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

PRINTED: 10/10/2013
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 _____	09/25/2013

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 September 23, 2013 and completed on September 25, 2013 the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents 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 F323	
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON SEPTEMBER 20, 2012. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure use of assistive devices to prevent accidents for 4 of 7 sampled residents (Resident #2, #4, #6, and #9) and one supplemental resident (Resident #12) observed transferred with a gait belt. Failure to properly use a gait belt increased the risk of a fall or injury to the resident. Findings include:	F 323	1. The Gait Belt Safety policy dated 10/01/2013 was reviewed and continues to remain appropriated. Nursing staff were in-serviced 10/2/2013 by RN and CPTA on proper Transfer Belt placement and training regarding safe transfers. A follow up in-service is scheduled for 10/30/2013. 2. All residents who require assistance with transfers have the potential to be affected. 3. Random Audits will be completed by DON/designee 3x/week times 4, then Weekly x4 or until 100% compliance is achieved then quarterly. Audits will be tracked through the QA nurse for team review at our monthly TQM meeting. 4. Completion Date:	10/30/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 10/24/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Review of the facility policy titled "Gait Belt Safety" occurred on 09/25/13. This policy, dated 10/01/12, stated, ". . . Gait belts are used with any resident requiring "hands on" assistance for ambulation or transfer . . . Procedure . . . 4. Grasp the belt, as you would in a strong handshake, palm up. . . ." - Review of Resident #2's medical record occurred on all days of survey and included a history of falls. The current care plan stated, ". . . When transferring [Resident #2] staff are to use a gaitbelt if [Resident #2] will let you . . . one staff to transfer. . . ." A physician's order, dated 09/23/13, identified the resident may bear weight as tolerated. Observation on 09/23/13 at 2:50 p.m. showed a certified nursing assistant (CNA) (#3) transported Resident #2 in her wheelchair into the bathroom. The resident rose quickly and transferred herself onto the toilet. When assisting the resident back to her wheelchair from the toilet, the CNA (#3) failed to apply a gait belt to transfer the resident. On 09/24/13 at 10:05 a.m., observation showed a CNA (#4) transferred Resident #2 from her wheelchair to the toilet using a gait belt. During the transfer, the CNA (#4) held onto the gait belt with one hand and pulled under the resident's left arm with his other hand when assisting the resident to stand. Observation on 09/24/13 at 1:50 p.m. showed two staff members (#5 and #6) transferred Resident #2 from the recliner to her wheelchair without using a gait belt. During the transfer, both staff members (#5 and #6) pulled under the resident's arms to assist her to transfer to the wheelchair.	F 323		

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F 323	Continued From page 2 - Review of Resident #6's medical record occurred on all days of survey and included a history of falls. The current care plan stated, ". . . transfer using the asssit [sic] of one and gait belt. . . ." Observation on 09/23/13 at 2:20 p.m. identified a CNA (#7) transferred Resident #6 from her wheelchair to the toilet without using a gait belt. Observation showed the resident was unsteady and required several attempts to rise from her wheelchair. During the transfer, the CNA (#7) pulled under the resident's right arm to assist her to transfer both on and off the toilet. On 09/24/13 at 8:30 a.m., observation showed a CNA (#9) transferred Resident #6 from her wheelchair to the toilet without using a gait belt. The CNA (#9) grasped the back of the resident's pants to assist her to transfer on and off the toilet. - Review of Resident #9's medical record occurred on 09/25/13. The current care plan stated, ". . . Transfer [Resident #9] using a gaitbelt with 1-2 staff . . . or standup lift when he is tired. . . ." Observation on 09/25/13 at 12:20 p.m. identified a CNA (#4) transferred Resident #9 from his wheelchair to the toilet using a gait belt. During the transfer, the CNA (#4) held onto the gait belt with one hand and pulled under the resident's right arm with his other hand when assisting the resident to stand from his wheelchair and again from the toilet. On 09/25/13 at 12:35 p.m., a CNA (#4) and a contracted agency CNA (#8) transferred Resident	F 323		

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F 323	Continued From page 3 #9 from his wheelchair to his bed. During the transfer, both CNAs (#4 and #8) held onto the gait belt with one hand and pulled under the resident's arms with their other hand. - Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . requires extensive assistance. . . . Interventions: 1-2 staff to assist . . . to be out of bed in wheelchair or recliner. Staff to use gait belt when transferring. . . ." Observation on 09/24/13 at 9:30 a.m. showed a CNA (#8) transferred Resident #4 from the wheelchair to the toilet and back to the wheelchair after toileting. Although the resident wore a gait belt, the CNA (#8) held onto the resident under her arm instead of holding onto the gait belt. Observation on 09/24/13 at 10:35 a.m. showed two staff members (#8 and #9) transferred Resident #4 from her wheelchair to a reclining chair. The CNA's (#8 and #9) held under the resident's arms during the transfer, and one CNA (#9) grasped the back of the resident's pants instead of holding onto the gait belt. - A random observation on 09/25/13 at 1:05 p.m., showed two staff members (#8 and #10) transferred Resident #12 from her wheelchair to a recliner using a gait belt. During the transfer, the CNA (#8) held onto the gait belt with one hand and pulled under the resident's arm with her other hand. Review of Resident #12's medical record occurred on 09/25/13. Resident #12's current care plan stated, ". . . Transfer using gaitbelt . . ."	F 323		

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F 323	Continued From page 4 During an interview on 09/25/13 at 3:50 p.m., two administrative staff members (#1 and #2) stated they expect staff to use gait belts when physically assisting residents with transfers and staff should avoid pulling on residents' arms.	F 323		