STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355051	A. BUILDING _____ B. WING _____	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	950 DAKOTA AVE HATTON, ND 58240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 03/16/15 and completed on 03/18/15, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	**Plan of Correction F0329** 1. The psychiatrist reviewed Resident #6's medical record and discontinued the use of Ambien for this resident. 2. Residents who receive a sedative/hypnotic medication have the potential to be affected. Currently, no residents receive Ambien or another sedative/hypnotic medication.	3/23/15 3/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	4/10/15

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.

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F 329	Continued From page 1 Based on record review, review of professional reference and the State Operations Manual (SOM), and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 1 sampled resident (Resident #6) receiving medication to treat insomnia. Failure to periodically attempt a gradual dose reduction (GDR) or document the clinical contraindication of a GDR placed Resident #6 at risk of receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: "Nursing 2015 Drug Handbook," 35th edition, Lippincott, Williams & Wilkins, Pennsylvania, pages 1481 and 1483, stated regarding Ambien, "Indications & Dosages: Short-term management of insomnia . . . Nursing Considerations: . . .Use drug only for short-term management of insomnia, usually 7 to 10 days . . ." The SOM, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, page 358, stated, Tapering Considerations Specific to Sedatives/Hypnotics: For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included insomnia, depression, and dementia. Current medications included Ambien (hypnotic) 5 milligrams (mg) at bedtime, Trazodone (antidepressant used as a sleep aid) 50 mg at	F 329	3. Residents who receive a sedative/hypnotic medication will be seen and reviewed by psychiatrist at least every 3 months. If a resident refuses to see the psychiatrist, the resident will be seen and reviewed by their primary physician at least every 2 months. The review will address a gradual dose reduction (GDR) or identify why a GDR is clinically contraindicated. The written review, Progress Note, will be placed in the resident's medical record. 4. A monthly audit will be conducted by the DON on all residents who receive a sedative/hypnotic medication. The audit will include the medication and dosage; adequate indications for the use of the medication; presence of adverse consequences and when the dose was last increased or decreased. QA Committee will review the audits monthly for compliance.	Ongoing Compliance Date: 3/23/15 Completion Date: 1 year Audit 4/01/16 Same as above

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F 329	Continued From page 2 bedtime. Cymbalta (antidepressant) 120 mg daily, Wellbutrin (antidepressant) 300 mg daily, and Abilify (antipsychotic) 2.5 mg daily. Resident #6's quarterly Minimum Data Set (MDS), dated, 12/14/14, identified feeling down, depressed, or hopeless; trouble falling or staying asleep, or sleeping too much; feeling bad about herself; and trouble concentrating on things nearly every day. Review of Resident #6's physician notes, psychiatric notes, and consultant pharmacist notes identified the following: *07/31/14 (psychiatry) - ". . . No changes in psych meds [medications]." *08/20/14, 10/15/14, 12/10/14, and 02/04/15 - seen by primary care physician and no changes were made to Resident #6's medications. *02/07/15 (psychiatry - seven months after the last psychiatry note) - ". . . Sleep-I don't sleep good. . . . TREATMENT/PLAN RECOMMENDATIONS: . . . if depression worsens [increase] abilify first (5 mg)." The above notes identified Resident #6's use of Ambien and stated the benefits outweigh the risks for a GDR even though the resident stated she slept "terrible". The facility failed to attempt a GDR or identify why the GDR is clinically contraindicated. During an interview on the afternoon of 03/18/15, an administrative nurse (#3) stated the facility failed to address Resident #6's Ambien use for seven months.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 3 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to properly cool potentially hazardous food in a safe and sanitary manner for 1 of 2 meals observed. Failure to follow safe food sanitation practices has the potential to increase the risk of food borne illness and can affect all residents who eat the improperly cooled food item. Findings include: Review of a facility temperature log form titled "Cooling Potentially Hazardous Foods to Correct Temperature - roasts and turkeys" occurred on the evening of 03/16/15. The log form included the following policy/procedure: "Cooked foods must be cooled to from 140 to 70 degrees in 2 hours and to 41 degrees in an additional 4 hours (6 hours total), Cut into smaller pieces, Spread pieces out to allow plenty of room for air to circulate, Leave uncovered, Put in freezer, Please check and record temperature approximately every hour until 41 degree temperature is reached, All cuts of meat should be checked. Record temps [temperatures] as a range. If	F 371	**Plan of Correction F371** 1. Facility will diligently follow revised policy and procedures on properly cooling potentially hazardous food. Facility policy and procedures have been revised to meet the Two Stage Cooling Process identified in the North Dakota Red Sanitation Book and the NRAEF ServSafe 6th Edition, which includes the 2013 Food Code guidance regarding the two stage cooling process. 2. All residents have the potential to be affected by failure to properly cool potentially hazardous food. Facility will follow revised policy and procedures as described above. 3. All cooks and cook helpers have been trained on the revised policy and procedures. Our facility's Dietary Consultant will do additional training for our cooks and cook helpers.	4/03/15 Ongoing 4/03/15 4/16/15

