

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  355051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Hatton Prairie Village		STREET ADDRESS, CITY, STATE, ZIP CODE  950 Dakota Ave Hatton, ND 58240	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>39211</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or the resident's representative a written notice of transfer or a copy of the notice to the State Long Term Care Ombudsman for 1 of 1 resident (Resident #4) reviewed for hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights and does not allow the ombudsman to be aware of facility practices regarding transfer and discharge or advocate on the resident's behalf.</p> <p>Findings include:</p> <p>Review of the facility policy Transfer and Discharge of Resident occurred on 09/05/24. This policy, dated October 2022, stated, . Notify the resident and resident's representative in writing of the transfer . Give original notice to resident and resident's personal representative by first class mail or personal delivery; . send copies of transfer and discharge notices to the Office of the State Long Term Care Ombudsman .</p> <p>Review of Resident #4's medical record occurred on all days of survey. A hospital transfer occurred on 06/17/24. The medical record lacked evidence the facility provided the resident and/or representative with a written transfer notice or a copy of the transfer to the ombudsman.</p> <p>During an interview on 09/05/24 at 9:20 a.m., an administrative staff member (#1) confirmed the facility failed to provide a written notice of transfer to the resident or their representative, and send the notice to the ombudsman.</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
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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>39211</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or resident's representative a written bed hold notice for 1 of 1 resident (Resident #4) reviewed for hospital transfer. Failure to provide a written copy of the bed hold notice and include the reserve bed amount does not allow the resident and/or their representative to make an informed decision regarding their rights.</p> <p>Findings include:</p> <p>Review of the facility policy Holding A Resident's Bed During Absences occurred on 09/05/24. This policy, dated November 2016, stated, . will inform a resident, legal representative and interested family members of our policy on holding a resident's bed during a resident's absence from our facility. prior to any hospitalization or therapeutic leave, including the amount of the bed-hold charge.</p> <p>Review of Resident #4's medical record occurred on all days of survey. A hospital transfer occurred on 06/17/24. The medical record lacked evidence the facility provided the resident and/or their representative with a written bed hold notice or the reserve bed hold amount.</p> <p>During an interview on 09/05/24 at 9:20 a.m., an administrative staff member (#1) confirmed the facility failed to provide a written bed hold notice or the reserve bed hold amount to the resident and/or their representative.</p>

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>40489</p> <p>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to complete a significant change is status assessment (SCSA) for 1 of 1 supplemental resident (Resident #35) who elected hospice services. Failure to complete a SCSA may affect the development of a comprehensive care plan and the care provided to the resident.</p> <p>Findings include:</p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, page 2-25 stated, . An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program . The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election.</p> <p>Review of Resident #35's medical record occurred on September 3-4, 2024. A progress note, dated 07/03/24, identified the resident elected hospice services. The facility failed to complete a SCSA when Resident #35 elected hospice services.</p> <p>During an interview on 09/05/24 at 8:30 a.m., an administrative nurse (#7) confirmed the facility failed to complete a SCSA following Resident #35's election to hospice services.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39211</p> <p>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 13 sampled residents (Resident #4, #12, and #32). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents.</p> <p>Findings include:</p> <p><b>SECTION I: ACTIVE DIAGNOSES</b></p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, pages I-7 to I-8, stated, . Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.</p> <p>Review of Resident #12's medical record occurred on all days of survey. The care plan identified a problem, goals, and interventions related to Post-Traumatic Stress Disorder (PTSD). Review of psychiatry notes, dated 06/11/24 and 08/13/24, identified PTSD as a current diagnosis.</p> <p>Resident #12's annual MDS, dated [DATE], lacked identification of the PTSD diagnosis.</p> <p><b>SECTION N: MEDICATIONS</b></p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-6 to N-7, stated, . Code all high-risk drug class medications according to their pharmacological classification . N0415: High-Risk Drug Classes . Coding Instructions . N0415F1. Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period. N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., [example] . clopidogrel) was taken by the resident at any time during the 7-day observation period.</p> <p>- Review of Resident #4's medical record occurred on all days of survey. Physician's orders, dated 06/20/24, included clopidogrel 75 milligrams daily. The significant change in status assessment (SCSA) MDS, dated [DATE], lacked coding of the antiplatelet.</p> <p>During an interview on 09/05/24 at 8:30 a.m., an administrative nurse (#7) confirmed staff failed to code the MDS correctly for Resident #4.</p> <p>- Review of Resident #32's medical record occurred on all days of survey. The record identified the resident received doxycycline (an antibiotic) since 05/11/23. The quarterly MDS, dated [DATE], lacked coding of the antibiotic.</p> <p>During an interview on 09/04/24 at 5:43 p.m., an administrative nurse (#1) confirmed Resident #32 had been taking doxycycline since 05/11/23 and staff failed to code it on the resident's MDS.</p> <p>(continued on next page)</p>		

