DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/22/14 and completed on 09/24/14, the sample included two (2) residents for complete review, eight (8) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	The facility has prepared and submitted this Plan of correction because of the requirements Under state and federal law that mandate submission of a plan of correction to participate in the title 42 program. The submission of the plan of correction should in no way be considered or construed as an agreement with the allegations of non-compliance shall constitute this facility's credible allegation of compliance. This applies to tag F156, F225, F278, F309, F314, F315, F323, F329, F371, F428, & F502	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	A poster providing a list of names of resident advocacy which include State Survey and Certification Agency, Protection and Advocacy Project, and Medicaid Fraud Control Unit will be made and posted again in a conspicuous public place in the facility. A copy of the information has been provided labeled "ND State Client Advocacy Contact Information" This has the potential to affect all facility residents. To ensure this info remains posted, a QA will be done by the Administrator 1x per quarter year for 1 year, then 2x/ year thereafter. A copy of the audit tool has also been provided. Completion Date:	10/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator / COO	11/20/14

...eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to post the names, addresses, and/or telephone numbers of State advocacy groups (State Survey and Certification Agency, the Protection and Advocacy Project, and the Medicaid Fraud Control Unit) on 3 of 3 days of survey. Failure to provide this information has the potential to limit residents' and their families' access to these agencies. Findings include: Review of the facility policy titled "Notice of Resident Rights and Responsibilities" occurred on 09/24/14. This policy, dated 09/01/07, stated, ". . . 8. To assure that our residents, staff, and visitors are continually informed and aware of resident rights, grievance procedures, responsibilities to the facility, etc., large print copies are posted or available in several areas, which may include the: a. Main lobby area; b. Resident's lounge . . . d. Activity room; and e. Nurses station. . . ."	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 156	Continued From page 3 Observation on September 22-24, 2014, showed the facility's display board failed to list contact information for the State Survey and Certification Agency, the Protection and Advocacy Project, and the Medicaid Fraud Control Unit. On 09/24/14, an administrative staff member (#5) indicated staff had posted a copy of the above information on the wall near the front offices prior to the latest home improvements. He confirmed the information was no longer posted on the wall.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	1) The corrective action accomplished to ensure that all injuries of unknown origin are reported and investigated is a change in the report sheet to specifically reflect skin/bruise issues and the education of staff concerning these actions. For Resident #11 this correction cannot be rectified due to her being deceased. In addition, the policy on Abuse and Neglect concerning the reporting of injuries of unknown origin was reviewed with staff at an all staff in-service meeting on 10/29/2014. CNA's were educated on the Stop & Watch tool and the importance of screening residents for skin issues and then reporting them in a timely manner to the charge nurse. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that on 10/28/2014, the facility's administration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 225	Continued From page 4 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #11) with bruising to her left foot. Failure to report and investigate an injury of unknown origin placed Resident #11 and other residents at risk for mistreatment and/or abuse, and did not enable the facility to determine causative factors for the injury and implement corrective action. Findings include: Review of the facility policy titled "Injuries of Unknown Source" occurred on 09/24/14. This policy, dated 09/13/07, stated, ". . . Injuries of unknown source will be reported and investigated . . . for signs of abuse and findings/conclusions will be documented. . . ." Review of Resident #11's medical record occurred on September 22-24, 2014. Diagnoses included history of a stroke (cerebrovascular	F 225	and department managers reviewed the current policy and process on reporting injuries of unknown origin and made determinations for possible areas of improvement. It was determined that the report sheet would be revised to include a section for noting skin issues and bruises for improved communication between staff. Education was required for nurses and CNA's to improve awareness of resident skin issues and current processes to be followed. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits to evaluate compliance to policy of reporting injuries of unknown injury. Audits will be done by the QA coordinator or designee monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented. Complete Date: 11-07-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 225	Continued From page 5 accident) and kidney disease. The quarterly Minimum Data Set (MDS), dated 08/22/14, identified severely impaired cognition and extensive assist required for all activities of daily living (ADLs). The current care plan stated, ". . . Interventions: . . . Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown. . . ." A progress note, dated 08/08/14, identified, ". . . Left foot is swollen [with] bruising . . ." The daily report/shift notes, dated August 11-12, 2014, identified, ". . . Monitor bruising and swelling on feet. . . ." The progress note, dated 08/19/14, identified, ". . . Left foot [and] lower leg swollen. . . . Bruising noted on base of toes on left foot top [and] bottom. . . ." Resident #11's medical record lacked evidence of an investigation as to the possible causative factors of the bruises. During an interview on 09/24/14 at 3:45 p.m., a managerial nurse (#4) stated staff are expected to report and investigate injuries of unknown origin. She agreed the facility failed to investigate the causative factors of Resident #11's bruises, and stated, "The nurses must have assumed it was from admit, without checking the chart."	