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 _____	01/25/2018

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 The standard Medicare/Medicaid recertification survey started on 01/23/18 and concluded 01/25/18.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but	F 574		3/1/18

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

Electronically Signed | 02/22/2018

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F 574	Continued From page 1 not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview with the resident council, observation, review of the admission packet, and resident interview, the facility failed to provide	F 574	F 574 Required Notices and Contact Information	

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F 574	Continued From page 2 residents, in writing, with a complete and/or accurate list of names, addresses (mailing and email), and/or telephone numbers of all the pertinent State regulatory, advocacy, and informational agencies, which includes the State Survey, Certification & Licensure Agency, the State Long-Term Care Ombudsman program, the protection and advocacy project, the agency to report Medicaid fraud and abuse, adult protective services, the aging and disability resource link, the local contact agency for returning to the community, and the home and community-based services program; and failed to provide residents with a statement that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements and requests for information regarding returning to the community. Failure to provide this written information to residents has the potential to limit residents' and their families' access to these agencies. Findings include: During the resident council interview on 01/24/18 at 10:00 a.m., the residents revealed some uncertainty about how to contact the pertinent State regulatory, advocacy, informational agencies, etc. During an interview on 01/24/18 at 4:15 p.m., Resident #35A provided the information he received from the facility on admission in the past 30 days. The information included a Residents' Rights guide, dated 11/22/16, and a document titled "Appendix A: Listing of Routine Drugs, Supplies & DME [durable medical equipment] for	F 574	1. Updated Resident Rights policy was explained to Resident # 35 A. 2. All other residents have the potential to be affected. 3. Upon admission and yearly thereafter, the resident/personal representative will be educated on Resident Rights. This will be documented in the progress notes. The admission packet will include current Resident Rights policy. Staff will be educated yearly on resident rights by the QA Director. All residents residing in the facility were educated on resident rights on 2/21/18 by Social Services. 4. QA was initiated on 2/13/18. Education on resident rights will be monitored for all new admissions and yearly there after by DON/Designee. The audit results will be reported by the QA director at the monthly QAPI/QA meetings.	

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F 574	Continued From page 3 Nursing Facilities." The Residents' Rights guide included "Important Agencies and Contact Information," which included incomplete and/or inaccurate email address information. The packet failed to include a statement informing residents that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. On 01/24/18 at 4:45 p.m., a social services staff member (#14) provided a copy of the facility packet of written information/material provided to the residents upon admission. Upon review, this admission packet contained a Resident's Rights pamphlet, dated 11/22/16, which included the same incomplete and/or inaccurate email address information Resident #35A received. The packet failed to include a statement informing residents that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community.	F 574	5. Corrective action will be completed on March 1, 2018	
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law	F 575		3/1/18

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F 575	Continued From page 4 provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post a complete and/or accurate list of names, addresses (mailing and email), and/or telephone numbers of all the pertinent State agencies and advocacy groups on 2 of 2 days observed (January 23-24, 2018); and failed to post a statement that the resident may file a complaint with the State survey agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. Failure to post this information has the potential to limit residents' and their families' access to these agencies. Findings include: Observation on 01/24/18 at 11:25 a.m., showed a document located on a wall by the entrance to	F 575	1. No specific residents were identified in the citation. 2. All residents have the potential to be affected if the list of agencies contains inaccurate/incomplete information. 3. Upon admission, each new resident/personal representative will be educated on the required posting of agencies. The Social Worker will review the list of agencies with the resident/personal representative yearly with their annual review. This will be	

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F 575	Continued From page 5 the building, that contained written information for the residents and public to view. The document listed some names, mailing addresses, and telephone numbers, such as the State Ombudsman program, the State Survey Agency, etc. However, the list contained some inaccurate and/or incomplete information (i.e. email addresses) and failed to include all the pertinent required agencies. In addition, the document lacked a statement informing residents that they may file a complaint with the State Survey Agency concerning any suspected violation of nursing facility regulations, non-compliance with the advance directives requirements, and requests for information regarding returning to the community. During an interview on the afternoon of 01/24/18, a nurse administrator (#1) and an administrative staff member (#13) stated they believed they had received an email from the Department of Health with updated agency/advocacy group contact information, but had not yet replaced the above incomplete/incorrect contact information with the updated information.	F 575	documented in the progress notes. Staff will be educated yearly by the QA director If there is a change in the required list of agencies, this will be updated and posted at the main entrance and will be included in the Admission packet. Posting of Agencies was completed on 1/26/18 by Judy Jung, DON. It is located at the main entrance and is included in the Admissions packet. Staff were educated on the posting of agencies on 1/31/18 by Judy Jung, DON. All residents were educated by Social Services as of 2/28/18. 4. Documentation stating that the resident was educated on the list of agencies upon admission and there after yearly will be monitored for all residents weekly x4, monthly x5, and quarterly x 2. Audit results will be reported at the monthly QAPI/QA meeting by DON/Designee. QA was initiated on 2/14/18. 5. Corrective action will be completed on	

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F 575	Continued From page 6	F 575	March 1, 2018.	
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F 582		3/1/18

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F 582	Continued From page 7 transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Notice of Medicare Non-Coverage (NOMNC) forms and staff interview, the facility failed to provide an updated Quality Improvement Organization (QIO) name and phone number to 3 of 3 residents (Resident #20, #38, and #41) reviewed for termination of Medicare coverage. Failure of the facility to provide updated QIO information limited the residents' ability to exercise their rights in regard to Medicare Part A services. Findings include: A review of Medicare NOMNC forms occurred on 01/25/18 at 7:15 a.m. and identified the facility failed to update the QIO name and phone number on the forms. During an interview on 01/25/18 at 7:24 a.m. an administrative nurse (#1) stated she was unaware the NOMNC forms had incorrect QIO	F 582	1. Resident # 20 did not receive the updated NOMNC form. Resident # 20 was given the updated NOMNC form with the correct QIO contact information on 2/12/18 by Barb Frick, MDS Coordinator. Resident # 38 and 41 are no longer residents in this facility. 1 other resident received the incorrect form but is no longer a resident in this facility. 2. All other residents have the potential to be affected.	