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F 371	Continued From page 4 drippings are to be used for gravy, it must also be temped [temperature measured]. Record temperature of drippings separately from meat, If not cooling quickly enough, meat should be cut into smaller pieces, When all cuts and drippings are cooled to 41 degrees or below, move to cooler and cover, If food does not reach correct temperature in allotted time, it must be discarded . . . ." This log prompted recording of date, food, time, and temperature. An initial tour of the kitchen occurred on 03/16/15 at 6:30 p.m. Observation of the walk-in cooler showed a metal pan containing three, approximately five pound cooked corned beef brisket roasts stored on the top shelf of a cart. Dietary staff had lined the pan with a plastic oven bag, layered the roasts within meat drippings/water, and covered the pan with aluminum foil. A second pan which was stored on another shelf of the cart contained one, approximately 5 pound roast. Dietary staff stored the roast as above. During an interview conducted on the initial tour, a cook (#1) stated she placed the roasts in the walk-in cooler around 4:00 p.m. (two and a half hours prior). An administrative dietary staff member (#2) entered the kitchen around 6:50 p.m. and placed the cart in the walk-in freezer. Upon request, the staff member (#2) checked the temperatures of the roasts. A roast in the first pan measured at 80 degrees Fahrenheit (F) and a roast in the second pan measured 110 degrees F. The staff member (#2) made adjustments to the cooling process per surveyor request so the roasts cooled to the proper temperature in the required amount of time. At 7:30 p.m., the dietary staff member stated the roasts and meat	F 371	Facility's Certified Dietary Manager (CDM) will review weekly the daily Cooling Temperature Logs. 4. Monthly audits of cooled foods that have the potential to be hazardous will be conducted by the CDM. QA Committee will review audits monthly to ensure revised policy and procedures are being followed.	4/03/15 And Ongoing Compliance Date: 4/03/15 Completion Date: 1 year audit 4/01/16 Same as above

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F 371	Continued From page 5 drippings/water had cooled to less than 41 degrees F within an acceptable alternative cooling time of four hours. During an interview on the evening of 03/16/15 and the afternoon of 03/18/15, the administrative dietary staff member (#2) confirmed dietary staff failed to complete the cooling temperature procedure as per facility policy.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, the facility's consulting pharmacist failed to recognize and report medication regimen irregularities for 1 of 1 sampled resident (Resident #6) on a hypnotic. Failure to identify irregularities and recommend a gradual dose reduction (GDR) may result in residents receiving unnecessary medications. Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnoses included	F 428	**Plan of Correction F428** 1. Facility's psychiatrist reviewed Resident #6's medical records and discontinued the use of Ambien for this resident. 2. All residents who receive a sedative/hypnotic medication have the potential to be affected. Currently, no residents receive Ambien or another sedative/hypnotic medication. 3. Our pharmacy consultant reviews all residents' medication regimen monthly. Our pharmacy consultant will review monthly the psychiatrist and physician progress notes, along with current medications, and will identify when a gradual dose	3/23/15 3/23/15 Ongoing

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F 428	Continued From page 6 insomnia, depression, and dementia. Current medications included Ambien (a hypnotic) 5 milligrams (mg) at bedtime (initiated 06/21/11). A "Pharmacy Review," dated 03/16/15, stated, "Review . . . zolpidem [Ambien] with regards to gradual dosage reduction." Prior to this, the medical record lacked evidence the pharmacist recommended a GDR for zolpidem [Ambien] from March 2014 until March 16, 2015. The pharmacist noted no problems from July 2014 until March 16, 2015.	F 428	reduction (GDR) is recommended. GDR recommendations will be identified on the monthly pharmacy review. Our pharmacy consultant will report any GDR recommendation to a resident's physician and Director of Nursing. Resident's physician and DON will act upon the pharmacy consultant's recommendation. 4. The DON will conduct monthly audits on all residents who receive a sedative/hypnotic medication, using the pharmacy consultant's monthly reviews. Audits will include name of the sedative/hypnotic medication, the dosage, when the dose was last increased or decreased, when the last GDR was attempted or recommended and what action was taken by resident's physician and DON. QA Committee will review audits monthly for compliance.	Compliance Date: 3/23/15 Completion Date: 1 year audit 4/01/16 Same as above