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

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 _____	10/19/2011

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 October 17, 2011 and completed on October 19, 2011, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 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's F221, F314, & F371	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, resident and staff interview, the facility failed to ensure 3 of 3 sampled residents (Resident #3, #4, and #9) remained free from physical restraints not required to treat the residents' medical symptoms. Failure to identify the side rails as potential restraints resulted in their use without identification of need and the medical symptom they are indicated for. Findings include: The Centers for Medicare and Medicaid Services (CMS) have defined the standards of practice regarding the use of restraints. Physical Restraints are defined as any manual method or physical or mechanical device, material, or	F 221	1.Residents #3, #4 & #9 will be assessed for appropriateness of the use of Physical Restraints (side rails) using a facility created form: "Restraint Assessment." As of 10/20/2011 these assessments have been completed. Residents #3 & #9 were found to not need side rails however requests side rails for a sense of safety. Currently resident #3 is not using side rails pending POA's consent and has not voiced a sense of not feeling safe in bed. WHCC will continue to monitor side rail use. Resident #4 was found to not need side rails. Of the residents that do not need side rails and the rest of the facility, the side rails were zip tied in the "up" position as a repositioning device to remind staff to not use them in the "down" position. 2. All residents have the potential to be affected. 3. WHCC has four (4) forms on order from Med-Pass to further address the issue of restraints. WHCC will assess every resident for restraint use using the form: "Pre-Restraint Evaluation" from Med-ass. WHCC will assess every resident on the use of side rails using the Med-Pass form: "Evaluation For The Use Of Side Rails." If a restraint is indicated/needed, WHCC will obtain consent using the Med-Pass	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator/COO	11/4/11

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 221	Continued From page 1 equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. - Review of Resident #3's medical record occurred on all days of the survey. Diagnoses included a prior cerebral vascular accident (CVA) with right-sided hemiplegia. The annual Minimum Data Set (MDS), dated 10/07/11, indicated intact cognition, extensive assistance of one person for bed mobility, extensive assistance of two or more persons for transfers, and limited range of motion of the upper and lower extremity on one side of his body. The current careplan listed the problem "Turning/positioning in bed . . . . requires extensive assistance." Interventions included ". . . Has repositioning rails on both side [sic] of bed for repositioning self or assist. . . ." Observations on 10/17/11 at 2:20 p.m., 10/18/11 at 9:15 a.m. and 2:00 p.m., and 10/19/11 at 10:20 a.m., showed Resident #3 lying in bed with a half-length side rail lowered at the center of the bed on both sides of the bed. The position of these rails prevented the resident from exiting the bed without moving to the foot of the bed or crawling over them. Record review identified no assessment, monitoring or physician order for the side rails. - Review of Resident #9's medical record occurred on 10/19/11. Diagnoses included a prior CVA with right-sided hemiplegia and depression. The annual MDS, dated 10/03/11, indicated	F 221	form: "Informed Consent For Use Of Restraints" and Physician's orders for the restraint. WHCC will re-evaluate every resident that has a restraint annually, quarterly, re-entry & significant change. This will be done with the MDS schedule. The form that will be used is: "Physical Restraint Elimination Review." 4. MDS Nurse & Unit Manager will monitor the completeness of these forms weekly. This will be tracked through the QA nurse for team review monthly at our TQM meeting. QA nurse will track this monthly for three (3) months or until 100% compliance is achieved then quarterly. DON will follow up on any forms that are not completed as outlined and will ensure the assessments are completed as soon as possible. Staff education will be provided on 11/03/2011 on restraints and their proper use (F 221). 5. Completion Date: ~~01/19/2012~~ 11/23/2011 A.D.T.O. 11/8/11 1045 c Jonathan Anderson, DON	