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F 582	Continued From page 8 contact information.	F 582	3. NOMNC form with correct QIO contact information was updated by Judy Jung, DON on 1/29/18. Residents charts were reviewed for those residents that did receive Medicare Part A services to ensure the correct form was issued by Barb Frick, MDS Coordinator on 2/16/18. Staff were educated on 1/31/18. 4. QA was initiated on 2/16/18. DON or designee will perform audits on any residents that received the NOMNC form to determine if the correct form was used. Audits will be performed weekly x4, monthly x5, and quarterly x 3. Audit results will be reported at the monthly QAPI/QA meeting by DON/Designee. 5. Completion date is March 1, 2018.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		3/1/18

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F 585	Continued From page 9 grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of	F 585		

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F 585	Continued From page 10 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585		

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F 585	Continued From page 11 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 06/07/17. Based on the resident council interview, resident interview, observation, review of the admission packet, and staff interview, the facility failed to ensure 5 of 5 residents (Resident C, D, E, F, and G) attending the Resident Council interview, and 1 sampled resident (Resident #35A) obtained accurate information on how to file a grievance or complaint. Failure to establish and/or implement a grievance policy, which included: 1) notification individually or through postings of the right to file grievances orally or in writing, 2) right to file anonymously, 3) contact information of the Grievance Official, 4) a reasonable time frame for completing review of the grievance, 5) right to a written decision, 6) contact information of independent entities with whom grievances can be filed, 7) identification and duties of a Grievance Official,	F 585	1. Resident # c,d,e,f,g, and 35A were educated on the new form and policy on 2/5/18 by Social Services. 2. All other residents have the potential to be affected. 3. Residents were educated at Resident Counsel on 2/5/18 regarding the policy on grievances. Social Services educated those residents that did not attend Resident Counsel 2/23/18. Personal representatives were sent information regarding the grievance policy 2/9/18. The grievance policy and form were updated on 1/19/18 by QA Director.	

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F 585	Continued From page 12 may inhibit residents from filing a grievance and prevent prompt resolution of all grievances. Findings include: During the Resident Council interview on the morning of 01/24/18, Resident C, D, E, F, and G stated they did not know if the facility had a Grievance Official. Resident C stated he did not know how to fill out a grievance. During an interview on 01/24/18 at 4:15 p.m. with Resident #35A, when asked how this recently admitted resident would file a grievance, he stated he wasn't told how to fill anything out, but was told to talk to someone in the office and they would file it. On the afternoon of 01/24/18, observation showed a large envelope containing grievance forms hung on the wall behind the desk by the entrance. The envelope contained a generic grievance form, with blank lines to fill in the date, resident's name, person filing the complaint, details of the complaint, etc. The form also included blank lines for the Grievance Official's follow-up and signature. The form failed to state the name and contact information of the facility's Grievance Official. On 01/24/18 at 4:45 p.m., a social services staff member (#14) provided, upon request, a copy of the facility packet of written information/material provided to the residents upon admission. Observation showed the admission information lacked a copy of the facility grievance policy. This staff member provided an "Authorizations" form which she stated the facility gave residents on	F 585	4. Documentation of the education provided to the resident/personal representative upon admission and yearly will be monitored by DON or designee weekly x 4 monthly x 5 and quarterly x2. 5 records will be reviewed each time. Audit results will be reported by the DON/Designee monthly at th QAPI/QA meeting. QA was initiated on 2/5/18. 5. Corrective action will be completed March 1, 2018.	

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	355042	A. BUILDING _____ B. WING _____	01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 13 admission to review and sign, and then filed in the resident's record. She stated the facility does not have a grievance policy other than this "Authorizations" form. The form included a section titled "Grievance Procedure" which stated, "A resident or family member may voice a grievance to the appropriate department head or Social Services. . . ." This procedure lacked a Grievance Official/contact information, timeframe for response, ability to receive review in writing, and other required areas. On the morning of 01/25/18, an administrative nurse (#11) stated the facility does have a grievance policy, but the facility may not have provided/educated the residents on it. Review of the "Grievance Policy," dated 09/13/17, showed the facility included the seven required items. Failure to implement a grievance policy and instruct residents on the policy, how to file a grievance, and the name and contact information of the Grievance Official does not ensure residents' rights are protected.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		3/1/18

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F 623	Continued From page 14 discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email),	F 623		

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F 623	Continued From page 15 and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of	F 623		