F 225		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278	1) The corrective action accomplished to ensure that all MDS's accurately reflect the resident's status and will be coded appropriately is correction and resubmission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 278	Continued From page 6 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 7 of 10 sampled residents (Resident #1, #2, #3, #5, #6, #7, and #8) coded incorrectly on the MDS. Failure to code portions of the MDS correctly does not provide an	F 278	of Section E on Resident #1, #2, #3, #5, #6, and #7 and Section M of Resident #8. In addition, the responsibility on completing Section E of the MDS has changed from Social Services to the MDS Coordinator for 6 months. After six months, the Social Services Designee will complete this section with supervision from the MDS nurse. An addendum procedure is in place that reflects the MDS Coordinator will code Section E and orientate the Social Service Designee to Section E in that time frame to accurately code Section E. 2) The facility recognizes that all residents with an MDS submission have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that on 10/28/2014, the facility's administration and department managers reviewed the current policy and process for MDS assessments and coding practices, specifically in correlation with the Social Services office. It was determined that the responsibility for completing Section E of the MDS would be changed from the Social Services Designee to the MDS Coordinator for 6 months. There after which, the Social Services Designee will complete with MDS nurse supervision. Education on the current process was presented and discussed on 10/29/2014 at the monthly Nursing Meeting. It was determined that CNA's will use their current list sheets to identity specific resident behaviors and report these to the Charge Nurse before the end of their shift. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 278	Continued From page 7 accurate assessment of a resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the residents. Findings include: The Long-Term Care Facility RAI User's Manual Version 3.0, October 2013, stated the following: * Page E-2 and E-3, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. . . . If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion." * Page E-4 and E-5, "E0200: Behavioral Symptom-Presence & Frequency . . . Coding Instructions . . . Code 0, behavior not exhibited: if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days. . . . Coding tips and Special Populations . . . Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that	F 278	includes the implementation of Stop & Watch tools and appropriate use of current behavior flow sheets. Nurses were provided with education concerning appropriate documentation of behaviors from CNA observations, including their own professional assessment. The MDS nurse was reeducated on proper coding of Section M. Accuracy checks have been put into place via the QA nurse performing random audits for insurance of accuracy. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits to evaluate the current process for accuracy of behavior documentation (ensuring Nursing documentation and CNA documentation correlate via review of the submitted list sheets). Audits will be done monthly x 3 then quarterly x 1 year. This item will also be integrated to the monthly QA reporting by the MDS nurse to the QA team. Specifically that MDS behavior coding has the necessary supporting documentation. MDS nurse will provide QA coordinator or designee with monthly MDS nurse schedule. QA coordinator or designee will then perform random audits on Section M of the MDS monthly x 3 then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented. Complete Date:	11-07-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 278	Continued From page 8 the behavior can be explained or should be tolerated. Code as present, even if staff have become used to the behavior or view it as typical or tolerable. Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care. . . . A. Physical behavioral symptoms directed toward others . . . B. Verbal behavioral symptoms directed toward others . . . C. Other behavioral symptoms not directed toward others . . ." * Section M1200D (Nutrition or Hydration Intervention to Manage Skin Problems), pages M-38 and M-39, stated, "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. . . . If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation . . . and obtain dietary consultation as needed,' . . ." DELUSIONS AND BEHAVIORAL SYMPTOMS - Review of Resident #1's medical record occurred on September 22-24, 2014. Diagnoses included dementia without behavior disturbance. A quarterly Minimum Data Set (MDS), dated 09/09/14, identified severely impaired cognition and delusions during the assessment period. Review of nursing and social service staff notes, dated September 03-09, 2014 failed to identify any delusional thoughts. - Review of Resident #7's medical record occurred on September 22-24, 2014. Diagnoses	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 278	Continued From page 9	F 278		

included traumatic brain injury and anxiety state. A quarterly MDS, dated 07/19/14, identified severely impaired cognition and other behavioral symptoms not directed toward others during the seven day assessment period.

Nurse's notes, social service notes, and behavior charting failed to identify the presence of behavioral symptoms during the seven day assessment period.

Review of nursing and social service staff notes, dated July 13-19, 2014 failed to identify any behaviors demonstrated by Resident #7.

- Review of Resident #3's medical record occurred September 23-24, 2014. Diagnoses included depression with anxiety. The quarterly MDS, dated 06/29/14, identified long and short term memory problems and delusions during the seven day assessment period.

A social services progress note, dated 06/27/14, stated, ". . . She [Resident #3] is unable to verbalize or maintain a conversation due to her cognitive decline and delusional thinking. [Resident #3] is often unaware of her surroundings and believes she is somewhere else. She continues to struggle [with] depression and anxiety . . ."

Resident #3's nurse's progress notes identified a hospitalization from June 18-25, 2014. The progress notes, social service notes, and behavioral charting, dated June 25-29, 2014, failed to identify the presence of delusions.

