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 _____	09/05/2024

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 The standard Medicare/Medicaid recertification survey started on 09/03/24 and concluded on 09/05/23.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		10/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2024

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 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: 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 1of 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.	F 623	1. DON will send Notice of Transfer or Discharge for Resident #4 to the State LTC Omubsman today (September 19, 2024) via email. 2. Other residents having the potential to be affected by this deficient practice are residents who are being transferred or discharged for any of the reasons listed in the Notice of Transfer or Discharge form. We will review all resident transfers and discharges for the last 30 days (appeal time frame) to ensure the Notice of Transfer or Discharge forms are sent to	

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F 623	Continued From page 3 Findings include: 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 . . ." 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. 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.	F 623	the State LTC Ombudsman and to families. 3. To protect residents in similar situations, DON will develop a Notice of Transfer or Discharge guidebook and checklist to be used by LPNs and RNs when transferring or discharging a resident. The guidebook and checklist will include when to send the form to the State LTC Oumbudsman and how to complete the form. DON will re-educate and train the nurses on the correct procedures when transferring or discharging a resident, including when to send notices to the State LTC Ombudsman and resident's representative. 4. DON will audit all transfer and discharge notices for six (6) months to ensure notices are being properly and timely sent to the State LTC Ombudsman and to resident's representative. DON will evaluate each notice for the effectiveness of the guide/checklist and re-education and training of the nurses. QAPI Committee will review weekly the audits for the first three (3) months and will review the audits monthly for the last three (3) months.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		10/10/24

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F 625	Continued From page 4 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: 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.	F 625	1. This deficient practice impacted Resident #4 and the bed hold time period has expired. We will provide this resident with a completed copy of his Bed Hold form to include the rate per day for holding his bed. 2. Other residents having the potential to be affected by this deficient practice are	

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F 625	Continued From page 5 Findings include: 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. . . ." 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. 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.	F 625	residents who are being transferred or discharged and are requesting a bed hold. We will review all bed hold forms for residents transferring or discharging within the past 45 days and if their daily rate was not included on the form, we will provide a completed form showing their daily rate for holding their beds. 3. DON will develop a bed hold guidebook and checklist to be used by LPNs and RNs when a resident requests a bed hold when transferring or discharging. DON will re-educate and train LPNs and RNs on the correct procedure when a transferring or discharging resident is requesting a bed hold, including the bed hold amount. 4. DON or DON's designee will audit every bed hold notice for six (6) months to ensure notices are being fully completed, including the bed hold amount. QAPI Committee will review the audits weekly for the first three (3) months and review the audits monthly for the last three (3) months.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 637		10/10/24

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F 637	Continued From page 6 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: 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. Findings include: 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. . . ." 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.	F 637	1. Resident #35 will have a comprehensive MDS assessment completed to identify the significant change (resident admitted to hospice). 2. Other residents who have the potential to be impacted by this deficient practice are any residents being admitted to hospice. We will review all residents on hospice to see if a significant change assessment was completed. If we did not complete a significant change assessment for a resident on hospice we will complete a significant change assessment for that resident. 3. MDS Coordinator/Manager will review the RAI manual on requirements for significant changes, including when residents are admitted to hospice. MDS Coordinator/Manager will make every effort to attend an in-person MDS assessment training. 4. DON will audit all MDS schedules for residents being admitted to hospice for six (6) months.	

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F 637	Continued From page 7 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.	F 637	DON will evaluate each MDS scheudle to ensure a signficant change MDS assessment was completed and completed timely. QAPI Committee will review audits monthly for six (6) months.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: 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. Findings include: SECTION I: ACTIVE DIAGNOSES 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	F 641	1. The corrective action for Resident #12 will be that the MDS Coordinator/Manager will complete a MDS modification to identify PTSD as a current diagnosis on assessment that has an ARD date of July 15, 2024. The corrective action for Resident #4 will be that the MDS Coordinator/Manager will complete a MDS modification to include use of an antiplatlet on assesdment that has an ARD date of June 25, 2024. The corrective action for Resident #32 will be that the MDS Coordinator/Manager will complete a MDS modification to include use of an antbiotic on assessment that has an ARD date of August 6, 2024. 2. All residents have the potential to be impacted by MDS coding errors. We will	10/10/24