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F 623	Continued From page 16 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE COMPLAINT SURVEY CONDUCTED ON 06/07/17 Based on record review and staff interview, the facility failed to provide the resident and/or the resident's family/legal representative a written notice of transfer, including the destination, the reason for the transfer, and the resident's right to appeal the action for 1 of 1 closed resident record (Resident #39) record reviewed and failed to have a process in place to send the Long Term Care (LTC) Ombudsman a copy of all notices of transfer/discharge completed by the facility. Failure to provide a notice of transfer or discharge does not allow the resident and/or family to make an informed choice regarding their rights and to keep the Ombudsman informed of all transfers/discharges. Findings include: Review of Resident's #39's medical record occurred January 24-25, 2018 and identified a transfer to the hospital on 12/11/17. The record lacked evidence the facility provided the resident or family member with a written transfer notice. During an interview on 01/25/18 at 01:28 p.m., an administrative nurse (#1) agreed Resident #39's record lacked evidence the facility provided the resident and/or family with a notice of transfer on	F 623	1. Transfer/Discharge form is unable to be corrected since resident # 39 is no longer a resident in this facility. 2. All other residents have the potential to be affected. 3. Transfer/discharge policy was updated on 2/9/18. Staff was educated on the transfer/discharge policy on 1/31/18 by DON. 4. DON or designee will audit all transfers or discharges to determine if forms were completed and faxed to the Ombudsman for all residents with a transfer or discharge weekly x4, monthly x5, and quarterly x2. QA was initiated on 2/9/18 by DON. Audit results will be reported at the monthly QAPI/QA meeting by DON/Designee.	

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F 623	Continued From page 17 12/11/17. The nurse confirmed the facility failed to have a process in place to provide a copy of all notice of transfers to the Long Term Care Ombudsman.	F 623	5. Corrective action will be completed on March 1, 2018.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE STANDARD CONDUCTED ON 10/27/16 AND THE COMPLAINT SURVEY CONDUCTED ON 06/07/17 Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 4 of 12 sampled residents (Resident #3, #8, #14 and #19). Failure to accurately complete Section J (health conditions), Section N (medications) and Section P (restraints) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual,	F 641	1. Incorrect coding on the MDS for resident # 3, 8, 14, and 19. These MDS's were coded correctly and submitted by Barb Frick, MDS Coordinator on 2/22/18. 2. All other residents have the potential to be affected. 3. MDS Coordinator and all other staff involved in the MDS process will be re-educated on accurate coding on 2/19/18 by Sandy White RN. 4. QA was initiated on 2/23/17 by DON. QA will be performed by DON or designee to ensure that MDS coding is accurate. 5 MDS's will be reviewed weekly x4, monthly x5	3/1/18

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F 641	Continued From page 18 revised October 2017, page J-23 stated, ". . . Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. . . ." - Review of Resident #14's medical record occurred on all days of survey. The quarterly MDS, dated 10/24/17, showed staff failed to code section J1300. During an interview on 01/25/18 at 8:53 a.m. the MDS Coordinator (#2) stated, " [Resident #14's name] is most definitely a smoker," and staff failed to code J1300 to identify Resident 14 smoked. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2017, page N-7 stated, ". . . N0410D, Hypnotic: Record the number of days a hypnotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) . . . N0410E, Anticoagulant (e.g. [example given], warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . . . Do not code antiplatelet medications such as aspirin/extended release. . . ." - Review of Resident #8's medical record occurred on all days of survey. A physician's order, dated 10/09/17, stated, Lunesta (a hypnotic) 3 milligrams (mg) daily at bedtime. Review of the medication administration record (MAR) showed, Lunesta given at bedtime all the	F 641	and quarterly x2. 5. Corrective action will be completed on March 1, 2018.	

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F 641	Continued From page 19 days in December 2017. The quarterly MDS, dated 12/27/17, failed to identify the use of a hypnotic, during the 7-day look-back period, in section N0410D. - Review of Resident #19's medical record occurred on all days of survey. The quarterly MDS, dated 11/03/17, showed staff coded N0410E with a 7 indicating Resident #19 received an anticoagulant seven times in the 7-day look-back period. Review of the resident's October and November 2017 MAR identified aspirin 81 mg two tablets daily, but not an anticoagulant. During an interview on 01/24/18 at 8:55 a.m., the MDS Coordinator (#2) agreed the aspirin failed to meet the N0410E coding requirements of an anticoagulant during the MDS 7-day look-back period. SECTION P: RESTRAINTS The Long-Term Care Facility Resident Assessment Instrument User's Manual, revised October 2017, page P-1 defines a restraint as, "Any manual method or physical or mechanical device, material or 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." Review of Resident #3's medical record occurred on all days of survey. A quarterly MDS, dated 01/05/18, showed staff coded P0100A: side rails used on a daily basis during the 7-day look-back period.	F 641		

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F 641	Continued From page 20 Observation on all days of survey identified quarter rails on both sides of the bed, and Resident #3 independent with transfers in her room. During an interview on 01/25/18 at 8:20 a.m., an administrative nurse (#1) stated the bed rails for Resident #3 are not used as a restraint and should not have been coded on the MDS.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		3/1/18

