

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER Sanford Hillsboro Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12 3rd St SE Hillsboro, ND 58045	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>46963</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure all forms of communication related to code level status accurately reflected the resident ' s wishes for 1 of 14 sampled residents (Resident #23) reviewed for advance directives. Failure to ensure the medical record and other forms of communication accurately reflected the resident's code status limited the facility's ability to communicate to direct care staff and emergency personnel the resident's choice in the event of a medical emergency.</p> <p>Findings include:</p> <p>Review of the facility policy titled Advance Care Planning occurred on 05/30/24. This policy, dated 11/13/23, stated, . Residents . have the right to make decisions concerning medical care, including the right to accept or to refuse medical or surgical treatment.</p> <p>Review of Resident #23's medical record occurred on all days of survey. The Uniform Code Level Directives for Cardiopulmonary Resuscitation, signed by the resident on 01/04/22, indicated Code Level 1: All available reasonable technology is used in the event of cardiac or respiratory arrest but would require transfer out of facility. *Wants chest compressions. No intubation.</p> <p>Observation on 05/28/24 at 5:39 p.m. showed a red dot on the spine of the resident's chart.</p> <p>During an interview on 05/28/24 at 5:39 p.m., an administrative nurse (#1) stated a green dot indicated a full code and a red dot indicated do not resuscitate (DNR). The administrative nurse (#1) confirmed that staff would identify Resident #23 as DNR based on the red dot on the resident's chart, and the facility would need another color circle to indicate resident's wishes of do not intubate (DNI).</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 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>45873</p> <p>Based on record review, staff interview, and review of facility policy, the facility failed to provide the resident or the resident's representative a written notice of transfer for 1 of 1 resident (Resident #9) 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.</p> <p>Findings include:</p> <p>A review of the facility policy titled Transfer to Hospital Guide occurred on 05/30/24. This policy, dated, 02/19/23, stated, . Notify the resident, family member or legal representative of the transfer in a timely manner. Document completion in the Medical Record.</p> <p>Review of Resident #9's medical record occurred on all days of survey and identified a hospital transfer on 11/07/23. The medical record lacked documentation the facility provided the resident and/or representative with a written transfer notice.</p> <p>During an interview on the afternoon of 05/29/24 an administrative staff member (#1) confirmed the facility failed to provide written notice of a transfer to the family/representative.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45873</p> <p>Based on observation and review of facility policy, the facility failed to follow professional standards of practice for 1 of 1 resident (#17) observed for insulin preparation and administrations. Failure to prime the insulin pens correctly may result in residents receiving an inaccurate dose.</p> <p>Findings include:</p> <p>Review of the policy Medication: Insulin Administration, Insulin Pens, Insulin Pumps occurred on 05/30/24. This policy, revised December 2023, stated . Insulin Pen . Turn the dosage knob to '2' units to prime the pen. Holding the pen with the needle pointing upwards, press the button until at least a drop in insulin appears.</p> <p>Observation on 05/29/24 at 11:30 a.m. showed a nurse (#3) prepared Resident #17's Humalog insulin pen for administration. The nurse (#3) dialed the insulin pen to the prescribed units without priming the insulin pen.</p> <p>The nurse (#3) failed to prime the insulin pen as per facility policy.</p> <p>During an interview on 05/29/24 at 4:52 p.m., an administrative staff member (#1) confirmed it is her expectation that staff prime insulin pens per policy.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28611</p> <p>1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure an environment free of accident hazards for 1 of 1 sampled resident (Resident #27) who experienced a burn related to hot coffee. Failure to ensure appropriate coffee/water temperatures resulted in Resident #27 sustaining a burn and placed all residents at risk for serious burns/injuries.</p> <p>During the on-site recertification survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 05/28/24 at 6:20 p.m. The IJ resulted from temperature readings obtained from the coffee/hot water machine, a lack of temperature monitoring by staff, and an injury to a resident. This finding placed residents in immediate danger due to hot temperatures and the potential for serious burns.</p> <p>*05/28/24 at 6:50 p.m. The survey team notified the administrator and director of nursing of the IJ situation, provided the IJ template, and requested a plan for removal of the immediate jeopardy.