

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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  Hatton Prairie Village		STREET ADDRESS, CITY, STATE, ZIP CODE  950 Dakota Ave Hatton, ND 58240	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [DATE], 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.</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of 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 &amp; 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.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>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 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.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 (<a href="https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html">https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html</a>), dated October 26, 2024, stated, . CDC recommends pneumococcal vaccination . age [AGE] years or older who have . Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown . 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.</p>		