- Review of Resident #5's medical record occurred on September 23-24, 2014. Diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 278	Continued From page 10 included Alzheimer's disease and dementia with behavioral disturbances. The quarterly MDS, dated 07/28/14, identified long and short term memory problems; delusions; physical and verbal behavioral symptoms directed toward others; and other behavioral symptoms not directed toward others during the seven day assessment period. A social services progress note, dated 07/28/14, stated, "Assessment from staff report and chart audit due to [Resident #5's] severe dementia and fragile cognitive status. [Resident #5] can get upset very easily and start having behaviors. . . ." The behavior flow sheet, dated 07/17/14, stated, "Behavior: hitting table when another resident reached for news paper in the middle . . ." Resident #5's nurse's progress notes, dated July 17-28, 2014, failed to identify the presence of delusions, or physical, verbal and/or other behavioral symptoms. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and anxiety. The current MDS, dated 08/11/14, identified delusions. Nurses' notes, social services notes, and behavior charting failed to identify the presence of delusions at any time during the assessment period. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety and depression. The current MDS, dated 06/15/14, identified delusions. Nurses' notes, social service notes, and behavior charting failed to identify the presence of delusions at any time during the seven day assessment period.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 278	Continued From page 11 NUTRITION/HYDRATION INTERVENTIONS - Review of Resident #8's medical record occurred on 09/24/14. The quarterly MDS, dated 06/28/14, identified nutrition/hydration interventions present for skin problems during the seven day assessment period. There were no pressure ulcers, wounds, or skin problems identified on the MDS. The medical record failed to contain a dietary note related to nutrition/hydration interventions for the skin problems coded on the MDS.	F 278		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide care and services in a manner that promoted physical, mental, and psychosocial well-being for 1 of 1 sampled resident (Resident #2) who exhibited behaviors and expressed distress during a nursing procedure (urinary catheterization). Failure to contact the medical provider to determine the necessity of the follow-up urinalysis (UA) resulted in Resident #2 displaying combative behaviors, receiving psychopharmacological medication, and	F 309	1) The corrective action accomplished to ensure that no harm is caused and only necessary catheterization procedures are performed on Resident #2 is a review in current policy for resident catheterizations and revision of policy to allow nursing staff to consult with physicians regarding the necessity of proposed procedure. In addition, the policy will outline an alternate process if a previous catheterization attempt is failed. To ensure Resident #2 receives no harm, the care plan will be updated with information concerning frequent history of UTI's and known combativeness with Urinary Catheterization. 2) The facility recognizes that all residents with orders for urinary catheterizations to be obtained have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that on 10/28/2014, the facility's administration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 309	Continued From page 12 unnecessary procedures which caused avoidable mental distress and psychosocial harm. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and a history of urinary tract infections (UTIs). The resident's current Minimum Data Set (MDS), dated 08/11/14, identified short and long term memory problems and severely impaired daily decision making skills. Record review identified a urine culture positive for Proteus mirabilis (a bacteria commonly found in the gastrointestinal tract) on 09/11/14 which was treated with Keflex (an antibiotic) from 09/12/14 through 09/18/14. A physician's order identified a repeat urinalysis/urine culture (UA/UC) to be collected 10 days after starting the antibiotic. Nurses' notes identified the following: *09/20/14 at 7:00 a.m.: ". . . Resident laid down by nursing personnel and explained procedure to resident. Resident mumbles and says 'I don't like this' - Resident told step by step re: [regarding] obtaining a cath [catheter] UA, what was being done - Resident would holler out et [and] scream during cathing procedure. Unable to get sample - 2nd attempt at cathing was done by [staff name] - two other nurses present. One helped holding legs apart et other nurse was holding hands of Resident et enc. [encouraged] her to hold on real tight. Was a little cooperative. UA obtained, was obtained and was sent [down] to lab. . . ." *09/20/14 at 7:20 a.m.: ". . . UA [urinalysis] taken [down] to Lab. . . ." *09/20/14 at 8:20 a.m.: ". . . Lab informed this	F 309	and department managers reviewed the current policy and process for accepting physician orders for resident urinary catheterizations. It was determined that physicians could be updated on resident tolerance and acceptance of the proposed procedure. Therefore, this provides them with the opportunity to alter or rescind their order. After one failed attempt by facility personnel, the physician will be provided with the opportunity to alter their order or proceed to another health care facility for further attempts. Education on the current process was presented and discussed on 10/29/2014 at the monthly Nursing Meeting. It was determined that administration will review this policy change with the Medical Director and then proceed with his recommendations for implementation. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits to evaluate the nursing consideration of physician orders for resident catheterization. Audits for all physician orders regarding urinary catheterization of residents will be done weekly x 4, monthly x 3, and then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented. Complete Date: 11-07-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 309	Continued From page 13 facility that UA was unable to be done b/c [because] no personnel to check it into the system. . . ." *09/22/14 at 9:20 a.m.: ". . . Another UA sent to lab today. Resident pre-medicated [with] topical Ativan [an anxiolytic] prior to procedure. Resident combative during procedure. . . ." (A nursing staff member identified the entries dated 09/20/14 actually occurred on 09/21/14 [a Sunday].) A written note to the physician identified the following: ". . . We got a follow up UA for [Resident #2] on Sunday morning. Lab refused to take it. [Resident #2] screamed et fought us on the first UA. She had behaviors [after] the first UA. The lab wouldn't accept the UA unless we brought her to the ER [emergency room]. We drew second UA on 9-22-14 but we gave her topical Ativan first and she still screamed et fought us. . . ." Although Resident #2 expressed extreme distress during the procedures, staff failed to contact the medical provider and continued to obtain a follow-up UA three times. As a result, Resident #2 displayed combative behaviors, received psychopharmacological medication, and was subjected to unnecessary procedures against her will which caused avoidable mental distress and psychosocial harm. Refer to F502.