</p> <p>*05/29/24 at 10:15 a.m. The survey team reviewed and accepted the facility's removal plan for the IJ.</p> <p>The removal plan contained the following:</p> <p>*Immediately disconnected power to coffee machines, coffee and hot water with temperatures at or below 150 degrees were made available in carafes</p> <p>*Implement focus audit to monitor coffee and hot water temperatures twice daily in carafes</p> <p>*Education was provided to dietary and nursing staff currently working and staff not present will be trained on their next scheduled shift</p> <p>*Message sent to nursing staff to review the policy related to hot liquids</p> <p>*06/05/24 The survey team verified the implementation of the removal plan as of 05/28/24 and the IJ removal. The deficient practice remained at an G scope and severity following the removal of the immediate jeopardy.</p> <p>Findings include:</p> <p>Review of the facility policy titled Hot Liquids - Food and Nutrition Services occurred on 05/29/24. This policy, revised 04/19/24, stated, . When self-service of hot liquids are available in the dining room: a. Consider serving liquids at temperatures at or below 150 degrees Fahrenheit . When serving hot liquids to residents with behavior or medical conditions that put them at increased risk for spills: . Allow hot liquids to cool before serving to reduce the risk and/or severity of burns. c. Add ice to hot liquids before serving, if resident agrees .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #27's medical record occurred on 05/28/24. Nursing progress notes included the following:</p> <p>* 05/24/24 at 5:47 p.m. Resident was sitting in dining room eating her meal and drinking coffee. Resident spilled her hot coffee into her lap. Nurse observed the incident and immediately pulled her polyester pants away from her legs and got her back to her room and took the pants off. Cold washcloths were placed over her legs for about 10 minutes. Right inner thigh, labia, and left inner thigh were affected. Red tissue is observed with no blistering. Resident c/o [complained of] the cold washcloths but has since denied c/o pain since the initial incident. Burn boundaries outlined with a sharpie. Burn areas to [NAME] for measurement. On-call provider [Doctor's name] notified @ [at] 1710 [5:10 p.m.] and new orders were received:</p> <ol style="list-style-type: none"> Daily dressing changes to affected areas with Silvadene and Telfa until resolved. Monitor for blistering and s/s [signs and symptoms] of complications; call provider if they appear. <p>Silvadene obtained from hospital. Son/POA [power of attorney] (name) was notified of incident and verbalized understanding of new POC [plan of care] @ 1720 [5:20 p.m.]. RRVH [Red River Valley Hospice] notified @ 1755 [5:55 p.m.]. DON [Director of Nursing] notified @ 1725 [5:25 p.m.].</p> <p>* 05/27/2024 12:14 p.m. Resident has 2nd degree burns to right and left inner thighs, and 1st degree to the right labia. Right inner thigh has a ruptured bullae [blister] measuring 2 cm [centimeters] in diameter and is 0.1 cm deep. Intact continuous serous filled bullae trace the inferior border of the right inner thigh burn. Small ruptured bullae measuring 1 cm x 0.3 cm x 0.1 cm to the left inner thigh is observed.</p> <p>Temperatures obtained by the survey team on 05/28/24 showed the following:</p> <p>*At 2:30 p.m. in the first floor dining room, the temperature of the coffee (dispensed from an automatic machine) was 178 degrees Fahrenheit (F). A sign posted on the coffee/hot water machine identified staff were to add one teaspoon of ice or wait three minutes before serving coffee/hot water to residents in order to avoid burns.</p> <p>*At 5:23 p.m. in the second floor dining room, the coffee and hot water (dispensed from an automatic machine) measured 180 degrees F and 181 degrees F, respectively. A sign posted on the coffee/hot water machine also indicated to add a teaspoon of ice or wait three minutes before serving. Observation showed an unidentified dietary aide brought two cups of coffee and one cup of tea to residents, but failed to add ice and/or wait three minutes to serve the hot liquids.</p> <p>During an interview on 05/28/24 at 6:05 p.m., a dietary supervisor (#6) verified staff do not complete routine or random temperature checks on the hot water/coffee machines.</p> <p>2. Based on observation, record review, policy review, and staff interviews, the facility failed to provide adequate assistance for 1 of 4 sampled residents (Resident #27) observed during a sit-to-stand mechanical lift transfer. Failure to ensure staff properly used assistive devices placed residents at risk for accidents and injury.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Findings include:</p> <p>Review of the facility policy titled Mobility, Support and Positioning occurred on 05/30/24. This policy, dated 05/06/24, stated, . Sit-to-Stand For residents who demonstrate leg strength for weight bearing and are able to hold their torso in an upright position . must have some upper body strength. Must be able to cognitively follow cues and cooperate with procedure.