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

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 _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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F 000	INITIAL COMMENTS An on-site revisit was conducted December 10-11, 2014 to determine compliance with the deficiencies identified during the October 16, 2014 survey. The revisit sample included seven (7) residents for focused review of the areas of non-compliance. The tag numbers enclosed in { } denotes citations that remained not met as determined by the on-site revisit.	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 F280, F323, F371, & F520.	
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to review and revise	{F 280}	F280 1) Resident #1's Care Plan was updated to reflect "off-loading boots to both heels" done on 12/11/14. Resident #1 Care Plan was also updated to reflect palliative care order on 12/11/14. 2) All residents have the potential to be affected. 3 & 4) The Care plan for Resident #1 was updated during the survey regarding off-loading boots and palliative care. To ensure all care plans reflect resident care, resident conditions, and changes that have occurred, all Care Plans will be reviewed. Besides the weekly MDS scheduled review and related Care Plan updating, 1-2 Resident Care Plans will be reviewed weekly at the Significant Change Assessment meeting where the IDT Team will comparing the existing care plan to the resident charting, treatment book, diagnostic book, and MAR's to ensure that the Resident Care Plan reflects current resident conditions and cares provided. Meeting minutes are kept by the MDS Coordinator. The Care Plans will be reviewed by the IDT Team using the Significant Change in Conditions Screening form to ensure continuity in reviewing the care plans. An Audit will be performed by the DON or Designee that documents the accuracy of the Care Plan or if the Care plan needed to be updated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1/13/15

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 280}	Continued From page 1 the comprehensive care plan to reflect the residents' current status for 1 of 7 sampled residents (Resident #1). Failure to revise the care plan related to palliative care and protective heel boots limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of Resident #1's medical record occurred on December 10-11, 2014. The record identified the facility initiated an off-loading heel boot for the resident's left heel on 11/07/14 and right heel on 11/12/14. Observation on 12/10/14 at 1:20 p.m. showed Resident #1 seated in her wheelchair with blue heel boots on bilaterally and the resident's heels off-loaded in the boots (not touching the bottom of the boots). The current care plan stated, "Problems: Stage 3 pressure ulcer . . . Interventions: . . . On right heel has blue foam bootie. Left heel boot off [off-loading] floating heel bootie . . ." The care plan failed to identify the off-loading heel boot on the resident's right heel. The facility's plan of correction (POC) identified a compliance date of 12/06/14. The POC stated, ". . . will have the MDS [Minimum Data Set] Nurse update [Resident #1] care plan to reflect palliative care . . ." The curent care plan failed to identify palliative care. During an interview on the afternoon of 12/11/14, an administrative nurse (#2) agreed Resident #1's care plan failed to identfiy palliative care and	{F 280}	The goal of this audit will be 95% to 100% compliance in comparing the Care Plan to the Resident's current condition, cares, and changes. This will be done weekly until all care plans have been audited and thereafter the audit will be incorporated into the weekly care plan review/ care conference meeting. The Care Plan Audit will be reviewed at the monthly TQM Committee Meeting. 5) Completion Date:	1/16/15

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{F 280}	Continued From page 2 the current intervention related to heel boots.	{F 280}		
{F 323} SS=D	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 in 1 of 1 dishwashing rooms. Failure to secure hazardous chemicals placed residents with memory loss and/or wandering behaviors at risk of exposure to the chemicals. Findings include: A tour of the dietary department occurred on 12/10/14 at 11:15 a.m. with the dietary manager (#3). The dishwashing area showed two entrances, one through the kitchen and another from the hallway. This hallway is used by residents and staff members. Observation in the dishwashing area showed two bottles of liquid Comet cleaner with bleach. The labels stated "Keep Out of Reach of Children." When asked why the chemicals were not secured, the staff member (#3) stated dietary staff are expected to close the door leading to the hallway if they leave the kitchen.	{F 323}	F 323 1) The Corrective Action taken regarding the identified bottles of Comet w/ Bleach and Dawn Dish Soap left unsecure when Kitchen Staff were not present were removed and stored in the kitchen chemical cupboard. 2) All resident have the potential to be affected. 3) Changes to the facility protocols will be put into effect regarding: • all small containers of chemicals used in the Dietary Department will be stored in the kitchen chemical cupboard. • All Kitchen doors will be closed when no one is present in the kitchen • The Dishwashing Room Door may be open only when staff are present in the Dishwashing Room and/ or doing dishes after which the door will be closed when done and when staff leave the area for a prolonged time. • Prolonged time is defined as time the room is left unattended that doesn't involve staff leaving the room to put something away in the kitchen (dried trays, dishes, etc..) and then immediately returning. • The Kitchen Door by the hand washing sink may only be open while Dietary Staff are present in the kitchen and will be closed when staff leave the area. This includes going to the store rooms for supplies unless another Dietary Staff Member is present in the Kitchen area. • Dietary Staff will be re-educated on storage of chemical bottles. • Dietary Staff will be re-educated on Kitchen and Dishwashing Room Door Protocol which	

