STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	**950 DAKOTA AVE , HATTON, North Dakota, 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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/22/25 and concluded 09/24/25.	F0000		10/02/2025
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to	F0578	The resident's physician order has been changed by the resident's physician to reflect the correct status of DNR/DNI. This correct status is in the electronic health record. This correction was made on 9/24/2025. All residents have the potential to be impacted this deficiency. We reviewed all of our residents' physician orders for code status to ensure they accurately reflect the residents' code status forms that the resident and resident's physician sign. Develop and implement a resident code status guidance to verify in all the places a resident's code status is documented and/or viewed (signed code status consent form, red or green stickers on residents' doors, green or red paper on residents' chart bindings, physician orders, care plans, Matrix banner, CNAs resident care guidelines) to ensure a resident's correct code status. All nurses will be trained on the code status guidance that has been developed. 4. Will audit accuracy of residents' physicians' orders regarding code status as follows: 5 random resident physician code orders weekly for 4 weeks. 10 random resident physician code orders monthly for two months. 5 random resident physician code orders monthly for 3 months.	10/27/2025

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 reverse for further 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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F0578 SS = D	Continued from page 1 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment for 1 of 13 sampled residents (Resident #29) reviewed for advance directives. Failure to ensure the medical record accurately reflected each resident's code status limited the facility's ability to communicate to direct care staff and emergency personnel the residents' choice in the event of a medical emergency. Findings include: Review of Residents #29's medical record occurred all days of survey. The quarterly Minimum Data Set (MDS), dated 08/20/25, identified intact cognition. A physician's order signed on 05/21/25 stated “code level I (All available reasonable technology will be used in the event of cardiac or respiratory arrest).” The resident's demographic face sheet and code status form, signed by the resident and facility representative on 08/27/25 showed "Code Status: DNR [do not resuscitate]/DNI [do not intubate]." The medical record lacked the current code status for Resident #29. During an interview on 09/24/25 at 11:40 a.m., an administrative staff member (#2) confirmed staff failed to obtain an updated physician's order to reflect Resident #29’s code status.	F0578	Continued from page 1 Audits will be reviewed monthly by the QAPI Committee for compliance. 5. Develop and implement a resident code status guidance and provide training: October 22, 2025 Audits: May 30, 2025	10/27/2025
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of	F0658	The coumadin order for the resident was corrected on 9/24/2025 in the resident's electronic health record and on the written physician order sheet to reflect the order that came from the anticoagulant clinic. 2. All residents on anticoagulation therapy have the potential to be affected by this deficient practice. 3. Will add an additional step in our current process of coumadin order verification by our night nurse. The night nurse is the person who verifies correct order transcription on all physician orders looking back 24 hours. The existing step is to compare the	10/27/2025

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F0658 SS = D	Continued from page 2 practice for 1 of 5 sampled residents (Resident #6) reviewed for unnecessary medications. Failure to correctly transcribe physician orders placed residents at risk for medication errors and adverse health events. Findings include:Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, "Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice." Review of the facility policy titled "Physician Signature" occurred on 09/24/25. This policy, dated June 2024, stated, ". . . To establish a consistent process for obtaining physician signatures on all required clinical and administrative documents . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included atrial fibrillation (irregular, rapid heartbeat). A faxed order from the anticoagulation clinic dated 09/23/25 at 3:13 p.m. stated ". . .Warfarin [an anticoagulant] 7.5 milligrams (mg) every Monday and Friday., 5 mg. all other days . . ."An order entry in the resident's electronic medical record (EHR), dated 09/24/25, showed Warfarin 7.5 mg Monday and Tuesday and Warfarin 5 mg the other five days. During an interview on 09/24/25 at 2:30 p.m., an administrative staff member (#2) stated a nurse (#4) incorrectly transcribed the order from the anticoagulation clinic onto a physician's order sheet as 7.5 mg. on Monday and Tuesday instead of Monday and Friday. The administrative staff member (#2) confirmed the nurse (#5) failed to verify the order before changing it in the EHR.	F0658	Continued from page 2 electronic health record against the handwritten physician order. The additional step is to also verify and sign off on the orders received from the anticoagulation clinic. Educate our nurses on this additional verification step. 4. All residents on anticoagulation therapy had their medical charts reviewed by Administrative RN on September 24, 2025 to ensure correct transcriptions of the orders that came from the anticoagulation clinic. DON or designee will audit all orders received from the anticoagulation clinic for 6 months to ensure that our night nurse has verified the physician order against the anticoagulation clinic orders. Audits reviewed by QAPI Committee weekly. 5. Review of all residents on anticoagulation therapy: September 24, 2025. Audits: May 30 2025	10/27/2025
F0880 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.	F0880	Unable to go back and correct improper hand hygiene, clean field for dressing change and glove procedures for Resident #12 during this wound dressing change (9/24/25). Nurse was re-educated on correct hand hygiene between glove changes, correct glove change from dirty to clean and correct clean dressing field procedures both verbally and in existing written policy on September 25, 2025. Residents having the potential to be affected by same deficient practice are residents requiring clean	10/27/2025

