STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225662	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor House Nursing & Rehabilitation Center	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)
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. 15214 Based on record review, policy review, and interview, the facility failed to ensure for one Resident (#323), out of a total sample of 24 residents, that the Resident received care and treatment in accordance with the medical care plan. Specifically, the facility failed to perform physician-ordered treatments to the Resident's external fixator pins. Findings include: Review of the facility's policy titled Charting and Documentation, revised in July 2017, indicated but was not limited to the following: -Documentation in the medical record may be electronic, manual or a combination. -The following information is to be documented in the resident medical record: Treatments or services performed -Documentation in the medical record will be objective (not opinionated or speculative) complete, and accurate. Resident #323 was admitted in July 2024 with diagnoses which included bilateral patellar tendon rupture with surgical repair. Review of the Minimum Data Set (MDS) assessment, dated 8/1/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the Resident was without cognitive impairment. Review of the Hospital Discharge Summary, dated 7/26/24, indicated that wound care to the internal fixator pins was to be done daily by nursing. Review of the Physician's Orders indicated: -Daily pin care with 1/2 normal saline and 1/2 hydrogen peroxide, apply gently with a Q-Tip to pin sites. Review of the Treatment Administration Record (TAR) indicated that on 7/27/24, 7/28/24,7/29/24, 7/30/24, and 7/31/24, the treatment to the external fixator pins to bilateral lower extremities was performed as ordered. (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	During an interview on 7/31/24 at 1:30 P.M., Resident #323 said that nursing staff had not touched the pins since he/she was admitted . The Resident said the last time the pins were cleaned was in the hospital on 7/26/24. The Resident was not sure how often the pins were supposed to be cleaned by the facility. During an interview with Nurse #4, Resident #323, and Resident #323's Family Member on 7/31/24 at 1:50 P. M., Nurse #4 said she only looked at the bottom fixator pins, and did not see the top pins. She said that she must have signed off cleaning the fixator pins in error because she didn't perform the cleaning/treatment to the pins. The Resident said that no one had unwrapped, or looked at the pins, since the physician did so on Friday morning. The Resident's Family Member said the pins have not been cleaned for five days. During an interview on 7/31/24 at 1:50 P.M., Nurse #1 said she didn't see the order for pin care; she must have missed it. Nurse #1 reviewed the TAR and said that she did not perform the pin care on 7/29/24, but she confirmed that she signed that she had performed the treatment on the TAR. During an interview on 7/31/24 at 2:22 P.M., Nurse #3 said that she looked around the gauze and did not see any redness or drainage. She said she did not see any order for a dressing change. She also said that she did not remove the gauze to look at the pins underneath the gauze. During an interview on 8/1/24 at 12:39 P.M., Nurse #2 said that she worked on Tuesday, 7/30/24. She said that she remembered mixing up the cleaning solution for the pins, she signed off on performing the treatment to the pins, however she said that she didn't get to do the treatment because she got distracted with a new admission. During an interview on 8/6/24 at 11:05 A.M., the Director of Nursing (DON) said that she wasn't sure if Nurse #6 performed the treatment to the fixator pins on 7/27/24 and 7/28/24, although the nurse signed off that she had done the treatments on that date. Additionally, she said that at least 3 of 5 signed treatments to the Resident's fixator pins were not performed as ordered between 7/27/24 and 7/31/24, although they had been signed off by nursing as being done. The DON also said that a nurse should not sign off that a treatment was performed without having performed it.

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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. 41106 Based on observation, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles for one Resident (#322), out of a total sample of 24 residents. Specifically, the facility failed for Resident #322, to ensure the medications were administered under direct supervision and not left at the bedside. Findings include: Review of the facility's policy titled Competency Assessment Administering Oral Medication, revised October 2020, indicated but was not limited to the following: -The purpose of this procedure is to provide guidelines for safe administration of oral medications. -Prepare the correct dose of medication. -Confirm the identity of the resident. -Allow the resident to swallow oral tablets or capsules at his or her comfortable pace. -Remain with the resident until all medications have been taken. -Notify the supervisor if resident refuses the procedure, -Report other information in accordance with facility policy and professional standards of practice. Resident #322 was admitted to the facility in July 2024 with diagnoses which included: Fracture right femur and dementia. Review of the Minimum Data Set (MDS) assessment, dated 7/31/24, indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the Resident was cognitively intact. Review of Resident #322's Self-Administration of Medication Assessment, dated 7/25/24, indicated the Resident did not want to have medications at the bedside or did not wish to administer his/her own medications. Review of Resident #322's care plan, dated 7/26/24, indicated but was not limited to the following: -Impaired cognitive function dementia or impaired thought processes. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #322's Medication Administration Record (MAR) for 9:00 A.M. pill administration indicated the following: -Amlodipine Besylate 2.5 milligrams (MG). Give one tablet by mouth for hypertension -Aspirin EC low dose delayed release 81 mg. Give one tablet by mouth for heart health. -Bupropion HCl Extended release (ER) extended release 12-hour 100 mg. Give one tablet by mouth in morning for depression. -Calcium Carbonate tablet chewable. Give 500 mg by mouth in the morning. -Donepezil HCl tablet 5 mg. Give one tablet by mouth for Alzheimer's. -Lamotrigine tablet 150 mg. Give one tablet by mouth in morning for bipolar. -Lexapro tablet 20 mg. Give one tablet by mouth in morning for depression. -Losartan Potassium tablet 100 mg. Give one tablet by mouth in morning for hypertension. -Vitamin D3 tablet 25 micrograms (MCG). Give one tablet by mouth in morning. -Docusate sodium capsule 100 mg. Give one capsule by mouth two times a day for constipation. -Sitagliptin-metformin HCl tablet 50-1000 mg. Give one tablet two times a day for diabetes. -Gabapentin capsule 300 mg. Give one capsule by mouth three times a day for pain. -Tylenol Extra strength tablet 500 mg. Give two tablets by mouth three times a day for pain dose of 1000 mg. On 7/31/24 at 10:40 at A.M., the surveyor observed a pill cup on Resident #322's bedside table containing 12 pills. During an interview on 7/31/24 at 10:40 A.M., Resident #322 said he/she asked the nurse to leave the pills and he/she would take them later. During an interview on 7/31/24 at 10:50 A.M., Nurse #4 said she did not give Resident #322 the medications this morning. Nurse #4 said the student nurse, under the supervision of her instructor, administered the medications. Review of the Nursing Note, dated 7/31/24, indicated this nurse [Nurse #4] observed medications unattended at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 11:11 A.M., the Director of Nurses (DON) said her expectation is the student nurses train with direct supervision from the instructor and stay with the resident until all the medications are consumed. The DON said Nurse #4 had notified her there were multiple pills left at Resident #322's bedside. She said Nurse #4 reconciled the pills because the Resident #322 told her he/she had already taken some. During an interview on 7/31/24 at 12:00 P.M., Nurse Student Instructor (NSI) said she did go in Resident #322's room with the student nurse and was standing by the end of the bed. She said she did not hear Resident #322 ask to leave the medication and thought Resident #322 had taken all the medication before they left the room. The NSI said she should have made sure Resident #322 took all his/her pills before leaving the room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36542 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure facial hair was restrained during food preparation; and 2. Maintain a safe and clean microwave in one out of three kitchenettes; and 3. Maintain a safe and clean ice scoop in one out of three kitchenettes. Findings include: 1. Review of the facility's policy titled Nutrition and Food Service: Employee Practices, dated as revised in September 2023, indicated employees shall use effective hair restraints when working in all food preparation areas to prevent contamination of food or food-contact surfaces. All hair must be restrained and tucked under hairnet. On 8/1/24 at 7:30 A.M., the surveyor observed Dietary Aide #1 at the meal preparation assembly line putting placemats and silverware on the trays. The surveyor observed the Dietary Aide not wearing a hair net on top of their head and not wearing a beard net on their facial hair. On 8/1/24 at 11:30 A.M., the surveyor observed Dietary Aide #1 at the meal preparation assembly line putting placemats and silverware on the trays. The surveyor observed the Dietary Aide wearing a hair net on the top of their head and not wearing a beard net on their facial hair. During an interview on 8/2/24 at 9:40 A.M., the Food Service Director said Dietary Aide #1 should be wearing a beard restraint while in the kitchen. 2. Review of the 2022 Food Code, a model for safeguarding public health and ensuring food is safe for consumption, indicated: 4-201.11 Equipment and Utensils. Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms . Equipment and utensils must be designed and constructed so that parts do not break and end up in food as foreign objects or present injury hazards to consumers. On 8/1/24 at 3:10 P.M. the surveyor observed the inside of the microwave in the South Two kitchenette with black markings on the back and top. The inside top contained food splatter and was bubbling and peeling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/2/24 at 9:55 A.M., the Food Service Director said the top of the microwave was peeling and there were black marks. He said the housekeeping staff were responsible for cleaning he microwaves, and he did not know the inside of the microwave was peeling and he would have it replaced. 3. Review of the facility's policy titled Nutrition and Food Service: Ice Scoop Sanitation, dated as revised in September 2023, indicated ice machine equipment (scoops and receptacles that are used to hold or transport ice) will be cleaned and sanitized on a regular basis. Clean and sanitize the ice scoop and other ice receptacles daily or as needed in the dishwasher and allowed to air dry. Store ice scoop beside or on top of the machine in a clean non-porous container that allows the water to drain off and not pool around the scoop. On 8/1/24 at 3:02 P.M., the surveyor observed the North Two kitchenette ice scoop mounted on the wall in a cylindrical holder. The surveyor observed the bottom of the holder, where the ice scoop rests, with liquid and a brown substance. During an interview with observation on 8/2/24 at 9:50 A.M., the Food Service Director said the ice scoop and the holder should be checked for cleanliness when the dietary staff are checking the kitchenettes. He said the bottom of the scoop should not have pooling liquid and a brown substance.