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F 0641  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	40488

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39211</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect residents' current status for 5 of 13 sampled residents (Resident #4, #13, #15, #30 and #32) and 1 supplemental resident (Resident #35). Failure to update care plans limited staffs' ability to communicate needs and ensure continuity of care.</p> <p>Findings include:</p> <p>Review of the facility policy titled Care Plans and Care Plan Team occurred on 09/05/24. This policy, dated 10/28/22, stated, . The Care Plan Team will develop and implement a comprehensive care plan for each resident. The care plan includes the following: Resident's doctor's plan of medical care to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . Care plans will be individualized to meet the needs of a resident . Each resident will have care plan meetings when moving into the facility, quarterly, annually and if the resident has a significant change in health. The care plan team will review and revise a resident's care plan at each of these times.</p> <p>- Review of Resident #4's medical record occurred on all days of survey. The progress notes identified Resident #4 returned from a hospitalization on [DATE] with a new diagnosis of STEMI (ST-elevation myocardial infarction, a type of severe heart attack). The hospital return medication orders included an antiplatelet (prevents blood clots), diuretics (increases fluid and salt loss from the body), and blood pressure medications.</p> <p>Resident #4's care plan lacked a problem, goal, and interventions related to a change in condition regarding a new diagnosis of STEMI and medication changes post hospitalization .</p> <p>- Review of Resident #13's medical record occurred on all days of survey and included physician's orders for insulin (lowers blood glucose levels) and a blood thinner.</p> <p>Resident #13's care plan lacked a problem, goal, or interventions related to the resident taking insulin and a blood thinner.</p> <p>- Review of Resident #15's medical record occurred on all days of survey. A physician's order, dated 08/19/24, identified the resident wears a wanderguard. A progress note, dated 08/20/24 at 12:12 a.m., indicated the resident attempted to exit the building and entered several rooms within the facility.</p> <p>Resident #15's care plan lacked a problem, goal, and interventions related to wandering/exit seeking behaviors.</p> <p>- Review of Resident #30's medical record occurred on all days of survey and identified the resident admitted to the facility in March 2024 on hospice services with a diagnosis of liver cancer.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #30's care plan lacked a problem, goal, or interventions related to hospice and the diagnosis of liver cancer.</p> <p>During an interview on 09/04/24 at 3:15 p.m., an administrative nurse (#1) agreed Resident #30's care plan lacked a specific hospice problem.</p> <p>- Review of Resident #32's medical record occurred on all days of survey. A physician's order, dated 05/11/23, identified the resident receives an antibiotic for ongoing therapy for an eye condition.</p> <p>Resident #32's care plan lacked a problem, goal, and interventions related to long term use of an antibiotic.</p> <p>- Review of Resident #35's medical record occurred on September 3-4, 2024. The progress notes identified Resident #35 elected hospice services and the hospice admission occurred on 07/03/24.</p> <p>Resident #35's care plan lacked a problem, goal, and interventions related to hospice services.</p> <p>During an interview on 09/04/24 at 3:50 p.m., an administrative nurse (#1) stated she expected staff to update the resident care plans following a change in condition.</p> <p>40488</p> <p>40489</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40489</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring for 1 of 1 sampled resident (Resident #28) with an elopement. Failure to identify the resident's risk for elopement and implement, monitor, and modify individualized resident-centered interventions when necessary placed the resident's health and safety at risk when they eloped from the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled MISSING RESIDENT occurred on 09/05/24. This policy, dated November 2018, stated, . [NAME] Prairie Village assesses residents prior to and upon admission for elopement risk, including all cognitively impaired residents. It also reassesses residents periodically to see if elopement risk is now present, has decreased or increased.</p> <p>Review of Resident #28's medical record occurred on all days of survey and included the diagnoses of dementia and restlessness and agitation. The care plan, dated 07/24/24, stated, . Resident exhibits wandering and a risk for elopement R/T [related to] was outside facility .</p> <p>The medical record showed the facility admitted Resident #28 and her husband in 2022. Resident #28's husband moved to a different facility in October of 2023 and Resident #28 moved to a different room.</p> <p>Resident #28's progress notes included the following:</p> <ul style="list-style-type: none"> <li>* 10/01/23 at 5:56 p.m. she is confused and wanders throughout the facility up and down the halls . Resident and her spouse tried to go outside for a walk .</li> <li>* 10/21/23 at 7:29 a.m. Resident . stating 'I want to get out of here!' .</li> <li>* 10/21/23 at 10:32 a.m. resident . insisting that she is 'leaving, going somewhere else'. She paced around the facility .</li> <li>* 11/24/23 at 11:31 a.m. Just now again she [Resident #28] brought a folder with photos in it to the nurse's station wondering what to do with them because 'we're leaving tonight' .</li> <li>* 12/12/23 at 4:53 p.m. [Resident #28's name] was putting her belongings out in the hallway.</li> <li>* 07/20/24 at 3:12 p.m. Writer saw [Resident #28's name] through the window walking around the east side of the building, staff was immediately sent to catch up with [Resident #28's name]. She came back inside with staff willingly without issue. [Resident #28's name] was unharmed. Wander guard on [Resident #28's name] wrist to prevent future elopement.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/05/24 at 10:55 a.m., an administrative nurse (#1) verified the facility lacked documentation of an assessment of Resident #28's elopement risk on admission and prior to or after her elopement on 07/20/24.</p> <p>The facility failed to evaluate Resident #28's elopement risk on admission and even though the resident expressed her wishes to leave the facility on several occasions, the facility failed to recognize those behaviors as possible signs of elopement and implement individualized interventions to prevent an elopement.</p>		