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F 221	Continued From page 2 moderate cognitive impairment, extensive assistance of one person for bed mobility, extensive assistance of two or more persons for transfers, and limited range of motion of the upper and lower extremity on one side of her body. The current careplan listed the problem "Turning/positioning in bed . . . requires extensive assistance." Interventions included ". . . Has hand rails to assist as needed. . . . Two staff to reposition . . ." On 10/19/11 at 10:15 a.m., observation showed Resident #9 lying in bed with a half-length side rail lowered to the center of the bed on both sides of the bed. The position of these rails prevented the resident from exiting the bed without moving to the foot of the bed or crawling over them. Resident #9 stated, "I hold them [side rails] to move in bed, and they keep me from getting out." Record review identified no assessment, monitoring or physician order for the side rails. - Review of Resident #4's medical record occurred on all days of survey and included diagnoses of atrial fibrillation, congestive heart failure, and Gullaine Barre (a syndrome causing weakness beginning in the feet and hands.) Observations occurred on 10/17/11 at 9:50 a.m., 2:10 p.m., and 4:10 p.m. on 10/18/11 at 7:10 a.m., and 8:10 a.m. and on 10/19/11 at 11:30 a.m. of Resident #4's room and revealed the side rail on the left side of the bed positioned in the up position and the one on the right in the down position. The rail in the "down" position would limit the normal exiting pattern from a bed, and would inhibit a resident from exiting the middle of the	F 221		

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F 221	Continued From page 3 bed without staff assistance to remove the rail. Resident #4's current care plan listed no positioning devices and the medical record lacked an assessment for devices used while in bed or during transfer. During an interview on 10/19/11 at 11:30 a.m., an administrative nurse (#3) stated, when asked about a policy and procedure for side rail use, "we don't have one because we don't use side rails." On 10/19/11 at 1:00 p.m., an administrative nurse (#4) stated the facility removed all full-length side rails from use, and no longer completed side rail assessments as they did not consider half rails as restraints.	F 221		
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 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, review of professional reference, review of facility policy, and staff interview, the facility failed to assess, monitor and treat a pressure ulcer for 1 of 1	F 314	1.Resident #1 was assessed on 10/19/2011 before the surveyors left WHCC. The MD was notified of the surveyors findings and gave orders over the phone for a treatment and gave a follow up date that the MD will be up to further assess. As of 10/25/2011 & 10/28/2011 the Pressure Ulcer's have been resolved. 2.All residents have the potential to be affected. 3.WHCC has reviewed our policies on pressure ulcers. WHCC has implemented two (2) new policies having to do with pressure ulcers: "Pressure Ulcer Treatment" & "Pressure Ulcer Skin Breakdown – Clinical Protocol." These policies will offer direction to better pressure ulcer management and care. "Pressure Ulcer Wound Management Quick Reference" protocol will be made available to staff in the Nursing Policy Book under "Protocols" tab. Education on pressure ulcer treatment and management	

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F 314	Continued From page 4 sampled resident (Resident #1) with a pressure ulcer not identified by the facility. Failure to identify causative factors, implement preventive measures, assess on a consistent basis (with reapplication of ace wrap), and reevaluate, resulted in the development of pressure ulcers on Resident #1's foot. Findings include: The Centers for Medicare and Medicaid Services (CMS) have defined the standards of practice regarding the prevention and treatment of pressure ulcers. A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Friction and shear are important contributing factors to the development of pressure ulcers. The facility should have a system to ensure assessments are timely; interventions are implemented, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the practitioner, and addressed. Review of the facility policy titled "Pressure Ulcer Risk Assessment" occurred on 10/19/11. This policy, dated 2005, stated, "General Guidelines: . . . 3. Pressure can also come from splints, casts, bandages, and wrinkles in the bed linen. 4. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected. . . 6. Once a pressure ulcer develops, it can be extremely difficult to heal. . . 10 . . .the Charge Nurse will assess and document the condition of each resident's skin weekly for signs and symptoms of irritation and breakdown . . . Documentation: The following information should	F 314	(314) will be provided to staff on 11/03/2011. DON will prepare education on pressure ulcer identification, causes and reporting to management on 12/29/2011 to further educate staff. 4.Unit Manager will report all skin conditions to QA Nurse & DON on "Skin Conditions Report" on a weekly basis. To ensure no pressure ulcers are missed, the Chare Nurse will perform weekly skin assessments on all residents on resident's bath day. Charge Nurse will make an entry in TAR and Nurses Notes (if needed) to help track this. CNA's will report to Charge Nurse daily on any new skin condition. This will be logged on the "Daily Log Sheets" provided (daily) to the Charge Nurse. This will also be tracked through QA on a weekly basis for three (3) months and reporting to TQM meeting monthly for three (3) months or until 100% compliance is achieved then as needed (PRN). 5. Completion Date: ~~01/19/2012~~ 11/23/2011 Airphone 11/8/11 10:45 DL c Jan. Anderson, DON	