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	1) The corrective action accomplished to ensure that no further healing is delayed in Resident #5's pressure ulcer is clarification of facility protocol for pressure ulcer management. In addition, the policy will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 314	Continued From page 14 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of professional reference,the facility failed to provide the necessary treatment and services to promote the healing of pressure ulcers for 1 of 1 sampled resident (Resident #5) identified with a current pressure ulcer. Failure to implement established treatment interventions (floating heels) may have contributed to the delayed healing of Resident #5's pressure ulcer. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 937 relating to pressure ulcers, stated, "Providing Supportive Devices . . . To Protect a client's heels in bed, supports such as wedges or pillows can be used to raise the heels completely off the bed. . . ." Resident #5's medical record, reviewed on September 23-24, 2014, identified bilateral Stage II heel pressure ulcers, first observed on 08/10/14. Resident #5's "Weekly Pressure Ulcer Record" identified the right heel pressure ulcer as healed on 09/04/14. The record identified the left heel	F 314	updated to reflect that floating heels cannot touch any surface and new suspension booties purchased for further occurrences. Current skin processes, including medications and treatments as prescribed by consulting wound nurse, will continue to ensure the healing process. 2) The facility recognizes that all residents at risk for pressure ulcers and/or skin breakdown have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that upon receiving current understanding from State Surveyor, Resident #5 immediately had pillows placed beneath both her legs to float heels of off all surfaces. It was determined that that facility would purchase and upgrade medical equipment (i.e. booties) to ensure that proper suspension could occur. Protocol will be created with clarification regarding the definition of floating heels. Education was provided to all direct care staff at our monthly Nursing Meeting on 10/29/2014 regarding the clarified definition of floating heels. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits to evaluate staffs compliance with the new heel flotation protocol. Audit will be done monthly x 3 and if compliant, quarterly x 1 year. Results will be reported to the QA team with corrective action implemented. **Complete Date:**	**11-07-14**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 314	Continued From page 15 pressure ulcer as follows: *08/10/14 - "Stage II . . . [left] heel bruise size 4 cm [centimeters] -W [wide], 2 cm L [long] [with] a 1/2 cm w by 1 1/2 L slit near the circumference bruise area. Whitish looking . . . Interventions: Keep heel off bed - Float the heels . . ." *08/15/14 - "Stage II 4.5 cm L, 1.5 cm W . . . not open blackish looking . . . Interventions: . . . Blue Booties [heel protector boots] . . ." *08/21/14 - "Stage II 2 cm L, 2 cm W . . . smooth pinkish . . . Interventions: Wears Blue Heel Booties . . . Pillow under calves so heel floats . . ." *08/28/14 - "Stage II . . . 2.2 cm width by 3 cm L; in circumference of area area has a dark area 1.5 by .5 [cm] area non open . . ." *09/04/14 - "Stage II . . . 2.4 L by 2 cm W on top of circle is a .3 cm W dark brownish black scab by 2 cm L . . ." *09/12/14 - "Stage II 2 cm by 1 cm . . ." *09/19/14 - "Stage II 2.4 cm by .7 cm . . . black scab . . . booties to heels - Decub [decubitus] mattress . . ." Observation on 09/24/14 at 10:00 a.m. showed the nurse (#12) assessed, measured, and applied a dressing to Resident #5's left heel pressure ulcer. The ulcer measured 3.2 cm by 1.4 cm. Resident #5's care plan stated, "Problems: hx [history] blister both heels recently . . . Interventions: . . . 1) Reposition [every] 2 [hours] when in bed 2) Position [with] heels floating off bed [with] use of pillows . . . 5) Floatation mattress . . ." Observation on 09/23/14 at 10:05 a.m. and 12:55 p.m., and on 09/24/14 at 10:00 a.m. showed Resident #5 lying on her bed with bilateral blue heel boots on. All observations showed her heels	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 314	Continued From page 16 rested directly on the mattress.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and family interview, the facility failed to provide care and services to promote urinary continence and prevent urinary tract infections (UTIs) for 1 of 3 sampled residents (Resident #2) with a history of UTIs. Failure to follow a toileting schedule, offer fluids regularly, and ensure prompt initiation of antibiotics does not allow residents to maintain their urinary continence and may result in skin breakdown, and/or repeated UTIs. Findings include: During a confidential interview, a family member stated he/she does not feel that staff check on/change Resident #2 often enough, and that her incontinence brief is frequently wet. The family member stated he/she sometimes has to ask staff to toilet Resident #2.	F 315	1) The corrective action accomplished to ensure that Resident #2 has appropriate UTI prevention and treatment is proper toileting per policy, appropriate offering of fluids, and timely initiation of antibiotic therapy. In addition, facility policy will be changed to make every 2-3 hours and PRN the new toileting standard of care. A small table will be provided next to Resident #2's recliner in the day area, since she refuses to spend time in her room where water is routinely kept. Changes in process for receiving lab reports and timely initiation of antibiotic therapy will be implemented. 2) The facility recognizes that all residents at risk for UTI's have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur for Resident #2 is that on 10/20/2014 education was provided to all direct care staff concerning the new resident toileting policy. It was determined that the new facility standard would be every 2-3 hours and PRN. Discussion was held with both residents spouse and nursing staff and an accommodation was made for more accessible fluid access given her individualized situation. Small table will be placed next to Resident #2's recliner in the day area and staff reeducated on the importance of offering fluids with each interaction. Current lab report process	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 315	Continued From page 17 Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, a history of dehydration, and a history of UTIs. The current Minimum Data Set (MDS), dated 08/11/14, identified short and long term memory problems, frequent urinary incontinence, and extensive assistance from one person for personal hygiene and toilet use. Resident #2's current care plan stated, ". . . Eating - [Resident #2] requires extensive assistance. . . . Interventions . . . Offer water throughout each shift. . . ." Observation on 09/23/14 at 8:29 a.m. showed an unidentified certified nursing assistant (CNA) transferred Resident #2 to a recliner in the TV lounge. At 9:58 a.m., two CNAs (#10 and #11) assisted Resident #2 from the recliner to the bathroom. The resident was incontinent of bowel movement (BM) and urine. The CNA (#10) stated, "It's a big mess" and "She has some more in front" (referring to the resident's incontinent BM). The CNA (#10) stated the night shift had already assisted Resident #2 with morning cares/toileting before she arrived at 5:30 a.m. Upon completion of toileting, the CNAs (#10 and #11) assisted Resident #2 back into the recliner, where she remained until lunch time (approximately 11:30 a.m.). The CNAs failed to offer fluids with cares. At 12:15 p.m., Resident #2 was observed in the recliner in the TV lounge until 1:20 p.m., when two CNAs (#10 and #11) assisted her to the bathroom. The resident was incontinent of urine. Upon completion of toileting, the CNAs transferred Resident #2 into the recliner. The CNAs failed to offer fluids with cares.	F 315	is improved with two staff receiving access to labs electronic medial records for all residents. New process for follow-up on critical or suspect labs will be implemented and procedure for addressing concerns regarding these labs revised to include on-call physician if primary care provider is unavailable. In addition, accessibility to lab reports will be increased on weekends with the movement of printer to nurse accessible location. If current antibiotic prescribed is unavailable from contracting pharmacy, the West River Health Services pharmacy will be utilized for emergency supply. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits to evaluate staffs compliance with the new toileting policy, offering of fluids with each interaction, and timeliness of antibiotic initiation from lab notification. Audit will be done monthly x 3 and then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented. **Complete Date:**	**11-07-14**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 315	Continued From page 18 Observation on 09/24/14 at 6:32 a.m. showed Resident #2 asleep in the recliner in the TV lounge. At 8:00 a.m., Resident #2 ate breakfast in the dining room. After breakfast, staff members transferred the resident to the recliner where she remained until 9:45 a.m., when two CNAs (#2 and #10) assisted her to the bathroom. The CNAs then transferred Resident #2 back to the recliner and failed to offer fluids with cares. During an interview on 09/24/14 at 1:10 p.m., a CNA (#10) stated the staff toilet residents every 2 hours, as it is the facility's standard. She stated she did not toilet Resident #2 before breakfast on 09/23/14 and 09/24/14 because the night shift staff toilet her. The CNA stated she toilets Resident #2 after breakfast. During an interview on 09/24/14 at 3:10 p.m., a supervisory nurse (#9) stated he expected staff to toilet residents every 2 hours if they are unable to voice the need to use the bathroom, and that staff should offer fluids at each interaction with residents. Record review identified the following positive urine cultures: *12/10/13: Escherichia coli (a bacteria commonly found in the gastrointestinal tract) which was treated with Cipro (an antibiotic) and Macrodantin (an antibiotic) *01/05/14: Proteus mirabilis (a bacteria commonly found in the gastrointestinal tract). The record identified a final culture date of 01/05/14; however, staff failed to initiate Levaquin (an antibiotic) until 01/08/14. *06/18/14: Escherichia coli which was treated with Ceftin (an antibiotic)	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 315	Continued From page 19 *09/11/14: Proteus mirabilis which was treated with Keflex (an antibiotic) Facility staff failed to offer fluids between meals and failed to toilet Resident #2 every two hours. This may result in unnecessary incontinence and contribute to the development of UTIs. Failure to promptly initiate antibiotics resulted in delayed treatment of a UTI and may result in unnecessary discomfort and pain.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of product labels, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 2 of 2 resident living areas/units (East and West). Failure to secure hazardous chemicals placed residents with memory loss and/or wandering behaviors at risk of exposure to those chemicals. Findings include: An brief initial tour of the facility occurred on the evening of 09/22/14 and the morning of 09/23/14. An environmental tour of the entire facility occurred on 09/24/14 at 6:40 a.m. Observations	F 323	All chemicals have been removed and relocated into the soiled utility rooms on each end from the Bath and Clean Utility Areas on East and West ends. The soiled utility room is locked at all times. The chemical which was found in the Soiled Laundry Sorting room has been removed to a secure cabinet in the Laundry Room. Laundry Room Area is locked. All residents have the potential to be affected. To help monitor compliance with chemical storage, a daily audit will be done by the Environmental Supervisor or Designee for 1 month. After that, a weekly chemical audit will be done to ensure all hazardous chemicals are secured in the appropriate locked area. Date of Correction:	10/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 323	Continued From page 20 on all occasions showed the following: * Bathing Room, East Unit: 1 can Champion Foaming Cleanser on an open shelf in the shower room * Utility Room with Kitchenette, East Unit: 3 cans Champion Foaming Cleanser on an open shelf 1 bottle Febreeze Gain in an unlocked cupboard under the sink 1 can Fresh Linen Air Freshener in an unlocked cupboard under the sink * Laundry Room: 1 bottle Stain Blast on an open shelf * Bathing Room, West Unit: 1 can Champion Foaming Cleanser on an open shelf in an unlocked cupboard and 2 cans in the shower room 1 can Champion Spray Disinfectant in an unlocked cupboard 2 cans Fresh Linen Air Freshener in an unlocked cupboard 1 container Vinex II 256 One Step Disinfectant Cleanser and Deodorant in an unlocked cupboard The product labels stated the following: * Vinex II 256 One Step Disinfectant Cleanser and Deodorant: ". . . Eyes: Corrosive. May cause permanent damage including blindness. Skin: Corrosive. May cause permanent damage. Inhalation: May cause irritation and corrosive effects to nose, throat and respiratory tract. Ingestion: Corrosive. May cause burns to mouth, throat, and stomach. . . ." * Fresh Linen Air Freshener: ". . . Eyes: May cause irritation. Skin: May cause irritation. May be absorbed through the skin. Inhalation: Excessive intentional inhalation may cause respiratory tract irritation and central nervous system effects (headache, dizziness). Ingestion: May cause	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 323	Continued From page 21 stomach distress, nausea or vomiting. . . . harmful or fatal if swallowed. . . ." * Champion Foaming Cleanser: ". . . Irritating to the eyes on contact. May cause stinging, tearing, redness