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<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>45873</p> <p>Based on observation, review of professional reference, and staff interview, the facility failed to ensure food is stored in accordance with professional standards and in a sanitary environment in 1 of 1 kitchen (main kitchen). Failure to ensure food is safe from sources of contamination may result in a foodborne illness or adverse effects for residents, visitors, and staff.</p> <p>Findings include:</p> <p>The 2022 Food and Drug Administration (FDA) Food Code, Annex 3-100 stated, . Preventing contamination from the premises . 3-305.11 Food Storage. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate . can be sources of microbial contamination for stored food. Chapter 6-3 Physical Facilities . 6-202.12 Heating, Ventilating, Air Conditioning System Vents. Heating, ventilating, and air conditioning systems shall be designed and installed so that . air intake and exhaust vents do not cause contamination of FOOD, FOOD-CONTACT SURFACES, EQUIPMENT, or UTENSILS.</p> <p>Observation of the kitchen on 09/03/24 at 11:45 a.m. showed the following:</p> <ul style="list-style-type: none"> <li>- Walk-in Freezer: Two fans with icicles dripping onto an open pail of steak strips.</li> <li>- Kitchen preparation and serving area: Water from an air conditioning unit running down the wall adjacent to the countertop. Dietary staff had taped aluminum foil to the wall to guide water into a plastic collection receptacle. Water splashed outside the receptacle and onto the countertop.</li> </ul> <p>During an interview on 09/05/24 at 10:30 a.m., a maintenance staff member (#3) stated unawareness of the issue with the kitchen air conditioner.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39211</p> <p>Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standards of infection control for 2 of 5 sampled residents (Resident #4, and #12) and 1 supplemental resident (Resident #35) observed during cares. Failure to follow infection control practices during resident cares related to hand hygiene, glove use, and enhanced barrier precautions (EBP), has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled Glove Use occurred on 09/05/24. This policy, dated June 2024, stated, . Gloves shall be used for touching excretions, secretions, blood, body fluids, mucous membranes, and non-intact skin. Handwashing is necessary even if gloves are worn. Handwashing should be completed after every removal of gloves.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions (EBP) occurred on 09/05/24. This policy, dated April 2024, stated, . staff will use EBP (gowns and gloves) for residents with any of the following: . Indwelling medical devices, . Indwelling medical device examples include: . urinary catheters, . Employees will use EBP (gowns and gloves) when performing the following high-contact resident care activities: . Transferring .</p> <p>HAND HYGIENE/GLOVE USE:</p> <p>- Observation on 09/03/24 at 4:09 p.m. showed a certified nurse aide (CNA) (#4) donned gloves, removed Resident #35's soiled brief, assisted the resident onto the toilet, removed her gloves and failed to perform hand hygiene.</p> <p>- Observation on 09/04/24 at 1:34 p.m. showed a CNA (#5) completed perineal cares for Resident #4 after an incontinent bowel movement. During the cares, the CNA failed to perform hand hygiene between glove changes. After the cares, the CNA (#5) removed the soiled gloves and without performing hand hygiene applied a clean brief and adjusted the resident's clothing.</p> <p>ENHANCED BARRIER PRECAUTIONS:</p> <p>Review of Resident #12's medical record occurred on all days of survey. The physician's orders included an indwelling urinary catheter. A supply cart located outside the resident's room contained a sign indicating EBP.</p> <p>Observation on 09/03/24 at 5:30 p.m. showed a CNA (#6) entered Resident #12's room with a stand lift. The CNA failed to donn a gown and gloves before utilizing a mechanical stand lift to assist Resident #12 from the wheelchair into the recliner chair, removing the sling from behind the resident, and placing the resident's personal items and call light within reach.</p> <p>During an interview on 09/05/24 at 10:50 a.m., an administrative nurse (#1) confirmed she expected staff to follow the policy and procedures for hand hygiene, glove use, and EBP.</p>		