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{F 323}	Continued From page 3 - On 12/10/14 at 3:35 p.m., observation from the hallway through the open door showed two containers of Comet cleaner with bleach and Dawn dish-soap visible on a shelf in the dishwashing room. Upon entering the open door into the dishwashing room and walking into the entrance to the kitchen, observation revealed no staff in the kitchen, leaving the dish-room unsupervised with the door open and chemicals visible/available to residents. Observation throughout the day on 12/10/14 showed the door open between the dishwashing area and the hallway.	{F 323}	will include: • Kitchen door to be closed when no one is present in the Kitchen Area. • Dishwashing Room Door can only be open when Dietary Staff are present doing dishes and closed when completed or leaving the Dishwashing Room for prolonged period of time. 4) To ensure that the solutions and changes to the Dietary Department are sustained, the Dietary Manager or Designee will audit for chemicals left unsecured and Dietary Department Doors open when designated areas are left unattended. These audits will be done 3x daily for 3 months. If 100% compliance is met, the auditing will reduce to 1 week per quarter for 1 year. If 100% is not maintained, auditing frequency will increase per Dietary Manager's determination. All audits are reported to the TQM Committee monthly by the Dietary Manager or Designee. 5) Completion Date:	1/16/15
{F 371} SS=D	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 under sanitary conditions This REQUIREMENT is not met as evidenced by: HANDWASHING SINK 1. Based on observation and staff interview, the facility failed to ensure an area designated for handwashing in 1 of 1 kitchen. Failure to ensure the availability of sink, soap, towels, and garbage can has the potential for staff members to not wash their hands when appropriate, therefore	{F 371}	F371 1) A) Hand Washing Sink – The Corrective Action regarding hand washing sink having no garbage can was to purchase the appropriate garbage can for this sink. When the regular hand washing is under repair, an alternate hand washing sink protocol will be established to meet hand washing	

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{F 371}	Continued From page 4 increasing the risk of foodborne illness. Findings include: A tour of the dietary department occurred on 12/10/14 at 10:15 a.m. Observation showed the handwashing sink used by staff members under repair. When asked where this surveyor should wash her hands, an unidentified dietary staff member removed a kettle of hard boiled eggs from the food preparation sink and stated the surveyor could use the food preparation sink. Observation showed no soap or towels available and no garbage can by the handwashing sink. Observation on 12/10/14 at 1:15 p.m. showed the handwashing sink repaired but no garbage can nearby. Observation on the afternoon of 12/11/14 showed no garbage can near the handwashing sink. When asked where staff members discard used towels, an unidentified dietary staff member pointed to the garbage can across the room near the dishwashing room. During an interview of the afternoon of 12/11/14, the dietary manager (#3) stated the dietary handwashing sink was only out of service the morning of 12/10/14. FOOD HANDLING 2. Based on observation and staff interview, the facility failed to prepare and distribute food under sanitary conditions for 1 of 1 breakfast meal observed. Failure to ensure staff did not touch food items with the same gloved hand that touched non-food items may result in foodborne	{F 371}	requirements for sanitary conditions regarding the Dietary Department. B) Food Handling – The Corrective Action regarding this was immediate re-education of Dietary Staff regarding the changes to the facility sanitary food handling. 2) All residents have the potential to be affected. 3) A) (Handwashing) Changes the Dietary Department has made in regards to the hand washing sink and alternate hand washing sink are: • A hands-free covered garbage can was purchased to be beside the regular hand washing sink as well as be moved to the alternate hand washing sink when needed. • A bin was obtained as well as the contents of liquid hand soap dispenser and disposable hand towels are ready to be implemented in the event that the regular hand washing sink is ever under repair. If ever needed, a sink will be designated by Dietary as the hand washing sink and the contents of the bin will be placed by that sink as well as the garbage can from the regular hand washing sink. • A protocol for Alternate Hand Washing Sink will be established indicating what needs to happen and be put in place regarding designating another sink to wash hands at. • Dietary Manager or Designee will educate Dietary Staff on the Alternate Hand Washing Sink protocol. B) (Food Handling) Changes the Dietary Department has made in regards to food handling are: • Establish a protocol regarding items that do not require a utensil to serve the item will be handled in a sanitary manner. Example of such a food item are sandwiches being pre-rapped in foil or a bag before taking out to the Dining Room to be served	

