STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Horizons Care Center	**1104 HWY 12 , HETTINGER, North Dakota, 58639**

(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 and complaint survey started on 09/02/25 and concluded 09/04/25. The issues identified by the complainant were found to be in compliance with regulatory requirements.	F0000		09/26/2025
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative	F0583	The nurse involved was re-educated on the requirement for promoting privacy and confidentiality of the EMAR on all days of survey. All residents have the potential to be affected. The current policy for "Violation Sanctions HIPPA Policies" is being reviewed. A new policy/procedure for "Privacy and Confidentiality of the EHR" is being developed. All staff will be educated on in-serviced regarding privacy and confidentiality on 09/16/25 and 09/18/25. The DON/designee will be responsible to monitor/audit. The DON/designee will monitor medication pass to assure resident privacy. The DON/designee will monitor a minimum of one medication pass weekly for one month, monthly for three months, then quarterly thereafter for one year. If concerns are identified, immediate corrective action will be implemented. The DON/designee will submit a report of the monitoring results to the QA Coordinator at each scheduled meeting. 09/26/25	09/26/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

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F0583 SS = D	Continued from page 1 records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to promote privacy and confidentiality of the electronic medication administration record (EMAR) on 1 of 2 units (West Wing) observed. Failure to promote resident privacy and lock computer screens may result in unauthorized viewing of resident records by other residents, visitors, or unlicensed staff. Findings include: A review of facility policy titled "Violation Sanctions HIPPA Policies" occurred on 09/04/25. This policy, dated June 2020, stated, " . . . Confidentiality: It is the right of an individual to have personal, identifiable information kept private . . . Violations are defined into categories . . . failure to properly sign off from or lock computer when leaving a workstation. . ." Observation on 09/02/25 of the West wing medication cart showed the EMAR open and visible to visitors and residents at 11:51 a.m. and 12:30 to 12:34 p.m. without a nurse present. During an interview on 09/03/25 at 4:20 p.m., two administrative staff members (#1 and #2) stated they expected staff to close and lock the EMAR when unattended.	F0583		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600	"Past Noncompliance - no plan of correction required"	09/26/2025

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F0600 SS = G	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review, and review of the facility reported incident (FRI) investigation, the facility failed to ensure residents remained free from abuse for 1 of 1 closed record (Resident #40) who experienced sexual abuse from another resident. Failure to protect residents from sexual abuse resulted in fear, anxiety, and mental anguish. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include: The survey team determined a deficient practice existed on 04/27/25. The facility implemented corrective action immediately, completed corrective action on 04/28/25, and continued with staff education and monitoring. Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 09/03/25. This policy, revised May 2025, stated, "Each resident has the right to be free from abuse . . . Residents must not be subject to abuse by anyone, including . . . other residents . . . "Sexual Abuse" is non-consensual sexual contact of any type . . ." The initial FRI, dated 04/28/25, stated, "On 4/28/25 OT [occupational therapy] approached DON [director of nursing] and administrator stating [Resident #40] had reported to her that [Resident #15] had put her [sic (his)] hand down her shirt while she was sitting in the dining room, asked her if she liked it, in which [Resident #40] shook her head no." The 5-day FRI investigation, dated 05/01/25, indicated at the end of a therapy session on 04/28/25 staff asked Resident #40 if she would like to stay in her room or go out to main area. Resident #40 replied, "I am kind of scared to go out of my room." When asked why, she explained being left alone in the dining room the night before with Resident #15. Resident #40 stated, "He touched me, and it really upset me. . . . He reached his hand down my shirt, between my breast, and began rubbing up and down. . . . .I don't ever want it to happen again." The facility's review of the dining room video surveillance showed on 04/27/25 at 6:55 p.m.	F0600		

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F0600 SS = G	Continued from page 3 Resident #15 approached Resident #40, rubbed his hand on her chest, and walked away a few moments later. Review of Resident #40's medical record occurred on 09/03/25. Diagnoses included anxiety and post-traumatic stress disorder. An admission Minimum Data Set (MDS), dated 05/01/25, identified Resident #40 as cognitively intact. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented correction actions for all resident who may be affected by the deficient practice as follows: * Completed an immediate investigation following the incident. * Notified both residents' families of the incident. * Notified the physician of the incident. * Moved Resident #15 to another hallway of the building, occupied by male residents only. * Implemented one-hour checks on Resident #15's location. * Required staff to ensure Resident #15's is not left alone in same room with a female resident. * Educated all staff present during 04/28//25 shift and each shift thereafter, regarding the incident and monitoring Resident #15's location. * Updated care plans for Resident #15 and Resident #40. * Conducted a staff meeting on 05/01/2025 to further educate regarding abuse, and "Responding to Resident's Sexually Inappropriate Behavior."	F0600		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and	F0628	Resident #10 was transferred to the hospital on 04/28/25. At the time of transfer, a written notice of transfer, bed-hold notice, and Ombudsman notification were not completed. Resident #10 is no longer in need of this intervention. The resident and/or representative were contacted on 09/25/25 to review their rights regarding transfer and bed-hold, and the Ombudsman was also notified of the deficient practice All residents who are hospitalized have the potential to be affected.	09/26/2025