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F 657	Continued From page 21 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE STANDARD CONDUCTED ON 10/27/16 AND THE COMPLAINT SURVEY CONDUCTED ON 06/07/17 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 1 of 1 sampled resident (Resident #35 B). Failure to review/revise the care plan to reflect a residents' current status limited the staff's ability to communicate needs and ensure continuity of care for the resident. Findings include: Review of the policy titled "Comprehensive Person-Centered Care Planning" occurred on 01/25/18. This policy, dated September 9, 2017 stated, ". . . will develop and implement a baseline and comprehensive care plan to provide effective and person-centered care of the resident that meet professional standards of quality care . . . The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames . . . PERSON-CENTERED CARE: Person centered care means to focus on the resident as the locus [sic] of control and support the resident in making their own choices and having control over their daily lives. . . ."	F 657	1. Care plans for Resident # 35 B were not updated per current condition. Care plans were changed to reflect the resident's current plan of care on 1/26/18. 2. Care plans were reviewed for all residents. No other residents were affected determined by QA on 2/9/18. 3. Care plan policy was updated on 1/30/18 by Sandy White RN Staff education was provided on 1/31/18 by Sandy White RN. Care plans will be reviewed and changed as necessary following a hospitalization, with order changes and with resident status changes. 4. QA initiated on 2/2/18. QA Director/Designee will monitor 5 random care plans to determine if care plans were updated according to resident's current status and care needs. Monitors will be done	

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F 657	Continued From page 22 Review of Resident #35B's medical record occurred on all days of survey. Diagnosis included: dementia, hypokalemia, hypertension (HTN), congestive heart failure (CHF), recent urinary tract infection (UTI) 12/04/17 and history of UTI's. Observation on 01/23/18 at 11:23 a.m. showed Resident #35B seated in her wheel chair (WC) at the dining room table. An unidentified staff member brought the resident her lunch plate consisting of a meat, full baked potato cut in half, and peas. The Resident picked up her spoon, laid it on top of the baked potato and looked at her plate, not eating. At 11:40 a.m., an unidentified certified nurse assistant (CNA) arrived to assist the resident. The CNA mashed the inside of her baked potato, placed butter and pepper on it, and cut her meat. After set up assistance with her meal, the resident then started eating. - The current care plan identified, ". . . [Resident #35B] . . . She is able to eat and drink per self. . . ." The Quarterly Minimum Data Set, dated 01/01/18, identified Resident #35B needs supervision, oversight, encouragement and cueing. Review of Resident #35B's care plan failed to accurately reflect the level of assistance she required for assistance with meals. Observation on 01/23/18 at 2:16 p.m. showed two certified nursing assistants (CNAs) (#6 and #7) transfer Resident #35B from her WC to bed using a full body mechanical lift and	F 657	weekly x4, monthly x5, and quarterly x2. Audit results will be reported by QA Director or Designee monthly at the QAPI/QA meetings. 5. Corrective action will be completed on March 1, 2018.	

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F 657	Continued From page 23	F 657		

checked/changed the resident's wet/soiled brief. One CNA (#7) stated Resident #35B does not assist with peri cares and is always incontinent of urine and bowel.

Observation on 01/24/18 at 8:18 a.m. showed two CNAs (#6 and #8) transfer Resident #35B from her WC to bed using a full body mechanical lift and check/changed the resident's wet/soiled brief.

- The current care plan identified, ". . . [Resident #35B] BOWEL AND BLADDER: Resident is usually incontinent of urine. She is continent of bowel . . . Assist with incontinent products . . . Toilet [Resident #35B] every 2-3 hours and on demand using Hoyer lift and 2 persons. . . ." The Quarterly Minimum Data Set (MDS) dated 01/01/18, identified Resident #35B's toilet use as extensive assist and staff support two (plus) persons during entire 7-day look back period.

Review of Resident #35B's care plan failed to accurately reflect the current level of assistance needed with bowel, bladder and peri cares.

Observation on 01/23/18 at 12:16 p.m. showed two CNAs (#6 and #7) lower both Resident #35B's full side rails to provide pericares. When completed, the CNAs raised both full side rails and exited the room.

Observation on 01/24/18 at 8:18 a.m. showed both full side rails raised on Resident #35B's bed. The right side rails was lowered before Resident #35B was transferred from her WC to bed using a full body mechanical lift. Two CNAs provided pericares with both full side rails raised. The

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F 657	Continued From page 24	F 657		

resident was able to hold onto the right and left bed rails when given assistance and verbal direction during the wet/soiled brief change.

- The current care plan identified, " . . . [Resident #35B] BED RAILS: Resident uses the right side rail for positioning. . . ."

Review of Resident #35B's care plan failed to accurately reflect the use of the left side bed rail for positioning and the use of both side rails while in bed.

Observation on 01/23/18 at 11:25 a.m. showed Resident #35B seated in the dining room in a WC. The resident was receiving oxygen per nasal cannula (NC) that was attached to a portable oxygen tank.

Observation on 01/23/18 at 12:03 p.m. showed Resident #35B being transported in her WC by a CNA (#5) to her room. The CNA (#5) switched the resident's oxygen tubing from the portable tank to the in room O2 concentrator.

Observation on 01/23/18 at 2:02 p.m. showed Resident #35B asleep in her room, nasal cannula on, O2 tubing attached to the in room concentrator.

Observation on 01/24/18 at 7:07 a.m. showed Resident #35B sitting in her room dressed and sleeping in her WC, nasal cannula applied, and attached to portable oxygen.

