observation on 4/23/26 at approximately 11:30 a.m. with Staff E of the (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility revealed a boiler located in the mechanical room behind the main kitchen with a temperature gauge that read 180 degrees Fahrenheit. In the chemical storage room near the main kitchen, there was a water holding tank with no temperature gauge. The storage room between the chemical storage room and the laundry room, there was a water holding tank with three temperature gauge and none of them were above 140 degrees Fahrenheit. Further observation revealed a room next to the rehabilitation room revealed two boilers that had temperature gauges that read 180 degrees Fahrenheit when the pump was on and a water holding tank with a temperature gauge that read approximately above 140 degrees Fahrenheit. Interview on 4/23/26 at approximately 11:30 a.m. with Staff E confirmed the above observation and that he/she did not check the temperature of the water holding tanks that was in the chemical storage room and the room between the chemical storage room and laundry room. Review on 4/23/26 of the weekly temperature logs from January 2026 to April 2026 revealed missing temperatures and locations for the boilers and water holding tanks: On 1/2/26, 1/9/26, 1/16/26, 1/23/26, and 1/30/26, no temperatures and locations were documented for the three boilers and three water holding tanks; On 2/26/26, 2/13/26, 2/20/26, and 2/27/26, no temperatures and locations were documented for the three water holding tanks. On 2/13/26, boiler #1 (located in the [NAME] unit next to the rehabilitation room) had a temperature of 100 degrees when the pump was off and no temperature was documented when the pump was on; On 3/6/26,3/12/26, and 3/27/26, one (160 degrees) temperature was documented for a water holding tank and it did not specify which water holding tank. On 3/16/26, no temperatures and locations were documented for the three boilers and three water holding tanks; and On 4/3/26, 4/10/26, and 4/17/26, one (160 degrees) temperature was documented for a water holding tank and it did not specify which water holding tank. Review on 4/23/26 of the weekly flushing logs for the water lines in unoccupied resident room sink, bathroom sink or shower/tub unit, and dead legs from January 16, 2026 to March 2026 revealed the following:Flushing was documented on 1/16/26, 1/23/26, 1/30/26, 2/6/26, 2/13/26, 2/20/26, 2/27/26, 3/5/26, 3/12/26, and 3/27/26 at the following locations: Central Supply, Derryfield Soiled, Laundry sink/hopper, [NAME] Soiled, [NAME] Supply, [NAME] Tub, Rehabilitation dishwasher, and Rehabilitation washing machine. On 3/27/26, flushing was also documented for room [ROOM NUMBER] and room [ROOM NUMBER]. There was no documentation indicating dead legs were flushed weekly. Review on 4/24/26 of maintenance logs revealed that there were five HVAC in the facility and the PTAC cleaning log revealed that PTAC units were last cleaned on 3/23/26. The log did not indicate which PTAC units were cleaned and how many were cleaned. Interview on 4/24/26 at approximately 11:00 a.m. with Staff G (Regional Maintenance Director) revealed that the all the PTAC units were cleaned and that the cleaning log did not specify how many and which PTAC units were cleaned. Staff G also revealed that there were six PTAC units in the facility.Review on 4/24/26 of the CDC website title, Controlling Legionella in Potable Water Systems, dated 1/3/25, retrieved from:https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html, revealed, .Operation, maintenance, and control limits Monitor temperature, disinfectant residuals, and pH [potential of hydrogen] frequently based on performance of WMP or Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation does not fall below 120 F (49 C). Recirculate hot water continuously, if possible .Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits . Legionella control measures Review on 4/24/26 of the CDC website title, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, dated 9/30/25, retrieved from: https://www.cdc.gov/control-legionella/media/pdfs/toolkit.pdf, revealed .Elements of a Water Management Program .Describe Your Building Water Systems Using (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Text .This description should include details like where the building connects to the municipal water supply, how water is distributed, and where pools, hot tubs, cooling towers, and water heaters or boilers are located Describe Your Building Water Systems Using a Flow Diagram .Identify Areas Where Legionella Could Grow & Spread .Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in your building water systems .Control Measures & Corrective Actions: The Basics .Decide Where Control Measures Should Be Applied .Control measures and limits should be established for each control point .Control measures and limits should be established for each control point .Decide How to Monitor Your Control Measures .Decide How to Monitor Your Control Measures Verification: Are we doing what we said we would do? Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program is being implemented as designed. This step is called verification. For example, if you said you would test the hot tub daily for chlorine and record and communicate those results, have you been doing that? If you found a problem, did you take the action included in your program? People should not verify the program activity for which they are responsible. For example, if one person is responsible for maintaining the hot tub and another is responsible for the cooling tower, they could verify each other's work, not their own .Validation: Is our program actually working? Now that you have a water management program, you need to be sure that it is effective. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called validation .Document & Communicate All the Activities of Your Water Management Program .