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F0628 SS = D	Continued from page 4 appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §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.	F0628	Continued from page 4 The current policy/procedure "Bed Hold Policy" will be reviewed. All staff will be in-serviced regarding bed holds and notice of transfers on 09/16/25 and 09/18/25. Transfer packets and checklists are being developed for nursing staff. The DON/designee will be responsible to monitor/audit. The DON/designee will monitor to assure timely notification of bed hold and notice of transfer to the appropriate entities. The DON/designee will audit completion of bed holds and notice of transfers for all residents weekly for one month, monthly for three months, and then quarterly thereafter for one year. The DON/designee will submit a report of the monitoring results to the QA Coordinator at each scheduled meeting. 09/26/25.	

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F0628 SS = D	Continued from page 5 (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; (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.);	F0628		

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F0628 SS = D	Continued from page 6 and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the 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(l). §483.15(d) Notice of bed-hold policy and return- §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.	F0628		

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F0628 SS = D	Continued from page 7 §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. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). 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 their representative and the State Long Term Care Ombudsman a written notice of transfer and bed-hold notice for 1 supplemental resident (Resident #10) reviewed for hospitalizations. Failure to provide a notice of transfer and a bed-hold notice does not allow the resident and/or their representative to make informed decisions regarding their rights, or inform the Ombudsman of the transfer. Findings include: Review of the facility policy titled "Bed Hold Policy" occurred on 09/04/25. This policy, dated 05/15/25, stated, ". . . will provide written information to the resident or resident's representative regarding the bed hold policy prior to a transfer . . . the resident or resident's representative will be provided written information regarding the bed hold policy. . . . will be notified in writing the reasons for the move in a	F0628		

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F0628 SS = D	Continued from page 8 language and manner they understand. . . . The facility will send a copy of the notice to a representative of the Office of the State Long term Care Ombudsman. . . ." Review of Resident #10's medical record occurred on 09/03/25. A nurse's note, dated 04/28/25 at 3:09 p.m., stated, ". . . Clinic called at 1500 [3:00 p.m.] and stated that [Resident #10] was admitted for hyponatremia and hypoxia. . . ." The medical record lacked a written notice of transfer, a written notice of bed-hold, and notification of the transfer to the State Long Term Care Ombudsman. During an interview on 09/03/25 at 9:15 a.m., two administrative staff members (#1 and #7) confirmed the facility failed to complete a written notice of transfer form, a written bed-hold, and notify the Ombudsman.	F0628		
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 observation, and staff interviews, the facility failed to obtain a physician's order for 1 of 1 supplemental resident (Resident #17) observed receiving crushed medications. Failure to notify the provider regarding the resident's ability to swallow whole medications and obtain an order for crushed medications may result in an inconsistency in care and choking. Review of a nurse's report sheet occurred on 09/04/25. This form, dated 08/15/25, showed Resident #17 takes her medications "Whole". Observation of medication administration occurred on 09/02/25 at 12:42 p.m. and showed a nurse (#11) crush Resident #17's medication, placed them in pudding, and administered them to the resident. The medication administration record (MAR) lacked documentation indicating staff were to crush the resident's medications.	F0658	For Resident # 17 an order was received 09/03/25 to reflect crushed medications, care plan was updated, and nurses' report sheet was updated on 09/04/25. All residents have the potential to be affected. A new policy/procedure for Medication Administration-Crushing Medications is being developed. All staff will be in-serviced regarding crushing medications on 09/16/25 and 09/18/25. All residents who have medications crushed will be assessed for orders for crushed medications. The DON/designee will be responsible to monitor/audit. The DON/designee will monitor medication administration orders to ensure medications are prepared in accordance with physician orders, resident preferences, and medical needs. Observation of medication passes will be performed weekly for one month, monthly for three months, quarterly there after for one year. 09/26/25.	09/26/2025