Observation on 01/24/18 at 8:18 a.m. showed a CNA (#8) transporting Resident #35B to her room. The resident was wearing a nasal cannula

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 _____	01/25/2018

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WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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F 657	Continued From page 25 attached to a portable O2 tank. Chart review of provider orders occurred on 01/24/18 at 8:15 a.m. stated, " O2 at (@) 5 liters (L) nasal cannula (NC) continuous to maintain O2 saturation (SATS) > 90%, Active 01/11/2018. . . . Provider physical notes RESPIRATORY INSUFFICIENCY/FAILURE monitor oxygen saturations. . . ." An order for O2 SATS and lung sounds were not found in the provider orders. - The current care plan identified, " . . . has a diagnosis of chronic obstructive pulmonary disease (COPD) and Asthma . . . O2 SATS and lung sounds per orders and as needed (PRN). . . . " The facility failed to care plan the type of oxygen delivery system Resident #35B required, and equipment settings for the prescribed flow rate. Failure to update the care plan may result in incomplete delivery of care. Observation 01/23/18 at 12:03 p.m. showed Resident #35B being transported in her WC by a CNA (#5) to her room. Resident did not attempt to propel herself. Observation on 01/24/18 at 8:18 a.m. showed a CNA (#8) pushing Resident #35B into her room. Resident #35B did not attempt to propel herself. - The current plan identified, " . . . FALLS: may be at risk for falls related to Osteoporosis and Osteoarthritis . . . Interventions . . . also uses a w/c and is able to propel herself. . . ." Resident #35B's care plan did not reflect the	F 657		

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F 657	Continued From page 26 residents current mobility status. During an interview on 01/25/18 at 1:24 p.m., an administrative nurse (#11) stated "yes [Resident #35B] did return from the hospital on 01/11/18, and it is our policy to update the resident's care plan 1-2 days after a resident returns from the hospital."	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and staff interview, the facility failed to provide sufficient fluid intake to maintain proper hydration and health for 1 of 2 sampled	F 692	1. Resident # 35 B did not receive adequate fluids or assistance with fluids. Resident # 35B was moved to a table	3/1/18

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F 692	Continued From page 27 residents (Resident #35B) needing assistance with fluids. Failure to frequently offer fluids placed residents at risk for dehydration, urinary tract infections (UTI) and fluid/electrolyte imbalances. Findings include: Review of the facility policy titled "HYDRATION" occurred on 01/24/18. The policy, dated November 5, 2017, stated, " . . . 1. A dehydration risk assessment will be performed upon admission, quarterly and with significant changes. . . 3. Dehydration risk assessment will include the following: Skin, Mobility, Fluid Intake Eating, [sig], Weight, Continence, Risk factors, Predisposing factors, Medication, Scoring-Scores of 10 or higher indicate resident is at risk for dehydration and further investigation will be conducted to review fluid status. . . Care planned. . . . " Review of Resident #35B's medical record occurred on all days of survey. Diagnoses included: dementia, hypokalemia, hypertension (HTN), congestive heart failure (CHF), recent urinary tract infection (UTI) 12/04/17 and history of UTI's. The resident's most current care plan identified, ". . . BOWEL/BLADDER: Resident is usually incontinent of urine . . . Interventions. . . Report any s/s of UTI to Practitioner. . . has a need for adequate nutrition. . . has had a unplanned weight loss. . . watch for more weight loss. . . has a diagnosis of Hypertension and CHF. She has edema bilaterally to lower extremities. Interventions. . . Water mug on bedside table. . .	F 692	with an aide that provided assistance with fluids and food at meal times. 2. All residents have the potential to be affected. 3. Hydration policy was updated on 2/1/18 by QA director. Staff was educated on the updated policy on 1/31/18 by Judy Jung, DON. Memo was posted by the DON regarding offering fluids during cares for all residents and a list of times to pass fresh water and ice to all residents. 4. DON or designee will audit fluid assistance at meal times and in resident rooms for those residents that are high risk weekly x4, monthly x5 and quarterly x2. QA was initiated on 1/29/18. DON/Designee will report audit results at the monthly QAPI/QA meeting. 5. Corrective action will be completed on March 1, 2018.	

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F 692	Continued From page 28 . " The current Minimum Data Set (MDS), dated 01/01/18, stated " . . . eating requires supervision, oversight, encouragement and cueing. . . ." Observation on 01/23/18 at 12:03 p.m. showed a certified nursing assistant (CNA) (#5) transported Resident #35B in her wheelchair from the dining room to her room, covered her with a blanket and exited the room. The CNA failed to offer fluids before she exited the resident's room. Observation 01/23/18 at 12:16 p.m. showed two CNAs (#6 and #7) transferred Resident #35B from her wheel chair to bed using a full body mechanical lift and check/changed resident's incontinence brief. The two CNAs failed to offer fluids after providing care. Observation on 01/24/18 at 8:18 a.m. showed two CNAs (#6 and #8) assisted Resident #35B from her wheelchair to her bed using a full body mechanical lift and checked/changed the resident's incontinence brief. The CNAs failed to offer fluids after providing care. During an interview on 01/24/18 at 03:07 p.m. an administrative nurse (#1) stated, "yes, I do expect my staff to offer hydration with cares and throughout the day."	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		3/1/18

