

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

PRINTED: 08/12/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355042		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025	
NAME OF PROVIDER OR SUPPLIER WESTERN HORIZONS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			F 000			
F 689 SS=G	An unannounced onsite investigation survey regarding a facility reported incident was completed on January 14 - 16, 2025. During the report investigation the facility was found noncompliant with regulatory requirements. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility reported incident (FRI) report, review of facility investigation documents and camera footage, and staff interview, the facility failed to ensure resident safety for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to ensure door alarms are engaged and in working order allowed Resident #1 to elope from the facility and sustain injuries. Findings include: Review of the "Initial Allegation of Mistreatment, Abuse, Neglect, or Theft and Facility Reported Incidents Reporting Form" occurred on 01/14/25. This form, dated 01/10/25, stated, ". . . Date of the allegation: 01/10/25 . . . Time of the allegation: 0215 am [2:15 a.m.] . . . [Resident #1] . . . Amount of injury unknown at this time.			F 689	1. Thirty-minute rounding was initiated 01/10/25 for Resident #1 and documented by the Charge Nurse. All elopement attempts are documented by the Charge Nurse and audited by the DON implemented on 01/10/25. Resident #1 s care plan was updated on 01/10/25. On 01/11/25 the QA Nurse ensured Wanderguard was in place and functioning appropriately and documented in resident s chart. Resident #1 s Wandering Risk Assessment was updated 01/10/25. On 01/10/25 twice daily audits were implemented for all six Emergency Exits by Charge Nurse and Maintenance to ensure alarms are functioning appropriately. Written and verbal education given to all nursing staff on 01/10/25. Care Conference was held		2/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/03/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 689	Continued From page 1 Awaiting additional report from hospital. At this time, we only know resident has a cut on his head and abrasions to his body. . . . Resident is frequently exit-seeking and attempts elopement. It is unknown at this time how resident was able to elope the building as all doors were checked by Charge Nurse and all found to be locked, and door alarms are in working order. Resident wears wander guard. At approximately 0215 [2:15 a.m.] Charge Nurse received a call from the hospital asking if resident was missing . . ." Review of Resident #1's medical record occurred on 01/14/25. Diagnoses included dementia and adjustment disorder. A quarterly Minimum Data Set (MDS), dated 11/24/24, identified severely impaired cognition. The current care plan stated, ". . . has an elopement risk/wanderer r/t [related to] impaired safety awareness . . . wander guard as ordered . . . is a HIGH risk for falls r/t Confusion, Deconditioning, Gait/balance problems . . . " A Wandering Risk Assessment, dated 10/04/24, identified the resident at "moderate risk for wandering." Review of Resident #1's nurses' notes identified the following: * 01/10/25 at 6:02 a.m., (late entry for a call received at approximately 2:45 a.m.), "Facility phone rang and it was the ER [emergency room] nurse from the hospital. We were asked if there were any of our resident's [sic] missing, as the ambulance was dispatched for an elderly man in his socks and brief. This nurse stated that there have been no alarms that have gone [sic] off as the door [sic] all have alarms on them. After call ended, all staff went and looked in rooms. This nurse found resident's [Resident #1] room to be	F 689	with the resident and family on 01/14/25 and discussed options for care to meet resident s safety needs. Resident #1 was transferred to the ND State Hospital on 01/23/25 for specialized evaluation and treatment related to resident s ongoing exit-seeking behaviors per family preference and physician order. 2. All residents have the potential to be affected by this deficient practice. 3. A new policy/procedure for Elopement Response was approved on 01/16/25. The facility will notify local Law Enforcement of the updated Elopement Response policy by 02/07/25. All residents currently using a Wanderguard device were audited by QA Nurse to record expiration date and test the function of transmitters on 01/11/25. Current assessment for checking Wanderguard placement in the EHR was updated to include Wandergaurd device function testing to be completed weekly by the Charge Nurse. All Staff education on Elopement, Elopement Response Policy, and Exit Door Alarm use was held on 01/13/25. A new policy/procedure for Wandering and Elopement Management is being developed to ensure the safety of residents who are at risk for these types of behaviors, improve monitoring, and ensure that a person-centered approach to their unique psychosocial needs are met. RF Technology evaluated wander management alarm functioning on 01/21/25. The facility implemented a		