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F0658 SS = D	Continued from page 9 During an interview on 09/02/25 at 12:43 p.m. a staff nurse (#11) stated, "We have been crushing her meds for a couple of weeks now since she (Resident #17) came back from the hospital after her stroke." During an interview on the morning of 09/04/25, two administrative staff members (#1 and #10) confirmed Resident #17's medical record lacked an order to crush Resident #17's medications.	F0658		
F0689 SS = G	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 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 procedure, review of manufacturer's use instructions, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #8) who fell from a mechanical lift. Failure to safely use the mechanical lift resulted in a fall with injury. Findings include: Review of the facility procedure "Use of Hoyer (Full Body) Lift" occurred on 09/04/25. This undated procedure stated, ". . . Mechanical Lift from Bed to Chair . . . Positioned the lift under the bed and widened the base of the lift. . . ." Review of the "Volaro Series 4 Lift Operator's Manual" occurred on 09/04/24. This manual, dated March 2019, stated, ". . . Safety Notes . . . Lift legs must be fully extended into the wide position when lifting a patient or resident. . . . Lifting from Bed to Chair using the Divided Leg Sling: . . . If the base is in the narrow position, adjust it to the widest position once you are clear from the bed and always before turning the lift. . . . General Procedure Guide for Training . . . 19. Check the legs are in the wide	F0689	1.Immediately following the incident on 09/02/2025, Resident #8 was assessed by nursing staff and transferred to the emergency department for evaluation per facility protocol. The resident's care plan and transfer needs were reviewed and confirmed. The facility completed a full investigation of the incident and reviewed the care plan to ensure accuracy. Immediate staff education was conducted for the staff involved regarding proper mechanical lift use and adherence to manufacturer instructions. 2.All residents requiring mechanical lift transfers had the potential to be affected. 3.The facility implemented the following system changes beginning 09/04/2025: •Re-education of all CNA's and nurses working on 09/04/2025 regarding proper mechanical lift operation, including the requirement to fully widen the lift base prior to any turning or movement when lifting from any surface to another surface (e.g., bed to wheelchair). •Distribution of an education message to all CNAs and nurses via the HomeBase app on 09/04/2025 reinforcing manufacturer requirements for safe lift operation. •Updated facility policy and procedure for "Use of Hoyer (Full Body) Lift" to specifically reference the manufacturer's requirements on 09/04/2025. 4.The facility completed all corrective actions related to this incident on 09/04/2025. At that time, a Plan of Correction and ongoing audits were not required due to the survey team's initial determination of past non-compliance. Following notification from the State Agency that the tag requires a standard Plan of Correction, the facility has developed and implemented a prospective monitoring plan as follows: •The Director of Nursing (DON) or designee will complete weekly mechanical lift transfer audits for 4 weeks, then biweekly for 2 months, then monthly audits for 3 months. Any concerns identified will result in immediate re-education and follow-up audits. Should trends or patterns be identified, the facility will adjust its monitoring frequency and corrective actions through QAPI.	09/05/2025

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F0689 SS = G	Continued from page 10 position . . . If base position must remain in a narrow position, make sure the lift area between the bed and chair are clear of any obstacles. Widen once clear from bed. . . ." Review of Resident #8's medical record occurred on all days of survey. Diagnoses included hemiplegia [paralysis of one side of the body]. The current care plan stated, ". . . requires Mechanical Lift (hoyer) with (2) [two] staff assistance for transfers. . . ." Review of Resident #8's nurse's notes identified the following: *09/02/25 at 9:10 a.m., ". . . [Resident #8] was in the process of being transferred from the bed to the Broda [tilt-in-space mobile positioning chair] chair. [Resident#8] is tall and his legs do not bend so he needs to be placed in the Broda chair sideways. His legs will hit the bar of the lift if he is put in the chair forward. [Resident #8's] foot became entangled in the Broda chair and as a result the hoyer lift began to tilt sideways. One aid grabbed his feet and the other grabbed his head and [Resident #8] was placed on the ground. RN [registered nurse] was paged to the room patient was laying on his back on the floor. Asked patient from top to bottom if any area was hurting him and he stated 'no'. It was noted that his left great toe had a laceration at the time and was bleeding. ER [emergency room] nurse called and EMS [emergency medical services] called. Family notified of transfer to the hospital. . . ." *09/02/25 at 09:18 a.m., ". . . Received report from [name] RN at hospital. [Resident #8] has no injuries from the fall. . . . dermabond [a sterile liquid skin adhesive] on . . . left great toe and steristrips . . ." *09/04/25 at 2:25 a.m., ". . . resident moaned in pain. . . . Knee has some swelling now to it, and he complained of pain upon ROM [range of motion] of Left knee and leg. Will continue to evaluate this leg. Will offer resident an ice pak [sic] to knee." *09/04/25 at 6:55 a.m., ". . . Resident has swelling in his left knee which is migrating up to his Left hip. Ice was applied x2 [two times] which did not offer reduced swelling. Patient c/o [complained of] 10/10 pain upon moving him. This nurse called his son . . . who requested him being sent to ER for evaluation that may have not been noted on his last ER visit." *09/04/25 at 11:11 a.m., ". . . This nurse spoke to	F0689	Continued from page 10 5.09/04/2025	