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F 695	Continued From page 29 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, policy review and review of professional reference, the facility failed to provide the necessary care and services for 1 of 1 sampled resident(Resident #35B) with orders for continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like many medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." Review of the procedure titled "Oxygen Administration" occurred on 01/24/18. This policy, revised October 2010, stated, " . . . The purpose of this procedure is to provide guidance for safe oxygen administration . . . Verify that there is a physicians's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's	F 695	1. Resident # 35B. Physician was notified to clarify the resident's oxygen order. Oxygen order was changed to 2 liters. Staff were educated on 1/26/18 that her oxygen was to be at 2 liters continuously and not to be removed for longer than 2 minutes at a time. 2. One other resident in the facility has continuous oxygen. Order in place on chart. No other residents residing in this facility utilizes continuous oxygen as of 2/12/18 determined by Sandy White RN. 3. Oxygen administration policy was updated on 1/30/18. Staff were educated on the updated policy on 1/31/18 by Sandy White QA. Oxygen administration will become a part of the skills lab for the nursing staff yearly. 4. QA director will monitor residents with	

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F 695	Continued From page 30 care plan to assess for any special needs of the resident . . . Before administering oxygen, and while the resident is receiving oxygen therapy, assess the following: . . . signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); . . . signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion);. . . vital signs, lung sounds, oxygen saturations. . . ." Review of Resident #35B's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD) asthma, heart failure and anxiety. The admission Minimum Data Set (MDS), dated 01/01/18 stated, total dependence for bed mobility, and extensive assist for transfer, dressing, and personal hygiene. The physician order stated, " oxygen (O2) at (@) 5 Liters (L) nasal cannula (NC) Active 1/11/2018 10:00 continuous to Maintain O2 saturations (sats) greater than (>) 90 percent (%). . . ." Provider note stated, " . . . RESPIRATORY INSUFFICIENCY/FAILURE monitor oxygen saturations. . . ." Resident #35B's current care plan stated, ". . . Focus . . . [Resident #35B] has a diagnosis of COPD and Asthma. Goal . . . Exacerbation of COPD will be reported promptly to Practitioner. Interventions . . . O2 sats and lung sounds per orders and PRN. . . ." The medical record lacked evidence of nursing assessments of lung sounds and oxygen saturations.	F 695	continuous oxygen to determine if oxygen is on and at the correct liters per minute. If oxygen is off, the time it is off will be checked to determine if oxygen is off for longer than 2 minutes. Monitors will be completed 4 x week x 4 weeks, 10 x month x 5 months and 10 x per quarter x 2 quarters. QA was initiated on 2/6/18. QA director will report monitoring results at the monthly QAPI/QA meetings. 5. Corrective action will be completed on March 1, 2018.	

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F 695	Continued From page 31 - Observation on 01/23/18 at 11:25 a.m. showed Resident #35B seated in the dining room in her wheel chair (WC) with her portable oxygen tank regulator set to 3L O2 via NC. - Observation on 01/23/18 at 12:15 p.m. showed two CNAs (#6 and #7) entered Resident #35B's room. A CNA (#7) removed the NC from the residents nares, and cares were provided. At 12:30 p.m. a CNA (#6) reapplied the residents oxygen. Resident #35B was without her oxygen for 15 minutes. - Observation on 01/24/18 at 8:18 a.m. showed two CNAs (#6 and #8) enter Resident #35B's room. One CNA (#8) removed the resident's oxygen and provided cares. At 8:30 a.m. the CNA (#8) reapplied the resident's oxygen. Resident #35B was without oxygen for 12 minutes. During an interview on 01/24/18 at 8:18 a.m. a CNA (#8) stated Resident #35B is on" 4L" oxygen. During an interview on 01/24/18 at 03:07 p.m., an administrative nurse (#1) stated "yes, I expect if there is an order for continuous oxygen that staff make sure the oxygen is on at all times." The facility failed to consistently provide Resident #35B's oxygen at the ordered flow rate of 5L continuous oxygen, and the medical record lacked evidence of nursing assessments of lung sounds and oxygen saturations. nursing documentation of lung and O2 assessments.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		3/1/18

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F 725	Continued From page 32 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 06/07/17. Based on policy review, resident interview, family interview, group interview, and staff interview, the facility failed to assure sufficient nursing staff and related services available at all times to meet the	F 725	1. Resident # c,e, f, and g did not have their call lights answered in a timely manner. Call light response time was monitored for the above residents starting 2/1/18.	

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	355042	A. BUILDING _____ B. WING _____	01/25/2018

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F 725	Continued From page 33 residents' needs for 4 of 5 residents attending the group interview (Resident C, E, F and G), and one anonymous resident (Resident H) who required staff assistance. Failure to provide sufficient staffing and answer call lights in a timely manner does not promote each resident's rights and physical, mental, and psychosocial well-being. Findings include: Review of facility policy titled "Resident Rights" occurred on 01/25/18. This policy, dated 10/03/17, stated, ". . . 1. WHCC [Western Horizon Care Center] will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life . . ." - During an interview on 01/23/18 at 10:20 a.m., an anonymous resident (Resident H), identified by the facility as interviewable, stated the staff sometimes take 20-30 minutes to respond to the call light on the night shift, when the resident called to request pain medication. - During a confidential interview on 01/23/18 at 12:31 p.m., a family member (#1) stated the facility would have difficulty handling several crises at once due to the limited number of staff. - During the group interview on 01/24/18 at 10:00 a.m., when asked if staff provide cares in a timely manner, four residents (identified by the facility as interviewable) responded as follows: * Resident G stated, "I waited 30 minutes one time when on the toilet."	F 725	2. All residents have the potential to be affected. 3. Call light response time policy was reviewed by QA director on 1/29/18. Staff were educated on the call light response time policy on 1/31/18 by QA director. 4. QA was initiated on 2/5/18 by QA Director. QA/Designee will monitor 3x per wk for all residents x 4 weeks, 3x per month for all residents x 5 months, and 3x per quarter for all residents x 2 quarters. QA Director will report audit results at the monthly QAPI/QA meeting. 5. Corrective action will be completed on March 1, 2018.	