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F 689	Continued From page 2 empty. . . This shift he had been to the nurses [sic] station multiple times to ask for coffee. He would then go to his room, or to the recliner to watch TV. Resident was not found in the building. This nurse called ER back and stated that we could not find this particular resident. Gave the ER nurse a description of resident and name. While on the phone with the ER, the nurse stated that the resident was able to give his name and it was our resident. Ambulance was going to transport resident to ER to get a full check-up. . . . " * 01/10/25 at 9:03 a.m., ". . . returned to [facility] from the hospital Er [sic] . . . When asked how he was able to get out . . . said 'I just walked out' but he could not recall where and when. [Resident #1] stated that it was 'dark and cold' and when he asked if he fell he stated 'more than once.' . . . There were no scrapes or bruises on his head. He has a tegaderm [transparent dressing] on his right wrist, and he has scrapes on the second, third and forth [sic] digits on his right hand. . . . The left hand has scrapes on the second and third digits. The left knee is scraped, the right knee is scraped. The right great toe is missing the toenail." * 01/11/25 at 2:16 a.m., "Resident has a blister that has formed on his right second digit/index finger. The tip of the thumb is also reddened and firm. He has complaints of pain/discomfort of that thumb. Clear dressing was applied to the blister for now. The blister is fluid filled and intact. Blister may be related to latent frost bite effects. . . . Paperwork from Hospital Doctor also states to monitor hand and feet for any evidence of frost bite for the next 48-72 hours." The ER note, dated 01/10/25 at 5:58 a.m., stated,	F 689	Resident Courtyard policy to establish expectation for the use of the areas and resident monitoring while in use on 01/17/25. All Staff Education on Alarms, Emergency Alarms, Resident Safety, and Resident Courtyard policy was held on 01/22/25. Door locks will be placed on the East and West Courtyard doors by 02/07/25. 4. The DON or designee will be responsible for conducting Wanderguard placement/testing completion weekly X4 weeks, biweekly X2 months, and minimum of monthly thereafter. The EVS Director or designee will be responsible for conducting Door Alarm Drills weekly X4 weeks, bi-weekly X2 months, and a minimum of monthly thereafter. The EVS Director or designee will be responsible for monitoring/auditing the Emergency and Courtyard door logs. The EVS Director and Administrator or designee will be responsible for conducting Mock Elopement Drills with staff monthly to ensure staff competency. Facility Elopement Prevention Audit to be completed by Administrator or Designee monthly. Results of any audits will be reported to the QA Committee.		

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F 689	Continued From page 3 ". . . He [Resident #1] was out in the cold for an undertermined [sic] period of time in light clothing and no shoes. . . . His body temp [temperature] was 36 degrees [Celsius/96.8 degrees Fahrenheit] on arrival to the ER. He was found by travelers passing through town and they put him in their vehicle until the ambulance arrived. It was likely lower prior to getting in the vehicle. He fits the category [sic] of mild hypothermia [dangerously low body temperature]. . . . there is slight swelling in the soft tissue above the patella [knee cap] in the right knee. . . ." Review of the facility investigation documents occurred on 01/14/25. These documents identified the following: * The DON (Director of Nursing) called the administrator at 3:00 a.m. on 01/10/25 and informed her Resident #1 eloped from the facility and transferred to the local emergency department. DON and administrator arrived at facility at approximately 4:00 a.m., interviewed staff, and confirmed ER contacted facility at 2:45 a.m. to ask if a resident was missing from the facility due to ambulance call. * Review of camera footage identified Resident #1 ambulated throughout the facility from 12:15 a.m. to 12:58 a.m. then entered his room at 12:58 a.m. At 1:59 a.m. Resident #1 exited his room and at 2:00 a.m. exited the building through an emergency exit [Door 4A]. The alarm failed to sound. The camera footage showed Resident #1 dressed in long pants, a long sleeve shirt, and gripper socks. * A community member found Resident #1 0.2 miles to the east of the facility at approximately 2:30 a.m. Emergency medical services arrived at 3:00 a.m. and transported the resident to the ER.	F 689			

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F 689	Continued From page 4 * An audit of all emergency exit door alarms on 01/10/25 showed two of six door alarms were not engaged. * Initiation of documented checks of all emergency exit alarms on each shift to ensure alarms are engaged began on 01/10/25. * Initiation of documented 30-minute visual checks on Resident #1 began on 01/10/25 upon return from ER. Further review of Resident #1's nurses' notes identified the following: * 01/14/25 at 2:53 a.m., "Resident was reported by CNA [certified nurse aide] to be outside from the patio door. He was shaking the fence at the gate trying to get it open. He walked out with no coat on and no shoes. Just had grip socks on. CNA was able to redirect him back inside and resident cooperated with the redirection. CNA reported that the resident stated he was trying to go home." Observation on 01/14/25 at 9:36 a.m. showed a staff member (#4) opened the patio door. The alarms failed to sound. The staff member (#4) identified both alarms were battery powered and he needed to replace them. The staff member (#4) stated he noticed he noted the alarms to "sound funny" on 01/13/25 and indicated he planned to replace the batteries on 01/13/25 but failed to do so. Review of the facility camera footage occurred on 01/14/24 at 2:10 p.m. with an administrative staff member (#1). The footage showed Resident #1 exited the patio door at 1:16 a.m., the door alarms failed to sound. A CNA (#7) exited the nurses' station report room approximately one	F 689			

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F 689	Continued From page 5 minute later at 1:17 a.m. and redirected the resident back into the facility. Observation of all facility doors and door alarms occurred on the morning of 01/14/25 and showed 12 exit doors with three different alarm systems in place. The six emergency exit doors (door 1A, 2A, 2B, 3A, 3B, and 4A) showed alarms that required a key to turn the alarm "on" and "off." Resident #1 eloped from door 4A. Four doors (main entrance, door 2, 3, and 4) utilized the wander guard alarm system. The two remaining doors, one leading onto the enclosed patio, and one on the east side of the building, utilized two window/door alarms on each door. Audit forms for all emergency exit doors attached to each emergency exit and showed sign off each shift for engagement of the alarm. All emergency exit alarms were in "on" position. During an interview on 01/14/25 at 9:00 a.m., an administrative staff member (#1) confirmed two of the emergency exit door alarms were in the "off" position when checked by her on 01/10/25. She stated the only way to clear/stop the alarm sound required staff to turn it off then back on with the key, and the nurses and maintenance staff have keys to reset the alarms. She stated she expected staff to check the function of all door alarms weekly and confirmed the facility lacked documentation of the weekly alarm function tests.			F 689			