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F 314	Continued From page 5 be recorded in the resident's medical record: . . . The condition of the resident's skin [i.e., the size and location of any red or tender areas or open skin]. . . " Review of Resident #1's medical record occurred on all days of survey and included a diagnosis of a sprained right ankle which occurred on 10/03/11. Review of a "Clinic/Consultation Referral" form occurred on 10/18/11. This form, dated 10/03/11, stated, ". . . Progress notes: X-ray neg [negative] Rt [right] ankle swollen and warm and moderate tender [sic]. Ice ankle BID [twice daily] for 20 min [minutes] for 3 days keep ace wrap on x [times] 10 days [and] can come off @ [at] HS [hour of sleep] on in a.m. aid her in ambulation. New diagnosis: Sprained Rt ankle. New Orders: ICE, ACE Wrap, Elevation, assist on ambulation consult Physical Therapy for ankle Strengthen . . ." Review of Physical Therapy (PT) progress notes stated the following: *10/06/11 ". . . After taking shoe [and] sock off pt's [patient's] foot it was noted that pt has ace wrap to ankle and swelling noted above ace wrap. Wrap was removed. Pt has dime-sized blister on dorsal [top] surface of foot surrounded by redness (approximately size of half dollar). Nursing staff [staff names] notified . . . " *10/12/11 ". . . small (dime size) blister on achilles tendon. Drainage noted. Nursing notified [and] this will be debrided [and] dressed. Cont [continue] poc [plan of care]. . . " Review of physician orders regarding the blister	F 314		

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F 314	Continued From page 6 on the achilles tendon which was first noted on 10/12/11 by PT, stated the following: *10/12/11 "Place op-site over blister on back of R foot above heal [sic] Change PRN [as needed] . . ." A nurses note, dated 10/07/11, stated "[physician's name] called and notified of sm [small] blister [arrow up] R [right] foot, he will eval [evaluate] on his next visit to N.H. [nursing home]." *10/07/11 - 11:20 p.m., " . . . visited by [physician's name] this afternoon for the top of her left foot. It has a blister which is having [no] drainage. Bacitracin was applied, and a Band-Aid was put over. ACE wrap is also on the left foot to help with swelling . . ." (The documentation references the left foot, verses the right foot identified with the blister.) During an interview on the afternoon of 10/18/11, when asked about Resident #1's pressure ulcer on the top of her right foot, an administrative nurse (#3) referred to a physician progress note from the 10/07/11 visit. The note stated, ". . . I saw her a week ago for a right sprained ankle. As I look at it today, it is much more black and blue. . . but what has happened though is they believe she was without an Ace wrap or a shoe and probably without a sock and now on the front of her ankle she has developed an ulcer about 1 cm [centimeter] x 1 cm . . . I will follow her in a week to see if it will dry up or if I have to open this up. This could turn into a problem now. We will have to watch for an infection . . . Plan . . . The ulcer should be treated with some bacitracin and a Band-Aid, but we have to watch it closely. I am worried because of her age that this may break	F 314		

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F 314	Continued From page 7 down into something. I will see her in one week. . . . " The record lacked evidence Resident #1 was seen by the physician again, in one week. During an observation on 10/18/11 at 3:30 p.m., a staff nurse (#5) removed Resident #1's shoe and sock and measured the area on the top of the right foot. When asked about the area, the staff nurse (#5) stated, "it is a healing stage II [pressure ulcer] with no redness or infection and measures 1.7 cm x 2.2 cm." Observation showed the second blister identified on 10/12/11 on the achilles tendon no longer present. During an interview on 10/19/11 at 1:50 p.m., an administrative nurse (#3) indicated the blister on the top of the right foot would be considered a result of pressure from the ace wrap. Review of Resident #1's record identified the presence of a 1 cm x 1cm pressure ulcer to the top of her right foot, as noted in a physician's progress note on 10/07/11. The record identified orders, dated 10/03/11 for an ace wrap to come off at night and to place the ace wrap on in the morning. The record identified no further monitoring of the pressure ulcer after 10/07/11 until the observation on 10/18/11 (11 days later). On 10/12/11, Physical Therapy identified another pressure ulcer on the achilles tendon above the heel on the right foot. The record lacked any further monitoring or assessment of this area, as well.	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	1.Educate staff on sanitization policy and correct testing of sanitizing solution with proper test strips. Staff review policy and guidelines with dietary manager and chemical representative per phone call on 10-19-2011 and posters and checklist were placed on refrigerator across from	