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F 725	Continued From page 34 * Resident C stated, "They [staff] do not always answer timely, you wait usually 10-15-30 minutes." Resident C stated wait time varied due to the time of day, with increased wait time in the early morning before breakfast, after meals, or late evening/bedtime. * Resident F stated, "About once a day I wait up to 30 minutes, and they chew me out when I put the light back on." Resident F stated if you don't allow staff to assist you to bed before 7:00 p.m., then they don't get back to you until after 9 p.m. * Resident E stated, "A certified nurse aide recently told a resident who was waiting to use the toilet, 'You are not the only one who needs to use the bathroom.'" During an interview on 01/25/18 at 11:21 a.m., an administrative staff member (#11) stated, "Three to five minutes is an acceptable [call light] response time." Failure to respond to call lights in a timely manner may result in a decreased quality of life or increased pain for residents dependent on staff for assistance with personal cares or administration of medication.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/1/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 35 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to establish a system to account for all controlled medications awaiting destruction in 1 of 2 medication rooms (East). Failure to assure all controlled medications are accounted for until destruction has the potential for medication loss and/or diversion. Findings include: Observation of the East medication room occurred on 01/24/18 at 3:45 p.m. with a medication aide II (MAII) (#3) and showed a	F 755	1. Discontinued narcotics were not secured in the locked medication room. No specific residents were identified in the citation. 2. No residents could be affected by this practice as the door to the medication room was locked. No specific residents were identified in the citation.	

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F 755	Continued From page 36 locked cabinet containing blister packs of controlled medications designated for destruction. The medications included a bottle of morphine solution and blister packs of oxycodone, hydrocodone, and tramadol. The MAII stated nursing staff rubber-banded the final count sheet to the controlled medications and placed them in the cabinet. The key to the locked cabinet was located in an unlocked drawer below the cabinet. During an interview on 01/24/18 at 4:10 p.m., an administrative nurse (#1) stated the facility had no process in place to record or verify the controlled medications stored prior to destruction.	F 755	3. Policy was updated. Staff education was provided by Judy Jung, DON, on 1/31/18. A locked box with a slot was secured to the wall in the medication room on 1/26/18. Judy Jung, DON, has the only key to the box. The DON and the Pharmacist will destroy any discontinued narcotics. 4. DON/Designee will audit narcotic storage weekly x4, monthly x5, and quarterly x2. DON will report audit results at the QAPI/QA monthly meeting. QA was initiated on 2/1/18. 5. Corrective action will be completed on March 1, 2018.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		3/1/18

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	355042	A. BUILDING _____ B. WING _____	01/25/2018

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WESTERN HORIZONS CARE CENTER	**1104 HWY 12 HETTINGER, ND 58639**

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F 758	Continued From page 37 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 38 Based on record review, facility policy review, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 3 sampled residents (Resident #10 and #15) receiving as needed (PRN) antianxiety medication. Failure to attempt behavioral interventions prior to administering an antianxiety may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of the facility policy titled "Interventions to Manage Inappropriate Resident Behavior" occurred on 01/25/18. This policy dated 09/11/17 stated, ". . . utilize interventions to manage inappropriate resident behavior with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of residents are adequately protected. Interventions: 1. Offer food of choice. 2. Offer drink of choice. 3. Assist with toileting on a scheduled basis. 4. Visit with the resident. 5. Shoulder massage. 6. Hand massage. 7. Offer a blanket. 8. Offer a doll or stuffed animal. 9. Offer to walk with the resident if able. 10. Music Therapy. 11. Pet therapy. 12. Offer to call the resident's family. . . . Behaviors will be documented along with all interventions that were attempted prior to psychotropic use. . . . - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. Medications included, Xanax 0.25 milligrams (mg) 2 times a day as needed. Resident #10's care plan stated, "Psychotropic Medications: prior	F 758	1. Residents # 10 and 15 were given prn psychotropics without attempting or documenting non-pharmacological interventions. QA Director educated the Nurses/CMAs regarding documenting the non-pharmocological interventions attempted prior to giving Resident # 10 and #15 psychotropic medications. 2. All residents receiving prn psychotropics have the potential to be affected. 3. Policy was current. Staff were educated on the policy on 1/31/18 by Sandy White RN. A list of potential interventions along with a reminder was posted at each nurses station on 1/29/18 by QA director. Staff were educated on prn psychotropic interventions and documentation on 1/31/18 by QA director. 4. QA director will monitor to determine if interventions are attempted and	

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	355042	A. BUILDING _____ B. WING _____	01/25/2018