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F 641	Continued From page 8 status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. . . ." 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. Resident #12's annual MDS, dated 07/15/24, lacked identification of the PTSD diagnosis. SECTION N: MEDICATIONS 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. . . ." - 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 06/25/24, lacked coding of the antiplatelet. During an interview on 09/05/24 at 8:30 a.m., an	F 641	review the most current MDS assessments for all residents to ensure that (1) PTSD was coded correctly for residents diagnosed with PTDS, (2) use of antiplatlets was coded correctly for residents prescribed antiplatlets and (3) use of antibiotics was coded correctly for residents prescribed antibiotics. If we did not correctly code for PTSD, antiplatlets or antibiotics, we will complete modifications of the MDS assessments to include the correct coding. 3. MDS Coordinator/Manager will do additional training on Healthcare Academy on MDS sections I and N. MDS Coordinator will review sections I and N of the RAI manual. MDS Coordinator will make every effect to attend an in-person MDS assessment training. 4. After completion of a resident's MDS but prior to submission, DON will review/audit all MDS assessments for compliance with sections I and N for three (3) months and will review/audit fifty percent (50%) of MDS assessments for the last three (3) months of the audit period. QAPI Committee will review audits monthly for six (6) months.	

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F 641	Continued From page 9 administrative nurse (#7) confirmed staff failed to code the MDS correctly for Resident #4. - 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 08/06/24, lacked coding of the antibiotic. 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.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		10/10/24

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F 657	Continued From page 10 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: 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. Findings include: 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. . . ." - Review of Resident #4's medical record occurred on all days of survey. The progress notes identified Resident #4 returned from a	F 657	1. The corrective action for Resident #4 is that the Care Plan Team (IDT) will adjust the resident's care plan to reflect the new diagnosis of STEMI and medication chanages post hospitalization which will include identifying problems, goals and interventions. The corrective action for Resident #13 is that the Care Plan Team will adjust the resident's care plan to reflect the use of insulin and a blood thinner which will include identifying problems, goals and interventions. The corrective action for Resident #15 is that the Care Plan Team will adjust the resident's care plan to reflect the risk for wandering and exit-seeking behaviors which will include identifying problems, goals and interventions. The corrective action for Resident #30 is that the Care Plan Team will adjust the resident's care plan to reflect the electiion of hospice and diagnosis of liver cancer which will include identifying problems, goals and interventions. The corrective action for Resident #32 is that the Care Plan Team will adjust the	

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F 657	Continued From page 11 hospitalization on 06/20/24 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. 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. - 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. Resident #13's care plan lacked a problem, goal, or interventions related to the resident taking insulin and a blood thinner. - 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. Resident #15's care plan lacked a problem, goal, and interventions related to wandering/exit seeking behaviors. - 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.	F 657	resident's care plan to reflect the use of a long term antibiotics which will include identifying problems, goals and interventions. The corrective plan for Resident #35 is that the Care Plan Team will adjust the resident's care plan to reflect the election and admission to hospice which will include identifying problems, goals and interventions. 2. All residents have the potential to be impacted by these deficient practices. We will review all care plans for all residents to ensure the plans address residents' cardiac functions/conditions, insulin and blood thinners, wandering and exit-seeking behaviors, election and admission to hospice and long term use of antibiotics. If we find any applicable care plan is missing this required data/information, we will revise the care plan immediately to include the mising data/information. 3. The main cause of these deficient practices is that our nurses don't always update residents' care plans. DON will provide training to LPNs and RNs regarding needed revisions to residents' care plans. 4. Care Plan Team will audit residents' care plans for six (6) months to ensure residents with hospital readmissions, medication updates, long term antibiotics,	

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	355051	A. BUILDING _____ B. WING _____	09/05/2024

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F 657	Continued From page 12 Resident #30's care plan lacked a problem, goal, or interventions related to hospice and the diagnosis of liver cancer. 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. - 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. Resident #32's care plan lacked a problem, goal, and interventions related to long term use of an antibiotic. - 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. Resident #35's care plan lacked a problem, goal, and interventions related to hospice services. 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.	F 657	election of hospice services and risk for elopements have problems, goals and interventions identified and addressed in their care plans. We will audit 5 residents weekly for one (1) month, 5 residents monthly for two (2) months and 3 residents monthly for three (3) months. QAPI Committee will review the audits monthly for six (6) months. IF QAPI Committee, upon review of the audits, identifies any issues the audits will continue until the QAPI Committee is satisfied with compliance.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		10/10/24