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F0689 SS = G	Continued from page 11 nurse . . . at [critical access hospital] who stated resident would be transferred out due to left hip fracture . . ." Interviews with staff identified the following: *09/02/25 at 10:50 a.m. a certified nurse aide (CNA) (#3) confirmed the resident fell while she and another CNA (#4) transferred the resident from the bed to the Broda chair. The CNA (#3) confirmed the base/legs of the mechanical lift were closed while they moved Resident #8 from the bed to the Broda chair, the resident's leg caught on the chair, and the lift tipped on it's left side with the resident landing on the floor. The CNA (#3) confirmed staff kept the base/legs closed in order to get the lift under the Broda chair. *09/03/25 at 3:35 p.m., two CNAs (#5 and #6) confirmed they approach Resident #8's Broda chair from the side and the base/legs of the mechanical lift stay closed during transfers. The facility failed to ensure staff widened the base/legs of the mechanical lift while transferring Resident #8. The facility implemented corrective actions for all residents who may be affected by the deficient practice as follows: *Completed an investigation into Resident #8's fall. *Assessed and transferred Resident #8 for treatment. *Educated CNAs and nurses on proper mechanical lift use. *Sent an educational message to all CNAs and nurses via the "HomeBase" scheduling app regarding proper mechanical lift use on 09/04/25. *Educated all CNAs and nurses working 09/04/25 on proper mechanical lift use.	F0689		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the	F0761	No residents were affected by the deficient practice. All medication storage rooms and medication carts have the potential to be affected. The current policy/procedure "Expiration of Medications and Supplies" is being reviewed and revised. A new policy/procedure "Medication Storage" is being developed. All staff will be in-serviced regarding medication storage and locking the medication cart on	09/26/2025

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F0761 SS = E	Continued from page 12 expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to store meds and biologicals appropriately in 2 of 4 medication storage and supply areas (West Wing medication cart and West Wing medication room). Failure to secure medications in the medication cart and to dispose of expired needles has the potential for unauthorized access of medications and has the potential for inaccurate laboratory results. Findings include: Review of the facility policy titled "Expiration of Medications and Supplies" occurred on 09/04/25. This policy, dated October 2024, stated, " . . . 2. Weekly on every Wednesday, the CMA [certified medication aide]/nurse working on the East and West Nurses' station will check . . . the medication room . . . for . . . supply expiration dates . . . Any expired . . . supplies will be disposed of after removal from . . . medication rooms . . ." The facility failed to provide a policy regarding locking the medication cart. -Observation on 09/02/25 of the West wing medication cart showed the cart unlocked and unattended from 11:51 to 11:56 a.m. and from 12:30 to 12:34 p.m. with residents nearby.	F0761	Continued from page 12 09/16/25 and 09/18/25. Charge Nurse/designee will be responsible to monitor the medication storage rooms weekly to assure medications and biologicals are stored appropriately. The DON/designee will audit for compliance and accuracy of medication storage rooms and observe medication pass for locked medication cart weekly for one month, monthly for three months, and then quarterly thereafter for one year. If concerns are identified, immediate corrective action will be implemented. The DON/designee will submit a report of the audit results to the QA Coordinator at each scheduled meeting. 09/26/25.	