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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** Based on observation, interview, and record review, the facility failed to follow professional standards for1 of 3 resident observed for medication administration and for 1 of 1 residents reviewed for general concerns in a final sample of 18 residents. (Resident identifiers are #43 and #56.)Findings include: Standard: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .It is essential to verify the accuracy of every medication you give to your patients with the patient's order .Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 639 .Before administering medication, it is critical that all information is correct. You should check for accuracy three times: 1. First check is when the medications are pulled or retrieved from the automated dispensing machine, the medication drawer, or whatever system is in place at the agency. 2. The second check is when preparation of the medications for administration takes place. 3. The final check occurs at the patient's bedside just before medications are given . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication . Resident #43 Review on 4/23/26 of Resident #43's April 2026's MAR (Medication Administration Record) revealed the following physician's orders: Metoprolol Succinate Oral Capsule ER (extended release) 24 hour sprinkle 50 mg (milligrams), Give 1 capsule by mouth two times a day for AFIB (afibrillation) HOLD for SBP (systolic blood pressure) < 110 or HR (heartrate) <60, start date 4/7/26. Further review revealed: the following am doses were administered with vital signs not within the parameters of the order: 8:00 a.m. 4/17 bp (blood pressure) 101/65, 4/18 bp 101/52, and 4/22 bp 106/66. The following pm doses were administered with vital signs not within the parameters of the order: 4/15 bp 105/60, 4/21 bp 101/64, and 4/22 104/63. Enestro Oral Tablet 49-51 mg, Give 1 tablet by mouth two times a day for HTN (hypertension), hold for SBP <110 or HR <60. Further review revealed: the following am doses were administered with vital signs not within the parameters of the order: 4/17 bp 101/65, 4/18 bp 101/52, 4/21 bp 99/60, 4/22 bp 105/68. The following pm doses were administered with vital signs not within the parameters of the order: 4/15 bp 105/60, 4/16 bp 97/61, 4/21 bp 101/64, and 4/22 104/63. Interview on 4/23/26 at approximately 10:30 a.m. with Staff A (Director of Nursing) confirmed the above findings. Review on 4/23/26 of the facility policy titled, Medication Administration, General Guidelines, dated 1/26, revealed, 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Resident #56 Review on 4/23/26 at approximately 8:56 a.m. with Staff C (Licensed Practical Nurse) of Resident #56's Electronic Medication Administration Record (EMAR) during medication administration observation revealed a scheduled 9:00 a.m dose of Bupropion Hydrochloride (HCl) 75 milligram (mg) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was due to be administered. Observation on 4/23/26 at approximately 8:56 a.m. with Staff C revealed that Staff C prepared Resident #56's medications. Staff C retrieved the Bupropion HCl 75 mg bingo card with orange round tablets but did not pop a tablet into the medication cup. Staff C proceeded to click Y [Yes] for the Bupropion HCl 75 mg in the EMAR. After popping the remaining medications, Staff C locked the medication cart, did not verify that all scheduled medications were in the medicine cup, and proceeded to Resident #56's room. Interview on 4/23/26 at approximately 8:56 a.m. with Staff C revealed that he/she marked the scheduled medications as Y in the EMAR after he/she popped it out of the medication bingo card and into the medicine cup. Interview on 4/23/26 at approximately 9:10 a.m. with Staff C revealed that he/she had completed preparing the scheduled medications for administration, indicating that he/she was about to administer the medications without the scheduled Bupropion HCl 75 mg dose for Resident #56. Staff C confirmed that the Bupropion HCl 75 mg (orange round tablet) was not in the medication cup. Observation on 4/23/26 at approximately 9:12 a.m. with Staff C revealed Staff C proceeded to administer Resident #56's medications and did not double-check the contents of the medication cup before handing it to Resident #56. Interview on 4/23/26 at approximately 9:17 a.m. with Staff C revealed that he/she would verify that all the scheduled medications were in the medication cup prior to handing it to residents. Review on 4/23/26 of the facility policy titled, Medication Administration General Guidelines, dated 1/26, revealed, .Verifying medication is correct three (3) times before administering the medication. a. When pulling medication package from med [medication] cart b. When dose is prepared c. Before dose is administered .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, it was determined that the facility failed to ensure proper treatment and care for good foot health for 1 of 2 residents reviewed for ADLs (activities of daily living) in a final sample of 18 residents. (Resident identifier is #18.)Findings include: Observation on 4/22/26 at approximately 9:00 a.m. of Resident #18's left foot revealed his/her toenails were thick and elongated. Interview on 4/22/26 at approximately 9:00 a.m. with Resident #18 revealed he/she was unsure of the last time they were seen by a podiatrist.Observation and Interview on 4/23/26 at approximately 8:15 a.m. with Staff F (Unit Manager) of Resident #18's left foot confirmed his/her toenails were thick and elongated. Interview on 4/23/26 at approximately 8:40 a.m. with Staff F revealed that Resident #18 was last seen by a podiatrist on 9/25/25. Further interview revealed the podiatrist was last at the facility on 12/29/25.Review on 4/24/26 of Resident #18's last podiatrist note, dated 9/25/25, revealed, Progress note . Non-professional treatment is hazardous to the patient, . Recall: As medically necessary but no sooner than 60 days.Review on 4/24/26 of the Podiatry Schedule for 12/29/25 revealed Resident #18 was not on the list to be seen.Interview on 4/24/26 at approximately 11:00 a.m. with Staff A (Director of Nursing) confirmed the above findings.Review on 4/24/26 of the facility policy titled, NSG217 Foot Care, Revision Date 8/7/23, revealed, Patients who have complicating disease processes requiring foot care including, ., must be referred to qualified professionals such as podiatrists or other qualified providers. The center is responsible for assisting patients in making appointments and arranging transportation to obtain needed services. Purpose, To ensure patients receive proper treatment and care to maintain mobility and good foot health.