STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305048	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsborough County Nursing Home	400 Mast Road Goffstown, NH 03045

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** 38218 Based on observation, interview and record review, it was determined that the facility failed to follow medication administration instructions for and failed to handle medication according to professional standards for 1 of 5 residents observed for medication administration. (Resident identifier is #136.) Findings include: Standard: [NAME], P.A, [NAME], A.G., Stockhart, P.A., & Hall, A. (2021). Fundamentals of Nursing. Elsevier., page 640 . Skill 31.1 Administering Oral Medications, .Clean gloves (if handling an oral medication) Review on 4/2/25 of the Magnesium Lactate Extended Release manufacturer's instruction, dated 11/29/24, revealed .Warnings Follow all directions on your medicine label and package .Do not crush or chew an extended release tablet . Observation on 4/2/25 at approximately 8:10 a.m. during Resident #136's medication administration revealed that Staff A (Licensed Practical Nurse) crushed the Magnesium Lactate Extended Release (ER) 84 mg (milligrams) tablet. Further observation revealed the Magnesium Lactate ER 84 mg medication card had a pharmacy warning label that read Do not crush the medication. Observation also revealed that Staff A was putting his/her bare fingers in the medication cup to remove pills twice. Interview on 4/2/25 at approximately 8:10 a.m. with Staff A confirmed the above findings. Review on 4/2/25 of Resident #136's current physician orders revealed that Resident #136 did not have a physician's order to crush medication. Interview on 4/2/25 at approximately 9:40 a.m. with Staff B (Director of Nursing) confirmed that Resident #136 did not have a physician's order to crush his/her medications. Review on 4/2/25 of the facility policy titled, Medication Administration of P.O. (by mouth) Medications, Revision Date 1/13 revealed .2. Do not touch the oral solid medication with your bare hands .4. Some medications should not be crushed. 12. If a resident has difficulty swallowing pills whole, the practitioner will be notified, an order from the practitioner will be obtained if appropriate .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40522 Based on observation, interview, and record review, it was determined that the facility failed to implement policies and procedures for 1 of 1 resident reviewed for Transmission Based Precaution (Resident identifier is #173). Findings include: Observation on 4/1/25 at approximately 8:30 a.m. on C4 unit revealed that Resident #173's room had a contact precaution signage outside the door. Interview on 4/1/25 at approximately 8:30 a.m. with Staff C (Registered Nurse) revealed that Resident #173 was on contact precaution for Clostridium Difficile (C-diff) infection. Observation on 4/1/25 at approximately 10:28 a.m. on C4 unit revealed that Staff D (housekeeper) was in Resident #173's room wearing a gown and gloves, wiped down Resident #173's bed rails, bedside table, and furniture with a cloth. When finished, Staff D exited the room, doffed the used gown and gloves, and used an Alcohol Based Hand Rub (ABHR). Staff D did not wash their hands with soap and water. Staff D donned new gloves, Staff D did not wear a gown, re-entered Resident #173's room, and mopped the floor. Staff D exited the room, doffed the used gloves, and used ABHR. Staff D did not wash their hands with soap and water. Interview on 4/1/25 at approximately 10:28 a.m. with Staff D confirmed the above observation. Observation on 4/2/25 at approximately 12:23 p.m. on C4 unit revealed that Staff E (Licensed Nursing Assistant) donned gown and gloves, entered Resident #173's room with a meal tray, placed the meal tray at the bedside table in front of Resident #173. Staff E exited the room, doffed the used gown and gloves, and used ABHR. Staff E did not wash their hands with soap and water. Interview on 4/2/25 at approximately 12:23 p.m. with Staff E confirmed the above observation. Review on 4/2/25 of Resident #173's provider note, dated 4/1/25, revealed reason for visit was C-diff which Resident #173 completed additional Vancomycin regimen last week for another recurrent C-diff infection and that Resident #173 reported that his/her loose stool has reoccurred. Further review of the provider note revealed a diagnostic statement of recurrent enterocolitis due to C-diff. The plan was to extend the Vancomycin regimen and follow up with infectious disease. Review on 4/2/25 of Resident #173's C-diff infection care plan, with a revision date of 3/14/25, revealed that Resident #173 was positive for C-diff on 1/6/25, 1/23/25, and 3/13/25 with an intervention that contact precautions was reinstated on 3/13/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 4/2/25 of the facility policy titled, Contact Precautions, with no date, revealed .Contact Precautions should be implemented for the following: .C. difficile .Gloves And Handwashing: .remove gloves before leaving resident's room and wash hands immediately .remove gown and observe hand hygiene before leaving the resident's room .References: Centers for disease control and prevention. Guideline for Isolation Precautions: Preventing Transmissions of Infectious Agents in Healthcare Settings .2007 . Interview on 4/2/25 at approximately 3:15 p.m. with Staff G (Infection Preventionist) stated that for contact precautions, staff can use ABHR when staff are in a resident room not providing care and gloves are not visibly soiled. Staff G confirmed the above policy and that the policy stated to wash hands. Review on 4/2/25 of the CDC guidelines titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), dated 11/27/23, revealed .perform hand hygiene ~ in the following clinical situations: .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient .After removing gloves .Wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., C. difficile or Bacillus anthracis) is likely to have occurred. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorohexidine, iodophors, and other antiseptic agents have poor activity against spores .