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F0761 SS = E	Continued from page 13 -Observation of the West wing medication storage room occurred on 09/02/25 at 1:44 p.m. and showed the following: * Three boxes of needles used for lab draws expired in July 2025. * Three individually wrapped needles used for lab draws expired in December 2024. During an interview on 09/03/25 at 4:20 p.m., two administrative staff members (#1 and #2) stated they expected staff to close and lock the medication carts when unattended and audit the medication rooms for expired supplies.	F0761		
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of a dietary document, and staff interview, the facility failed to provide food in a form to meet individual needs for 2 of 2 sampled residents (Resident #15 and #20) with a physician's order for a minced and moist diet. Failure to provide minced and moist food as ordered may result in reduced meal intake, choking, and aspiration pneumonia. Findings include: Review of a document titled "Hormel Health Labs Checklists for IDDSI [International Dysphagia Diet Standardization Initiative - standardized system for classifying food and drink textures for individuals with swallowing difficulties] Levels 7, 6, 5, and 4" provided by the dietary manager (#14) occurred on 09/04/25. This undated document described Level 5 Minced and Moist requirements as "Soft and moist particle size - very small pieces ([less than] 1/8 inch - adults); Pieces fit between fork tines; Mimics a soft chewed bolus [a soft round mass] . . ."	F0805	For resident #20 and Resident #5 care plans and diet cards were reviewed. All residents on a therapeutic diet have the potential to be affected. A policy/procedure for Therapeutic Diet Orders is being developed. All staff will be in-serviced regarding therapeutic diets on 09/16/25 and 09/18/25. Nursing and dietary staff will receive IDDSI training. All residents who are on a therapeutic diet will have diet orders and care plans checked for accuracy. The Dietary Manager/designee will be responsible to monitor/audit. The Dietary Manager/designee will complete meal-time observations to ensure diet orders and guidelines are being followed weekly for three months and monthly for six months. The Dietary Manager/designee will submit a report of the monitoring results to the QA Coordinator at each scheduled meeting. 09/26/25.	09/26/2025

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F0805 SS = D	Continued from page 14 -Review of Resident #20's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) and dysphagia (difficulty swallowing). A physician's order, dated 02/28/25, stated, "Regular diet, Minced texture, Honey consistency." Observation of the lunch meal on 09/02/25 showed the facility served Resident #20 cooked peas and diced carrots along with the rest of his meal. Observation on 09/04/2025 at 8:17 a.m. showed Resident #20 ate approximately half of an egg omelet with small pieces of chopped peppers and ham, larger than 1/8 inch. At 8:30 a.m., a dietary manager (#14) attempted to mash the peppers in the eggs and noted the skins did not mash. The dietary manager agreed the peppers were not appropriate for the minced and moist diet. When asked about the cooked peas and carrots served on 09/02/25, she stated staff should have mashed them for Resident #20. -Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia and dysphagia, oropharyngeal phase (difficulty transferring food from mouth to throat). A physician's order, dated 07/28/25, stated, "Regular diet, Minced texture, Regular consistency." Observation on 09/02/25 of the lunch meal showed the facility served Resident #15 cooked peas and diced carrots along with the rest of his meal. During an interview on 09/03/2025 at 12:40 p.m., a dietary consultant (#15) stated a minced and moist diet required food no larger size than the tine of a fork, and the cooked peas and carrots would not be appropriate.	F0805		
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	All CNAs were verbally re-educated on hand hygiene expectations during survey. All residents have the potential to be affected. The current policy/procedure "Hand Hygiene" is being reviewed. All staff will be in-serviced regarding hand hygiene on 09/16/25 and 09/18/25. The Infection Preventionist/designee will be responsible to monitor/audit to assure compliance with hand hygiene weekly for one month, monthly for three months, and then quarterly thereafter for one year. The	09/26/2025

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F0880 SS = D	Continued from page 15 §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 corrective	F0880	Continued from page 15 IP/designee will submit a report of the monitoring results to the QA Coordinator at each scheduled meeting. 09/26/25.	

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F0880 SS = D	Continued from page 16 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 and policy review, the facility failed to follow standards of infection control and prevention for 1 of 6 sampled residents (Resident #19) and 1 of 1 supplemental resident (Resident #17) observed during cares. Failure to practice infection control standards related to hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 09/04/25. This policy, revised December 2024, stated, "Hand hygiene is the act of cleaning one's hands to remove potentially harmful substances and organisms. . . . Hand hygiene . . . highly effective method for preventing the spread of pathogens, such as bacteria and viruses, which can lead to infections. . . . PROCEDURE Indications for Performing Hand Hygiene: Before moving from work with a soiled body site . . . to a clean body site . . . After contact with . . . body fluids . . ." -Observation on 09/02/25 at 10:18 a.m. showed two certified nurse aides (CNAs) (#8 and #9) applied gloves and provided perineal cares for Resident #17. The CNAs removed their soiled gloves and provided perineal cares for Resident #17. The CNAs removed their gloves and failed to perform hand hygiene before moving on to other tasks. -Observation on 09/02/25 at 11:33 a.m. showed two CNAs (#8 and #9) transferred Resident #19 from the wheelchair to the bed. With gloved hands, the CNAs provided perineal cares, removed the soiled gloves, applied clean gloves, replaced clothing, transferred the resident to the wheelchair, and touched various	F0880		

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F0880 SS = D	Continued from page 17 items in the room before removing gloves and performing hand hygiene.	F0880		