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F0880 SS = D	Continued from page 3 §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; (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	F0880	Continued from page 3 dressing changes to wounds. Make clearer in our Dressing Change (Clean) policy when to remove gloves, correct glove change from dirty to clean, correct hand hygiene throughout the procedure and how to create clean dressing field. Our nurses will be re-educated on all of these items/procedures. DON or designee will audit 3 wound dressing changes weekly for 4 weeks then 5 wound dressing changes monthly for 5 months. QAPI Committee will review audits monthly. 5. Re-education of nurses: December 1, 2025. Dressing Change (Clean) Policy clarification: December 1, 2025. Education of nurses on revised Dressing Change (Clean) Policy: December 1, 2025.	10/27/2025

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F0880 SS = D	Continued from page 4 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, review of facility policy, and staff interview the facility failed to follow standards of infection control for 1 of 2 sampled residents (Resident #12) observed during a dressing change. Failure to follow infection control practices during wound care has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Dressing Change (Clean)" occurred on 09/24/25. This policy, dated June 2024, stated, ". . . Perform hand hygiene . . . Create clean field with paper towels or towelette dressing . . . Open dressing pack. Put on first pair of disposable gloves. Remove soiled dressing and discard . . . Dispose of gloves . . . Put on second pair of disposable gloves . . . Cleanse wound . . . Apply dressings . . ." Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . Resident has a pressure ulcer present upon admission . . . Monitor pressure ulcer daily, change dressing daily. . . ." A current physician's order stated, "Change Mepilex [an absorbent foam dressing] to coccyx [tailbone] daily and PRN [as needed]" Observation on 09/23/2025 at 8:30 a.m. showed a nurse (#3) performed Resident #12's dressing change. The nurse applied a gown and gloves and entered the resident's room. With gloved hands, the nurse opened and closed the resident's door to speak to someone in the hall. After the certified nurse aides (CNAs) positioned the resident on his side, the nurse (#3) placed a clean Mepilex dressing and an open saline wipe packet with the tip of the wipe exposed onto the resident's bed. The nurse removed the old Mepilex dressing, discarded it and without changing gloves, measured the wound, cleansed the wound with the saline wipe, and applied a new Mepilex dressing. The nurse (#3) removed the gloves and without performing hand hygiene, applied new gloves, used a pen from the	F0880		10/27/2025

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F0880 SS = D	Continued from page 5 resident's nightstand to write down the wound measurements, touched the resident's phone, and applied a medicated powder to the resident's groin. The nurse removed the gown and gloves and performed hand hygiene before exiting the resident's room. The nurse (#3) failed to establish a clean field on which to set dressing supplies, maintain glove cleanliness by touching the doorknob and other items, apply clean gloves before applying the new dressing, and perform hand hygiene between glove changes. During an interview on 09/24/25 at 4:45 p.m. an administrative staff member (#2) stated she expected staff to establish a clean field for a dressing change, change gloves from dirty to clean, and perform hand hygiene between glove changes.	F0880		10/27/2025
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F0883	The corrective action will be to again offer the pneumonia vaccine to Resident #5 through her Power of Attorney. If Power of Attorney consents to the vaccine, pneumonia vaccine will be administered timely by one of our nurses by November 15, 2025. All residents have the potential to be affected by the deficient practice because all residents in our facility are offered the pneumonia vaccine when medically indicated. Current process is that one nurse manages the immunization status of residents by reviewing consent forms and scheduling the administration of the pneumonia vaccines. New process is that the Infection Preventionist and Administrative Nurse will both review residents' pneumonia consent forms and ensure administration of the vaccines for consenting residents. Both the Infection Preventionist and Administrative Nurse will sign off on the reviews of the consent forms and the administration of the vaccines. Infection Preventionist and Administrative Nurse will be educated on the new process by December 1, 2025. Audit all residents' consent forms for the pneumonia vaccine for 6 months to ensure the vaccines were given to those residents consenting to the vaccine. Pneumonia vaccines are offered to residents upon admission and as medically indicated throughout their stay in our facility. QAPI Committee will review monthly all audits that are completed. 5. Development and implementation of double review of pneumonia vaccine consents and administration	10/27/2025

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F0883 SS = D	Continued from page 6 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, and staff interview the facility failed to ensure residents were offered the pneumococcal immunization for 1 of 5 sampled residents (Resident #5) reviewed for immunizations. Failure to administer the pneumococcal vaccine to all eligible residents and document the administration has the potential for non-immunized residents to contract pneumonia and spread the infection to other residents, visitors, and staff. Findings include: Review of the CDC: Vaccines and Preventable Diseases webpage (https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html), dated October 26, 2024, stated, ". . . CDC recommends pneumococcal vaccination . . . Age 50 years or older who have . . . Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown . . .”	F0883	Continued from page 6 of the vaccines: November 15, 2025. Audits: May 30, 2026.	10/27/2025

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F0883 SS = D	Continued from page 7 Review of Resident #5's medical record occurred on all days of survey. A form titled, “2023-2024 Vaccination Season,” signed on 09/28/23 by resident, resident representative and facility representative, indicated consent to receive the “pneumonia vaccine [pneumococcal vaccine].” The immunization records lacked documentation the resident received the pneumococcal vaccine. During an interview on 09/24/25 at 2:20 p.m., an administrative nurse (#2) verified the facility failed to provide Resident #5's pneumococcal immunization.	F0883		10/27/2025