and swelling of eyes. . . . May cause mild skin irritation, Prolonged and repeated contact may cause redness, burning, drying and cracking skin. . . . Deliberate inhalation of concentrate vapor or mist may cause headaches, nausea, and dizziness. . . . concentrating or inhaling aerosol products can be harmful or fatal. . . ." * Stain Blast: ". . . Eyes: Moderately irritating to eyes. Skin: Moderately irritating to the skin. May cause sensitization by skin contact. Inhalation: Moderately irritating to the respiratory system. Contains an ingredient that can cause asthmatic-like reactions in sulfite-sensitive individuals. Ingestion: Contains an ingredient that can cause asthmatic-like reactions in sulfite-sensitive individuals. . . ." * Champion Spray Disinfectant: ". . . Can cause irritation after contact with the eyes. . . . May cause skin irritation after prolonged contact with skin. . . . Deliberate inhalation of concentrate vapor or mist may cause headaches, dizziness and nausea. . . ." * Febreeze Gain: ". . . Do not spray in eyes. . . ." The staff identified residents with memory loss and wandering behaviors currently living within the facility. Two managerial staff members (#6 and #7), present during the environmental tour on 09/24/14 at 6:40 a.m., confirmed they expect staff to keep chemicals locked and out of reach of these residents.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	1) F 329	The corrective action accomplished to ensure that Resident #2, #5, #6, and #8 are free from unnecessary drug administration is assuring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 329	Continued From page 22 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure 2 of 9 sampled residents (Resident #2 and #8) on psychotropic medications received gradual dose reduction (GDR) unless clinically contraindicated; and failed to ensure 3 of 10 sampled residents (Resident #2, #5, and #6) were provided non-pharmacological or less invasive interventions prior to the use of as needed (PRN) medications. Failure to attempt a GDR of psychotropic medications or provide	F 329	~~implementation of gradual dose reductions of~~ anti-psychotics, attempting & documenting non-pharmacological interventions before administration of PRN medications, and following the facilities bowel protocol. Resident #2 and Resident #8 have successfully undergone gradual dose reductions since survey. Nurses were reeducated on the facilities bowel protocol and the importance of documenting non-pharmacological interventions prior to the administration of PRN medications. 2) The facility recognizes that all residents receiving scheduled and PRN medications have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that on 10/28/2014, the facility's administration and department managers reviewed the current policies regarding unnecessary drug administration. *It was determined that weekly behavior meetings would focus on anti-psychotics and planned gradual dose reductions. With a focus on ensuring that physicians are notified of this need and timely follow up is generated. *Once a gradual dose reduction is attempted, behaviors will be monitored via the treatment book. *The facilities consulting pharmacist and psychiatric nurse will be invited to attend monthly behavior meetings on the third Wednesday. *At weekly behavior meetings, staff will review the PRN's given within that time-frame and evaluate for appropriate supporting documentation of non-pharmacological	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 329	Continued From page 23 non-pharmacological interventions prior to the use of PRN medications may result in these residents and other residents receiving unnecessary medications and possible adverse reactions. Findings include: - Review of Resident #8's medical record occurred on 09/24/14. Diagnoses included dementia. Daily medications included Trazodone 100 milligrams (mg) at night (initiated on 01/25/12). The quarterly Minimum Data Set (MDS), dated 06/28/14, identified long and short term memory problems and severely impaired cognition. The current care plan stated, "Problems: [Resident #8] is taking Trazodone, an anti-depressant used as a sleeping agent, to assist in his symptoms of insomnia . . . Interventions: . . . Monitor medication with PCP [personal care provider] to find lowest baseline dosage that is effective for [Resident #8] to sleep. [04/09/14] - Baseline reached @ [at] 100 mg." Review of Resident #8's physician/provider's progress notes for the past year and a half identified one progress note, dated 08/27/14, which stated, "[Resident #8] has Trazodone 100 mg at bedtime ordered. This is in regards to his insomnia. [Resident #8] has been on this for several years. I spoke with him in regards to reducing the dose and at this time he wishes not to . . ." Resident #8's physician/provider progress notes failed to indicate the clinical rationale regarding continued use of Trazodone and/or why a GDR	F 329	~~interventions. Education was provided to~~ staff on 10/29/2014 regarding appropriate non-pharmacological interventions and suggestions for appropriate interventions will be available at the nurse's station. *Education was also provided at this time regarding the facilities established bowel protocol. Copies of the policy were provided to all nursing and dietary staff. CNA's were also educated on the importance of accurate bowel and bladder documentation within the ADL book. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator or designee to monitor by using audits to evaluate timeliness of gradual dose reductions, appropriate documentation of non-pharmacological interventions prior to PRN administrations, and compliance to facilities bowel protocol. Audits will be done monthly x 3 and then quarterly x 1 year. In addition, minutes will be taken and attendance filed/recorded at all behavior meetings. Results will be reported to the QA team with corrective action implemented. Complete Date: 11-07-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 329	Continued From page 24 would be contraindicated. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dementia. Current medications included Zyprexa (an antipsychotic) 2.5 mg daily (initiated 07/29/13). Resident #2's current MDS, dated 08/11/14, identified verbal behaviors occurring on 1-3 days of the assessment period. The previous MDS, dated 05/12/14, identified no behaviors. Resident #2's behavior charting identified the following: *August 2013: no behaviors charted *September 2013: one episode of "constant chatter" *October 2013: one episode of "constant chatter" *November 2013: no behaviors charted *December 2013: one episode of "foul language" and "constant chatter" *January 2014: one episode of "constant chatter" and one episode of "hitting," "foul language," and "constant chatter" *February 2014: three episodes of "foul language" and "constant chatter" and one episode of "hitting" and "constant chatter" *March 2014: three episodes of "constant chatter" and one episode of "foul language" *April, May, and June 2014: no behaviors charted *July 2014: five episodes of "foul language" *August 2014: one episode of "foul language" *September 2014: one episode of "foul language" and one episode of "constant chatter" Physician progress notes since the initiation of Zyprexa (over one year prior) failed to identify the clinical rationale for the continued use of Zyprexa	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 329	Continued From page 25 or contraindications for a dose reduction. - Review of the facility policy titled "Bowel Protocol" occurred on 09/24/14. This policy, dated 2009, stated, "This Bowel Protocol is being implemented to enhance and promote bowel movements for residents . . . 