STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355061	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Hillsboro Care Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the care plan to reflect the current status for 1 of 5 sampled residents (Resident #30) reviewed for unnecessary medications. Failure to revise the care plan limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Care Plan occurred on 06/26/25. This policy, dated 12/02/24, stated, . The plan of care will be modified to reflect the care currently required/provided for the resident. Review of Resident #30's medical record occurred on all days of survey. Physician's orders identified Lasix (diuretic) 40 milligrams twice a day and Tramadol (opioid pain medication) 50 milligrams twice a day and as needed for pain. Resident #30's care plan failed to identify problems and interventions due to the use of diuretic and opioid pain medication. During an interview on 06/26/25 at 11:00 a.m., an administrative staff member (#1) confirmed staff failed to update Resident #30's care plan.

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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(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. Based on observation, record review, review of facility policy, professional reference, and staff interview, the facility failed to follow professional standards of practice for medication administration for 1 of 1 supplemental resident (Resident #11). Failure to correctly administer and document medication administration may result in errors and/or adverse effects for the resident. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 832, stated, Practice Guidelines . Administering Medications . Administer only medications personally prepared. Review of the facility policy titled Medication: Administration Including Scheduling and Medication Aides occurred on 06/26/25. This policy, dated April 2025, stated . Purpose: . To administer medications correctly and in a timely manner . Medications are administered to the resident according to the 'Six Rights.' . Administer only those medications that you prepared. Do not ask anyone else to administer medications that you prepared. Do not administer medications prepared by anyone else. Observation on 06/26/25 at 9:20 a.m. identified a medication aide (MA) (#3) obtained a cup of medications and a cup of applesauce from the drawer of the medication cart and handed them to a nurse (#4). The nurse asked, Are these [Resident #11's name]? The MA (#3) replied Yes, and the nurse (#4) proceeded to Resident #11's room and administered the medications. The MA (#3) confirmed she dished Resident #11's medications earlier that morning and attempted to administer twice. Resident #11's electronic medication administration record (eMAR) identified the following medications documented as administered by the MA (#3) on 06/26/25 at 9:48 a.m.: *Aspirin 81 milligrams (mg) tablet *Bactrim DS (antibiotic) 800-160 mg tablet *Duloxetine (antidepressant) 60 mg capsule *Prevagen (memory loss) 10 mg capsule *Rivastigmine tartrate (memory loss) 6 mg capsule *Senna (laxative) 8.6 mg tablet *Seroquel (antipsychotic) 25 mg tablet *Vitamin B-12 1,000 micrograms (mcg) tablet *Vitamin D3 50 mcg tablet During an interview on 06/26/25 at 11:00 a.m., an administrative staff member (#1) confirmed she expected medication aides and nurses to administer medications they personally prepared.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and resident and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 2 sampled residents (Resident #30) reviewed for falls. Failure to lock tub chair brakes placed residents at risk for falls and/or injury. Findings include: Review of the facility policy titled Fall Risk & Prevention: Standards of Care occurred on 06/26/25. This policy, dated February 2024, stated, . Procedure: Transfer/Locomotion: 2. Follow care-plan for level assistance required . 4. Lock brakes on wheelchair for pivot transfer. Review of the facility policy titled Falls Resource Packet occurred on 06/26/25. This policy, dated April 2025, stated, . Fall reduction efforts include . Safe and proper use of any assistive device (wheelchair, walker, etc.) and not to use moveable items, (furniture, etc.) for balance or transfers . During an interview on 06/23/25 at 5:30 p.m., Resident #30 stated he had fallen in the shower room. They were helping me to stand, and I wasn't quite out of the [tub] chair, and it rolled back. I fell on my right side. Review of Resident #30's medical record occurred on all days of survey. The care plan stated, . ADL [activities of daily living] Deficit r/t [related to] diagnosis of weakness . minimum of 1 assist with transfers and ambulation . [Resident] is at risk for falls due to: history of frequent falling prior to move-in . A Resident Event Review, dated 06/11/25, identified Resident #30 fell on [DATE] at 10:00 a.m. and stated, breaks [sic] were not locked on tub chair. Resident attempted to transfer from tub chair to wheelchair. Tub chair rolled out from under resident and resident fell. Education provided to CNA [certified nurse aide] by charge nurse at time of event. No residual injury occurred from fall. During an interview on 06/25/25 at 4:00 p.m., an administrative staff member (#1) confirmed the CNA failed to lock the tub chair.