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F 689	Continued From page 13 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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. Findings include: Review of the facility policy titled "MISSING RESIDENT" occurred on 09/05/24. This policy, dated November 2018, stated, ". . . Hatton 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. . . ." 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 . . ." The medical record showed the facility admitted	F 689	1. Resident #28 had been assessed/evaluated for elopement risk on July 20 and a Wanderguard was placed on her wrist. We assessed Resident #28 for elopement risk on September 30 and she remains an elopement risk and her Wanderguard remains in place. Her Wanderguard is monitored/checked weekly. 2. All residents who have the ability to move themselves have the potential to be impacted by this deficient practice. 3. All residents currently residing at HPV will be assessed for elopement risk. Upon admission a resident will be assessed for elopement risk. Every resident will be assessed quarterly for elopement risk or sooner if we see exit-seeking behaviors or hear verbalization of wanting to leave the facility. DON or DON Designee will provide re-education and training for all staff on behaviors and verbalizations that may indicate an elopement risk and to timely report any behaviors or verbalizaions to the charge nurse or DON. The charge nurse will immediately put interventions in	

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F 689	Continued From page 14 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. Resident #28's progress notes included the following: * 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 . . ." * 10/21/23 at 7:29 a.m. ". . . Resident . . . stating 'I want to get out of here!' . . ." * 10/21/23 at 10:32 a.m. ". . . resident . . . insisting that she is 'leaving, going somewhere else'. . . . She paced around the facility . . ." * 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' . . ." * 12/12/23 at 4:53 p.m. ". . . [Resident #28's name] was putting her belongings out in the hallway. . . ." * 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. . . ." 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.	F 689	place. 4. DON or DON Designee will audit all residents' charts monthly for six (6) months to ensure elopement assessments, as described above. QAPI Committee will review audits monthly for six (6) months.	

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F 689	Continued From page 15 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.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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	F 812	1. The corrective action for the condensation from the two fans in the walk-in freezer is to correctly locate the drip pan under the fans to safely collect any condensation. The steak strips were immediately thrown away. The drip pan	10/10/24

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F 812	Continued From page 16 contamination may result in a foodborne illness or adverse effects for residents, visitors, and staff. Findings include: 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. . . ." Observation of the kitchen on 09/03/24 at 11:45 a.m. showed the following: - Walk-in Freezer: Two fans with icicles dripping onto an open pail of steak strips. - 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. 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.	F 812	will be emptied and cleaned regularly and correctly placed back under the two fans. The corrective action for the water running down the wall by the kitchen air conditioning unit is to have this issue fixed by the company that installed the air conditioning unit. 2. All residents could be impacted by these deficient practices. 3. Ensuring the drip pan is in the correct location under the two fans in the walk-in freezer will be added to the AM cook's daily checklist. Also added to the daily checklist will be for the AM cook to clean out the drip pan at least weekly. No systematic changes are needed for the air conditioning unit because it has been repaired. 4. To monitor the proper location of the drip pan in the walk-in freezer, the Dietary Manager or Designee will audit the AM cook's daily checklist and visually check th drip pan in the walk-in freezer for the first three (3) months and monthly for the last three (3) months. To monitor the repair of the kitchen air conditioning unit, the AM cook will visually inspect the unit for any water drips daily for one (1) month. QAPI Committee will review the audits weekly for the first three (3) months and	

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F 812	Continued From page 17	F 812	monthly for the last three (3) months.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		10/10/24

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F 880	Continued From page 18 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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)	F 880	1. The corrective action for Resident #4, Resident #12 and Resident #35 is that all CNAs will be re-educated and trained on hand hygiene, glove use and Enhanced Barrier Precautions (EBP).	

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F 880	Continued From page 19 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. Findings include: 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. . . ." 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 . . ." HAND HYGIENE/GLOVE USE: - 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. - Observation on 09/04/24 at 1:34 p.m. showed a CNA (#5) completed perineal cares for Resident	F 880	2. All residents who require assistance with cares or require EBP have the potential to be impacted by these deficient practices. 3. Root cause analysis showed that a barrier to proper hand hygiene is that hand sanitizers are not within easy reach when performing cares. The hand sanitizers are on the wall of the resident's room but not close to where cares are often performed. Pocket hand sanitizers will be provided to all CNAs to carry with them when providing cares to residents. We currently have in place and have had in place the following systemic procedures for residents on EBP: * Isolation cart outside resident's room with supply of gowns and gloves * List on isolation cart on when and how to use gown and gloves before providing cares to a resident * Laminated signs on resident's door indicating the resident is on EBP We will re-educate and train our CNAs on proper EBP. 4. To ensure proper hand hygiene and glove use during resident cares, DON or DON Designee will do 10 random hand hygiene and glove use audits each month on CNAs when providing cares to residents for six (6) months.	

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F 880	Continued From page 20 #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. ENHANCED BARRIER PRECAUTIONS: 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. 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. 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.	F 880	To ensure proper use of EBPs, DON or DON Designee will do 5 random EBP-use audits each month on CNAs when providing care to residents on EBP for six (6) months. QAPI Committee will review the audits monthly for six (6) months.	