</p> <p>Review of Resident #27's medical record occurred on all days of survey and included the diagnoses of dementia. The current care plan stated, [Resident #27's name] has a history of falling. Assist x2 w/ [with] pivot transfer. Standing lift/Hoyer [mechanical lift] assist of 2 per nurse's discretion.</p> <p>Observation on 05/29/24 at 10:55 a.m. showed a certified nurse aide (CNA) (#5) and a licensed nurse (#3) transferred Resident #27 from the wheelchair to the bathroom using the sit to stand mechanical lift. The resident had a difficult time holding onto the lift handles and hung from the harness in a semi-seated position. During the transfer the harness sling slid up the resident's back to the axilla area causing the resident's elbows to bow outward above the shoulders.</p> <p>During an interview on 05/30/24 at 12:03 p.m., an administrative nurse (#1) agreed residents should be able to bear weight while using the sit-to-stand lift.</p> <p>40489</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>28611</p> <p>Based on review of daily staffing information and staff interview, the facility failed to post daily staffing data for all shifts on 9 of 15 days reviewed (May 14-28, 2024). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift.</p> <p>Findings include:</p> <p>Review of daily staffing data from May 14-28, 2024 showed on nine of the days, staff failed to post the number of staff working on six day shifts, six evening shifts, and one night shift.</p> <p>During an interview on the afternoon of 05/29/24, an administrative staff member (#1) confirmed staff failed to post staffing data for each shift on some of the days.</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>40489</p> <p>45873</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 14 sampled resident's (#17, #21, and #27) observed during medication administration, resident cares, and wound cares. Failure to follow infection control standards related to hand hygiene and glove use has the potential to transmit infections to residents, staff, and visitors.</p> <p>Findings include:</p> <p>Review of the facility policy titled Hand Hygiene occurred on 05/30/24. This policy, dated 03/29/22, stated, . Policy: . All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. All employees in patient care areas . will adhere to the '4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene'. 1. Entering . After contact with a patient's non-intact skin, wounds . If gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves .</p> <p>- Observation on 05/28/24 at 5:35 p.m. showed a certified nurse aide (CNA) (#4) donned gloves and assisted Resident #21 off the toilet with a sit to stand lift. The CNA stood the resident, performed perineal cares, removed gloves and without performing hand hygiene donned new gloves. The CNA (#4) applied a clean brief, pulled up the resident's pants and removed the gloves. Without performing hand hygiene, the CNA positioned Resident #21 in the wheelchair, offered the resident a drink of water, and pushed the resident's wheelchair to the dining room.</p> <p>The CNA (#4) failed to remove gloves and perform hand hygiene after performing perineal cares and before performing other tasks.</p> <p>- Observation on 05/29/24 at 10:55 a.m. showed a nurse (#3) donned gloves and performed perineal care for Resident #27. The nurse removed the gloves and without performing hand hygiene donned new gloves and removed the soiled dressing from the wound on the resident's left leg. Without changing gloves or performing hand hygiene, the nurse cleansed the wound, and applied the new dressing. The nurse removed the glove on the right hand and without performing hand hygiene, placed another glove on the right hand, applied a prescription ointment to the glove and applied the silvadene cream to the resident's right and left thighs and right perineal area. The nurse then removed both gloves and performed hand hygiene.</p> <p>The nurse (#3) failed to remove gloves and perform hand hygiene before and after incontinent cares, dressing change, and applying an ointment.</p> <p>(continued on next page)</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>- Observation on 05/29/24 at 11:30 a.m. showed a nurse (#3) donned gloves, and scanned Resident #17's Dexcom (wearable device that tracks blood glucose levels). Without removing the gloves, the nurse exited the room, placed the monitor back into the medication cart, and typed on the computer. With the same gloves on, the nurse (#3) gathered supplies for Resident #17's insulin administration from the medication cart, and administered the insulin. The nurse exited the room, placed the insulin supplies back into the medication cart, removed the gloves, and without performing hand hygiene, typed on the computer.</p> <p>The nurse (#3) failed to remove the gloves and perform hand hygiene prior to exiting the room, after performing the blood sugar scan, and before and after the insulin administration.</p> <p>During an interview on 05/30/24 at 10:45 a.m., an administrative nurse (#1) stated she expected staff to follow infection control guidelines regarding hand hygiene and glove use.</p>		