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{F 371}	Continued From page 5 illness. Findings include: Review of the facility's plan of correction (POC) identified a compliance date of 12/06/14. The POC stated, ". . . To resolve the issue regarding the improper food handling observed during meal service . . . Dietary staff will be educated on correct serving techniques to include the use of tongs or placing these food items (sandwiches as an example) in a bag in the kitchen before taking out to the Dining Room to be served . . ." On 12/11/14 at 7:28 a.m. observation showed a staff member (#1) serving breakfast from a steam table in the dining room. The staff member wore the same pair of gloves during the entire observation. The breakfast meal consisted of sausage, pancakes, and/or toast. The staff member used her gloved right hand to place pancakes and sausage onto plates using tongs. Using the same hand, she placed the meal card for that resident onto the tray. Occasionally, she also used this hand to move trays over to continue meal service. This serving process continued until the staff member placed toast onto a plate. The staff member picked up the toast using her right hand; the same hand she used to handle tongs and meal cards, as well as moving trays. During an interview on the afternoon of 12/11/14, the dietary manager (#3) stated the dietary staff members had received education related to food handling.	{F 371}	• Dietary Manager or Designee will re-educate Dietary Staff regarding safe food handling and the protocol designating alternate safe handling food serving techniques. o Always use a spoon, tongs, or correct utensil when serving. o An alternative to serving sandwiches and like food items would be to pre-bag the food item readying the item to be efficiently and safely served in the Dining Room. 4) To ensure that the solutions and changes to the Dietary Department regarding the alternate hand washing sink protocol and safe food handling techniques are sustained, the Dietary Manager or Designee will audit for these items in the following manner: • Hand washing sink audit will be a documented drill where each Dietary staff member will locate the alternate hand washing sink supplies and set them up to implement an alternate hand washing sink to be used when the regular sink is under repair which includes designating the sink, setting up the hand washing supplies, and relocating the garbage can close to the designated sink as well as putting the items away when the sink is repaired. The audit/ drill will be done 1x monthly for 3 months then 1x quarterly for 3 quarters, then annually thereafter. • Observe for food being served in a safe manner for the safe food handling audit which will be done 3x daily for 1 month or until 100% compliance is observed, then PRN 3 meal services per month thereafter. If 100% is not maintained, the audit will revert back to daily auditing. All audits are reported to the TQM Committee monthly by the Dietary Manager or Designee. 5) Completion Date:	1/16/15
F 520 SS=B	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	Continued From page 6 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's plan of correction (POC), and staff interview, the Quality Assurance (QA) committee failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Findings include: Failure to effectively utilize QA resulted in	F 520	F 520 1) QA Committee will review and revise individual audits associated with each cited deficiency. 2) All resident have the potential to be affected. 3) Department Heads and staff involved in auditing and QA will review the QA policies. • QA committee will revise the individual audits to be more thorough in the auditing process. • DON and Administrator will educate staff performing the audit regarding: a. using the revised forms b. follow-up on issues found to correct issue immediately as well as continue to monitor c. reporting audit data on the TQM Report d. presenting and reviewing at TQM Committee Meeting e. Going forth to achieve or maintain audit goal 4) To ensure compliance by Auditors to achieve and maintain goal of the audits, the TQM Committee Meeting will review audit Compliance Goals, Data submitted, education provided, and help Department Head with attaining or maintaining goals of the audit. The QA Nurse or Designee will continue to keep attendance and minutes of meetings. TQM Meeting is monthly with the Medical Director attending at a minimum of at least one time per quarter year. 5) Completion date:	1/16/15

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F 520	Continued From page 7 noncompliance in the following: *F280 - reviewing and revising care plans *F323 - securing hazardous chemicals *F371 - safe food handling and access to a handwashing area Refer to F280, F323, and F371 on the 10/23/14 survey report for specific findings.	F 520		