

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>49819</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to determine clinical appropriateness of self-administration of medications for 2 of 4 residents reviewed for choices in a final sample of 13 residents (Resident Identifiers are #19 and #22).</p> <p>Findings include:</p> <p>Resident #19</p> <p>Observation on 9/5/24 at approximately 8:30 a.m. in Resident #19's room revealed 5 pills in a small coaster on Resident #19's tray table.</p> <p>Interview on 9/5/24 at approximately 8:30 a.m. with Resident #19 revealed that the pills were his/her morning medications and that the nurse leaves the pills for him/her to take everyday. Resident #19 stated that this is done at his/her request to take the medications at his/her own pace.</p> <p>Review on 9/5/24 of Resident #19's medical record revealed that there was no self-administer of medication assessment or physician's order to self-administer medications.</p> <p>Resident #22</p> <p>Observation on 9/4/24 at approximately 8:45 a.m. with Staff B (Registered Nurse (RN)) during medication administration revealed that Staff B left a cup of 7 pills that were: 1 Aspirin 81 milligrams (mg) EC (enteracoted), 2 garlic (dietary supplement) 1000 mg, 1 Lutein (eye vitamin) capsule 20 mg, 1 multivitamin with minerals, 1 vitamin D 1000 units, 1 jentadueto (anti-diabetic medication) 2.5mg/500mg, and 1 osteobilflex (joint supplement).</p> <p>Interview on 9/4/24 at approximately 8:45 a.m. with Staff B confirmed the above findings. Staff B stated that Resident #22 was cognitive enough to take medications by themselves.</p> <p>Obsrevation on 9/5/24 at 8:30 a.m. in Resident #22's room revealed a medicine cup of 3 pills.</p> <p>Interview on 9/5/23 at approximately 8:30 a.m with Resident #22 confirmed the above findings. Resident #22 stated that the pills were his/her medications and that the nurse left it for him/her to take on their own.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review on 9/5/24 of Resident #22's medical record revealed that there were no physician's order to self-administer medications and there was no self-administration assessment.</p> <p>Interview on 9/5/24 at 8:50 a.m. with Staff B confirmed the above findings.</p> <p>Interview on 9/5/24 at approximately 1:45 p.m. with Staff A (Director of Nursing) confirmed that Resident #19 and #22 were not assessed for self-administration of medications. Staff A was unable to provide a policy for self-administration of medications.</p> <p>50163</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	

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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>40522</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident was assessed and an informed consent was obtained for the use of full-length bed rails for 1 of 1 resident reviewed for restraints in a final sample of 13 residents (Resident Identifier #18).</p> <p>Findings include:</p> <p>Observation on 9/4/24 at approximately 10:00 a.m., 12:00 p.m., 1:00 p.m., and 3:00 p.m. revealed that Resident #18 was in bed with full-length bed rails up on the right and left side of the bed.</p> <p>Review on 9/4/24 of Resident #18's medical record revealed that there was no bed rail assessment and informed consent for the full-length bed rails.</p> <p>Review on 9/4/24 of the facility's policy titled, Bed Rail Consent Form, with no date, revealed that the facility will periodically and annually review and re-evaluate the resident's use of the bed rails.</p> <p>Interview on 9/4/24 at approximately 3:00 p.m. with Staff A (Director of Nursing) confirmed the above findings.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49819</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to ensure that medications were labeled and stored in accordance with currently accepted professional principles for 1 of 1 medication carts observed and 1 of 4 residents reviewed for choices (Resident Identifier #19).</p> <p>Findings include:</p> <p>Observation on 9/4/24 at approximately 8:20 a.m with Staff B (Registered Nurse) of the facility's medication cart revealed an open Lantus (insulin) vial with no resident identifier with an open date of 8/5/24 and discard date of 9/2/24.</p> <p>Review on 9/4/24 of Lantus manufacturer instructions revealed .Store in-use (opened) LANTUS vials .at room temperature .for up to 28 days .</p> <p>Resident #19</p> <p>Observation on 9/4/24 at approximately 8:45 a.m. revealed a Refresh eye drops (lubricant eye drops) at Resident #19's bedside table.</p> <p>Interview on 9/4/24 at approximately 8:45 a.m. with Resident #19 confirmed the above observation. Resident #19 stated that the eye drops were stored at bedside.</p> <p>Review on 9/5/24 of the facility policy titled, Medication Storage Procedure, with no date, revealed . Medications will be stored in a locked drawer in the patient's room .</p> <p>Interview on 9/05/24 at 1:30 p.m. with Staff A (Director Of Nursing) confirmed above facility policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	
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 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>49819</p> <p>Based on interview, it was determined that the facility failed to ensure the food service director met minimum qualifications.</p> <p>Findings include:</p> <p>Interview on 9/5/24 at approximately 11:30 a.m. with Staff C (Administrator) revealed that the dietician is part-time and that Staff C was the food service director. Staff C confirmed that he/she had been the food service director for years and had not completed a course of study in food safety and management.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49819</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that dishes were sanitized according to manufacturer's instruction for food services safety in the main kitchen.</p> <p>Findings include:</p> <p>Review on 9/4/24 of the facility's 2024 dishwasher temperature logs from August to September revealed that the facility documented one temperature per day. The temperatures ranged between 160 to 176 degrees Fahrenheit. The log did not indicate what an acceptable range would be or if the temperature was taken during wash or rinse cycle.</p> <p>Interview on 9/4/24 at approximately 10:45 a.m. with Staff E (Lead Cook) revealed that the above log temperatures were for wash cycle only. Staff E did not know the acceptable temperatures for wash and rinse cycle.</p> <p>Observation on 9/5/24 at approximately 12:00 p.m. with Staff F (Dietary Aide) of a dishwasher cycle revealed a wash temperature of 150 degrees Fahrenheit and rinse temperature of 174 degrees Fahrenheit.</p> <p>Review on 9/5/24 of manufacturer's instruction label for [NAME] LXe revealed minimum ranges for temperatures were 150 degrees Fahrenheit for wash and 180 degrees Fahrenheit for rinse.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	

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 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>40522</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that the facility assessment determined the amount of time required to fulfill the role of the designated Infection Preventionist (IP).</p> <p>Findings include:</p> <p>Review on 9/5/24 of the facility's facility assessment with a review date of 6/2024 revealed no determination for the amount of time required to fulfill the role of the IP.</p> <p>Interview on 9/5/24 at approximately 1:00 p.m. with Staff A (Director of Nursing) revealed that he/she was the designated IP at the facility. Staff A stated that he/she spends 1 hour a week dedicated to the facility's Infection Prevention and Control Program (IPCP).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Hillsboro House Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE Po Box 400 67 School Street Hillsboro, NH 03244	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49819</p> <p>Based on interview and record review, it was determined that the facility failed to develop and implement a comprehensive infection control guideline for facility water management that had the potential to effect the facility census of 26 residents who resided at the facility.</p> <p>Findings include:</p> <p>Review on 9/5/24 of the Facility Water Management Program with a revised date of 1/2024 revealed strategies for water management to be annual testing for legionella and weekly flushing of vacant rooms. Further review revealed no description of water flow, schematic, or map of plumbing or identified areas of concern available.</p> <p>Interview on 9/5/24 at approximately 11:00 a.m. with Staff A (Infection Preventionist) revealed he/she was unable to answer questions regarding water management or legionella testing.</p> <p>Interview on 9/5/24 at approximately 1:30 p.m. with Staff G (Administrator Assistant) revealed no logs for flushes or legionella test results available.</p>