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F 371	Continued From page 8 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, review of the facility's policy and procedure, and staff interview, the facility failed to properly prepare the sanitization solution in the kitchen sanitization bucket on 2 of 3 days (October 18-19, 2011) of survey. Without the correct concentration of sanitizing solution, the facility is unable to effectively clean/disinfect food/nonfood contact surfaces and food preparation equipment. This practice has the potential to increase the risk of foodborne illness and can affect all residents who eat food prepared and served in this area. Findings include: The 2005 FDA Food Code, Public Health Reasons, page 440 states, "the effectiveness of chemical sanitizers can be directly affected by the . . . concentration of the sanitizer solution used . . . Therefore, it is critical to sanitization that the sanitizers are used properly and the solutions meet the minimum standards. . . ." The Food Code, page 377, further states ". . . Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit . . ."	F 371	sanitizer pump sink. Test strips and thermometer are located beside sanitizer pump Routine checking and recording the test strip finding and water temperature 3x times per day. Inservice completed with chemical representative 11-2-2011. 2.All residents have the potential to be affected. 3. Monitoring checklists to ensure that deficiency will not reoccur. Staff will complete checklist 3x daily. Dietary manager will monitor checklist weekly x 1 month then monthly for 3 months or until 100% compliance then PRN as needed. Check list started and on spot education was provided to staff on10-19-2011. 4.Add bucket sanitizer to QA tracking form and give finding to QA nurse monthly to ensure correction has been achieved. 5.Completion date- ~~1-19-12~~ 11-23-11 per phone 11/8/11 10:45 DL c Jon Anderson, RDN	

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F 371	Continued From page 9 Review of the facility's policy titled "Sanitization" occurred on 10/19/11. This policy, dated December 2008, stated, ". . . 4. Sanitizing of environmental surfaces must be performed with one of the following solutions: . . . b. 150-200 ppm [parts per million] quaternary ammonium compound (QAC). A handwritten entry read, "150-400 acceptable range 250 with water temp [temperature] of 66-75 degrees . . ." Observations in the facility's kitchen area identified the following: - On 10/18/11 at 9:30 a.m., a dietary management staff member (#1) prepared a bucket of quaternary ammonia sanitizer and water. Upon request, she tested the chemical concentration of the sanitizer by immersing a test strip in the sanitizer for approximately 10 seconds with minimal change in color (100 ppm) identified on the strip. The dietary management staff member (#1) immediately repeated the process, with the same results. - On 10/19/11 at 8:15 a.m., a dietary staff member (#2) prepared a bucket of quaternary ammonia sanitizer and water. On request, she tested the chemical concentration of the sanitizer by immersing a test strip in the sanitizer for approximately 10 seconds with minimal change in color (100 ppm) identified on the strip. When asked what the chemical concentration of the sanitizer should be, she responded, "I don't know." When asked if the dietary department records the chemical concentration of the sanitizer in the buckets, she responded, "No, we don't keep one for that. We do [for] the washing machine."	F 371		

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F 371	Continued From page 10 During interview on 10/19/11 at 8:25 a.m., when asked what the chemical concentration of the sanitizer should be, the dietary management staff member (#1) located a sign posted in the kitchen and read the recommended concentration level of 150 ppm. At this time, the surveyor pointed out the test strips being used in the kitchen did not match the test strips on the illustration on the sign. The dietary management staff member (#1) threw the strips away, stating "He must have given me the wrong strips." She then retrieved another container of strips from the drawer which did match the sign.	F 371		