1. DAY ONE: Offer fluids and give regular prescribed medications . . . 2. DAY TWO: Offer fluids and give regular prescribed medications . . . 3. DAY THREE: Offer fluids and give regular prescribed medications . . . Give MOM [Milk of Magnesia] in the evening as ordered on PRN . . . 4. DAY FOUR: Offer fluids and give regular prescribed medications . . . Give Dulcolax Suppository in the morning as ordered on PRN medication list . . . - Review of Resident #5's medical record occurred on September 23-24, 2014. Diagnoses included constipation and dementia. Daily medications included Senna S for bowel stimulation/elimination. Resident #5's care plan stated, "Problems: At risk for constipation r/t [related to] decrease mobility. Goals: [Resident #5] will try to have soft, formed stool every 2-3 days . . ." Observation on 09/23/14 at 10:05 a.m. showed two certified nursing assistants (CNAs) (#1 and #2) assisted Resident #5 to the bathroom. The CNA (#1) removed the resident's brief and observation showed the brief soiled with stool. After the resident had voided on the toilet, the CNAs assisted her to stand and the CNA (#1) provided perineal cares. The CNA (#1) told the other CNA to lower the resident back to the toilet because she still had stool in her rectum. The CNAs then transferred Resident #5 to her bed.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 329	Continued From page 26 The CNA (#1) told the nurse (#3) the resident had a hard bowel movement. The nurse proceeded to administer a bisacodyl suppository without performing a digital rectal exam. Review of Resident #5's September 2014 bowel records identified bowel movements on September 2, 3, 4, 5, 8, 11, 12, 17, 21, and 23. The bowel record and medication administration record (MAR) showed no PRN medications (MOM or bisacodyl suppository) administered until September 23, 2014 when Resident #5 received a bisacodyl suppository. During an interview on the afternoon of 09/23/14, the CNA (#1) stated Resident #5 had a large, incontinent bowel movement after the suppository. The nurse (#3) administered a suppository on September 23 even though the bowel records showed Resident #5 had a bowel movement on September 21 and observation showed a bowel movement just prior to the administration of the suppository. Failure to allow Resident #5 to evacuate the stool on her own or administer a less invasive medication (MOM) per facility protocol, may have resulted in unnecessary medications and does not maintain her dignity and respect. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease. Current medications included Ativan (an anxiolytic) 0.5 mg three times daily prn. Resident #2's MARs identified the following: *September 2014: prn Ativan administered three	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 329	Continued From page 27 times *July 2014: prn Ativan adminstered one time *June 2014: prn Ativan administered seven times *May 2014: prn Ativan administered five times Facility staff failed to identify non-pharmacological interventions attempted prior to administering prn anxiolytics (except on one occasion in June). - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included anxiety and depression. Current medications included Klonopin (an anxiolytic) 0.25 mg twice daily prn. Resident #6's MARs identified the following: *June 2014: prn Klonopin administered three times *July 2014: prn Klonopin administered two times Facility staff failed to identify non-pharmacological interventions attempted prior to administering prn anxiolytics. Failure to attempt non-pharmacological interventions and evaluate their effectiveness before administering psychopharmacological medications may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	A revised policy for the dishwasher sanitizer has been developed. • Dishwasher chemical representative came 10/22/14 to check the dishwasher and reset sanitizer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 371	Continued From page 28 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, chemical parts per million (ppm) record review, policy and procedure review, interview with a consultant, and facility staff interview, the facility failed to ensure proper sanitation of dishware for 1 of 1 dish machine during 2 of 2 observations. Failure to ensure the strength of the sanitizer is not stronger than recommended has the potential to leave chlorine residue on the dishware. Findings include: Review of the facility policy titled "Dish machine Use" occurred on 09/24/14. This policy, dated 09/01/07, stated, ". . . Dish machine chemical sanitizer and concentrations will be per instructions. Concentrations will be recorded in a facility approved log. Dietary staff will check sanitizer daily and/or 3 times a day. . . . Of [sic] hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dish machine immediately until temperatures or PPM are adjusted. . . ." Observations on the mornings of September 23-24, 2014, showed a managerial staff member (#8) removing a rack of dishes from the dish machine. The managerial staff member (#8) confirmed the dish machine used chemicals to sanitize the dishware. In both instances, this staff member (#8) tested the chemical concentration	F 371	• An in-service for staff on correct usage of test strips was also done at that time. Due to the machine testing at 200 PPM and the test strips which are used to screen the sanitizer concentration does not differentiate 200 PPM concentration from >200 PPM concentration, the EcoLab Representative who sets and tests the concentrations of chemicals used by the dishwasher will return to the reset the sanitizer concentration to be more within a range of >100 PPM to <200 PPM which will be more easily differentiated by the test strip used so staff can ensure sanitizer concentration is at an appropriate strength. This date is set for 11/5/14. All residents have the potential to be affected. Sanitizer concentration is to be within a range from 50 PPM to 200 PPM, not to exceed 200 PPM concentration. This monitoring will be documented on a daily QA audit checklist which has always been done3 times per day by Dietary Staff to ensure a proper sanitizing concentration that has been set by Ecolab. The QA Audit done on the dishwasher by Dietary Staff will be reviewed by the Dietary Manger or Designee Daily which monitors the sanitizer concentration tested 3x daily by the Dietary Staff The Dietary Manager will monitor the checklist daily for 2 weeks, then weekly for 1 month, monthly for 1 month, then monthly for 3 months and then quarterly thereafter. Any