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 _____	04/20/2011

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 April 18, 2011 and completed on April 20, 2011, the sample included two (2) residents for completed review, eight (8) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop and implement a comprehensive plan of care for 1 of 1 sampled	F 279	1(A) Aggressive Behaviors Resident #9's aggressive behaviors towards Resident #12 occur during meal times. Resident #9 becomes upset and agitated when Resident #12 doesn't eat or eat as much as she thinks he should. We separated Resident #9 and Resident #12 during meal times; they eat at different tables. Both residents were accepting of this and Resident #9 showed no aggression towards Resident #12 with this eating arrangement. This intervention is included in Resident #9's care plan.	4/25/11 4/25/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Meckel by Cynthia Meckel — TITLE: Administrator — (X6) DATE: 5/9/11

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 279	Continued From page 1 resident (Resident #9) with aggressive behaviors and unsafe transfers towards another resident (Resident #12). Failure to develop and implement the resident's careplan with goals and preventative measures, for the reoccurring problems, limits the facility staff's ability to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, and could result/contribute to an adverse event for both residents. Findings include: Review of Resident #9's medical record occurred on April 19-20, 2010. The resident's diagnoses included dementia with behavioral disturbances, psychotic features, paranoia, anxiety, and depression. The resident's current medication administration record, dated April 2011, identified Risperdal (anti-psychotic) 0.5 milligrams (mg) daily (increased from 0.25 mg on 04/15/11) and Zoloft (anti-depressant) 100 mg daily. Resident #9's most recent Minimum Data Set (MDS), dated 04/07/11, indicated delusions and a Brief Interview for Mental Status score of 6 signifying severe cognitive impairment. The MDS further showed the resident was ambulatory and independent with all activities of daily living, except bathing. Resident #9's careplan, dated 02/15/11, stated "Problem: Concern over husband [Resident #12]. Goal: 1. Accept [Resident #12's] limitations. 2. Feel comfortable that [Resident #12] is being well cared for. Approach: 1. Family aware. 2. Reassure when agitated. 3. Therapeutic fibbing. 4. Meds & psych as scheduled. 5. Support from Hospice. 6. Document behaviors slapping,	F 279	1(B) Unsafe Transfers Resident #9's care plan includes the following: ▪ Large laminated sign in room that reminds Resident #9 not to assist Resident #12 with transfers from recliner or wheelchair ▪ More frequent checks on Resident #12 by CNAs & Nurses so staff meets his needs and wants before Resident #9 tries to meet his needs/wants ▪ Verbal reminders to Resident #9 each time CNA & Nurse are in room providing cares to Resident #12 not to try and transfer Resident #12, but to call for help These interventions are being followed by staff. Resident #12 died on April 30, 2011. 2. DON and SSD re-evaluated all other residents and no other resident exhibits aggressive behaviors to any other resident or tries to unsafely assist/transfer another resident.	4/25/11 4/25/11 4/29/11

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F 279	Continued From page 2 striking out @ [Resident #12] or staff. 7. Monitor mood, depression, anxiety, irritability." Review of Resident #9's nurses notes showed 14 different entries between 01/04/11 and 04/12/11 relating to inappropriate physical behaviors including hitting, slapping, and unsafe transfers by Resident #9 to Resident #12. An interview with an administrative staff member (#2) occurred the morning of 04/20/11. The staff member agreed Resident #9's careplan lacked specific interventions regarding the resident's aggressive behaviors and unsafe transfers of Resident #12. Resident #9's careplan failed to identify individualized behavioral interventions for Resident #9 to prevent or deter negative behaviors towards Resident #12 and failed to identify individualized interventions to prevent unsafe transfers of Resident #12 who had a history of falls. This has the potential to cause or contribute harm to both Resident #9 and #12.	F 279	3. DON will re-educate Inter-Disciplinary Team on the following: ▪ When resident-to-resident aggressive behaviors occur or unsafe assisting/ transfers occur, both residents' care plans must appropriately address the behaviors – both the resident that exhibits the behavior and the resident that is subject to the behavior. This is especially important when involved residents are husband and wife, like Resident #9 and Resident #12. ▪ Interventions must be monitored to see if they are effective for both residents and if not, new interventions will be tried/implemented. 4. DON and SSD will weekly review/audit residents' behaviors to ensure they are properly care planned and interventions are being implemented. DON and SSD will also look for additional interventions that could be tried/implemented. Weekly audits will be submitted to Quality Assurance Committee for review. Committee meets monthly and will review audits.	5/17/11 Weekly starting 5/9/11 for 6 months ending 10/31/11