change in results will be reported immediately to the Dietary Manager. Dietary Manager or Dietary Staff will notify the Ecolab	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 371	Continued From page 29 of the dish machine by dipping a chlorine test strip into the water/sanitizer remaining in the machine immediately following the wash/rinse cycle. The strip changed color to 200 ppm or greater. During interview on 09/24/14 at 1:45 p.m., a consultant (#9) (who specializes in chemical products) reported, "200 ppm is too high, because we want to keep it under 100 ppm. At 200 ppm, you may be leaving residue on the dishes." The consultant (#9) confirmed the chlorine test strips do not register concentrations above 200 ppms. During an interview on 09/24/14 at 2:00 p.m., when told of the acceptable range of 100 ppms, a managerial staff member (#8) stated, "The test strip was way, way stronger than that." Review of the September 2014 "dishwasher check [log]" hanging on the wall opposite the dish washer, identified, "Dishwasher check needs to be at 50 mm [millimeters]." The log showed dietary staff had checked "above" 50 mm each day. During an interview on 09/24/14 at 2:00 p.m., a managerial staff member (#8) reported the acceptable "50 mm" shown on the log was a mistake. She reported the log was intended for their "old machine, not their new one." The facility failed to ensure the strength of the sanitizer was not stronger than recommended which had the potential to leave chlorine residue on the dishware.	F 371	dishwasher representative for immediate correction of the problem. The Dietary Manager will submit a report of the monitoring to the QA Committee at each scheduled meeting. Completion Date: 11/7/14	
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 428 SS=D	Continued From page 30 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, the facility's consulting pharmacist failed to recognize and report medication regimen irregularities for 1 of 9 sampled resident (Resident #2) on a psychoactive medication. Failure to identify irregularities and recommend a gradual dose reduction (GDR) may result in residents receiving unnecessary medications. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and anxiety. Current medications included Zyprexa (an antipsychotic) 2.5 milligrams (mg) daily (initiated 07/29/13). A "Pharmacy Consultant Report," dated 07/31/14, stated, "Zyprexa- same dose [more than] 1 yr [year]- GDR?" The medical record lacked evidence of a pharmacy recommendation for a GDR prior to	F 428	1) The corrective action accomplished to ensure Resident #2 is free from irregularities and unnecessary medication administration due to delayed gradual dose reductions is active monitoring of the gradual dose reduction schedule and monitoring pharmacist compliance with issuing notifications. Resident #2 medication regime will be reviewed during the monthly behavior meetings. 2) The facility recognizes that all residents receiving medications that require gradual dose reductions or whose medications are monitored by the consulting pharmacist have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that on 10/28/2014, the facility's administration and department managers reviewed the current process associated with our pharmacy consultants review of gradual dose reductions. It was determined that the pharmacist consultant will be invited to monthly behavior meetings where resident gradual dose reduction requirements are reviewed in detail. In addition, the Social Service Designee will communicate with the consulting pharmacist regarding needed and accomplished gradual dose reductions based on her own monitoring log. 4) The facility plans to monitor its performance to makes sure solutions are sustained by assigning the QA coordinator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 428	Continued From page 31 07/31/14 (a year after the initiation of Zyprexa).	F 428	or designee to monitor by using audits to evaluate the pharmacist consultants compliance with the required	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure laboratory (lab) services to meet the needs of residents for 1 of 1 sampled resident (Resident #2) who was denied lab services. Failure to ensure a urinalysis (UA) was processed as ordered resulted in staff obtaining a second UA (by catheterization) and subjecting Resident #2 to an unnecessary procedure. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and a history of urinary tract infections (UTIs). Nurses' notes identified the following: *09/20/14 at 7:20 a.m.: ". . . UA [urinalysis] taken [down] to Lab. . . ." *09/20/14 at 8:20 a.m.: ". . . Lab informed this facility that UA was unable to be done b/c [because] no personnel to check it into the system. . . ." *09/22/14 at 9:20 a.m.: ". . . Another UA sent to lab today. . . ." A message to the physician identified the	F 502	gradual dose reduction schedule for each resident. These audits performed by QA Coordinator or Designee will occur monthly for 3 months, then quarterly thereafter. Results will be reported to the QA team with corrective action implemented. The facility contracts with West River Health Services for laboratory services to meet the needs of WHCC's residents. This agreement has been in place since September 2007. Regarding this citation, a new laboratory staff member staffing the lab and did not know how to process the sample registration. Due to communication issues between the lab and care center staff nurse, it was not communicated to staff nurse that the urine sample was going to be stored and process the next business day when the sample could be registered properly. This miscommunication resulted in the last attempt to acquire the sample. This has the potential to affect all residents of Western Horizons Care Center that have weekend lab testing done. The West River Health Services Laboratory has written a policy relating to this issue labeled as WHCC PATIENT LABS which went into effect on 10/2/14. This policy covers laboratory samples received from WHCC and the sample registration process of those samples. A copy of the policy has	11/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	09/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 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
F 502	Continued From page 32 following: ". . . We got a follow up UA for [Resident #2] on Sunday morning. Lab refused to take it. . . . The lab wouldn't accept the UA unless we brought her to the ER [emergency room]. . . ." During an interview on the afternoon of 09/24/14, a supervisory nurse (#9) stated staff obtained the UA on a weekend; therefore, there was not a receptionist available at the lab to check the UA into the system. Refer to F309.	F 502	been included. Staff education of updated policy will be done. The QA Coordinator or Designee will perform an Audit documenting all ordered lab testing was accepted by the reference lab timely ensuring resident quality of care. The audit will be done by the QA Coordinator or Designee weekly for 4 weeks, then monthly x3, then quarterly thereafter. This audit will be submitted to the QA Committee for review.	11/7/14