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F 758	Continued From page 39 to giving Xanax, attempt interventions such as: offer activities in the activity room, offer snacks and drinks, talk with Resident about her family and the things she used to do. Offer to stroll with her while she is in her wheelchair . . . " Review of Resident #10's medication administration record (MAR) for December and January showed, Resident #10 received PRN Xanax on 8 occasions in December 2017, and on 12 occasions from January 01-24, 2018. The staff failed to document any behavioral interventions attempted prior to administering Xanax on 4 of the 8 occasions in December, and on 6 of the 12 occasions in January. During an interview on 01/25/18 at 8:20 a.m., an administrative nurse (#1) stated she would expect the staff to attempt and document any behavioral interventions with Resident #10 prior to giving the PRN antianxiety medication. - Review of Resident #15's medical record occurred on all days of survey. Diagnoses included anxiety. Medications included Ativan 0.5 mg every 4 hours PRN for anxiety. Review of Resident #15's MAR for January 01-23, 2018, showed Resident #15 received PRN Ativan on eight occasions. The staff failed to document any behavioral interventions attempted prior to administering the Ativan on 3 of the 8 occasions.	F 758	documented prior to giving a prn psychotropic medication. QA was initiated on 2/1/18. Monitors will be done for all residents receiving prn psychotropic medications weekly x4, monthly x5, and quarterly x2. Audit results will be reported at the monthly QAPI/QA meeting by the QA Director/Designee. 5. Corrective action was completed on March 1, 2018.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		3/1/18

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F 759	Continued From page 40 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional references, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 9 residents (Resident #7) observed during medication pass. Two medication errors occurred during staff administration of 25 medications, resulting in an 8% error rate. Failure to ensure medications are administered correctly may alter the therapeutic effect and/or result in adverse side effects. Findings include: Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice, 10th Edition, page 776 stated, ". . . check if the medication can be crushed. . . . Some medications that should not be crushed include time-released and enteric-coated medications. . . ." Review of the facility's current medication reference titled "Nursing 2016 Drug Handbook, 36th Edition" occurred on 01/24/18. Page 792 stated, ". . . Imdur . . . Tablets (extended-release) . . . Don't crush or allow patient to chew tablets or capsules. . . ." Observation on 01/24/18 at 7:25 a.m. showed a staff nurse (#4) crushed and administered the following medications to Resident #7: - Imdur Tablet Extended Release 24 Hour 60 milligrams daily. - ICaps Lutein & Zeaxanthin Tablet Delayed	F 759	1. Resident #7 had medication crushed that was not to be crushed. MAR states to not crush these medications. DON educated the nurses/cma's regarding resident # 7's medications. 2. All residents have the potential to be affected. 3. All MARS were reviewed by the Pharmacist on 1/30/18. Judy Jung, DON checked with all nursing staff to determine what other medications are being crushed on 1/26/18. Judy Jung, DON, determined that no other residents were receiving crushed medication as of 1/26/18. Policy was updated on 2/9/18. Staff were educated on the updated policy on 1/31/18 by Sandy White RN. 4. QA was initiated on 2/21/18. QA Director/Designee will monitor to ensure that crushed meds are delivered per orders and policy weekly x 4, monthly x5	

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F 759	Continued From page 41 Release, twice daily. Review of Resident #7's current "Order Summary Report" identified the following: - Imdur Tablet "DO NOT CRUSH" - "May crush appropriate medications." During an interview on the afternoon of 01/25/17, a medication aide II (#9) stated Resident #7 swallowed medications whole and in apple sauce with no problems. The staff nurse (#4) crushed medications that were not to be crushed and administered them to Resident #7.	F 759	and quarterly x2. Audit results will be reported at the monthly QAPI/QA meetings. 5. Corrective action will be completed on March 1, 2018.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug	F 761		3/1/18

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F 761	Continued From page 42 Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly store medications and laboratory glucose control reagents in 1 of 2 medication rooms (East medication room). Failure to discard expired medications and laboratory supplies may result in residents receiving outdated medication with reduced efficacy and staff utilizing outdated glucose control reagents. Findings include: Observation of the East medication room, occured on 01/24/17 at 3:45 p.m. with a medication aide II (MAII) (#3) and identified the following expired medications and laboratory glucose control reagents: * Nine - 10 millimeter (ml) normal saline syringes expired May 2016. * One - 5 ml glucose control reagent expired 3/2017. During the observation, the MAII (#3) agreed the above mentioned items expired and should be discarded.	F 761	1. Expired supplies: normal saline and glucose control were found in the medication room and were disposed of by DON on 1/26/18. 2. All other residents have the potential to be affected. 3. Expired medication audit form and policy was updated to include expired supplies. Nursing staff are to check all medications given and supplies used at the time of dispensing and use. Nursing staff were educated on the change in policy and form on 1/31/18 by Sandy White RN. 4. QA was initiated on 2/14/18 by QA Director. Monitors will be performed weekly x 4 weeks and monthly x 11 months by QA/Designee. QA director will report audit findings at the monthly QAPI/QA meetings.	

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WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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F 761	Continued From page 43	F 761	5. Corrective action will be completed March 1, 2018.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE COMPLAINT SURVEY COMPLETED ON 06/07/17. Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, and staff interview, the facility failed to maintain a Quality Assessment and Assurance (QAA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. Findings include: Review of the North Dakota Department of Health, Division of Health Facilities provider files identified the facility failed to maintain compliance in the following areas cited during the 10/27/16 standard survey and/or the 06/07/17 complaint survey: F585 Grievances F623 Notice Requirements before	F 867	1. QAPI program was reviewed and updated to include PIP on 1/31/18. 2. All residents have the potential to be affected. 3. PIP team or teams will meet as necessary to determine which projects need to be started to reach goals pertinent to the problem areas in the facility or the Quality Indicators. All staff were educated on the QAPI process and PIP on 1/31/18 by Sandy White, QA director. 4. PIP meetings will be held as necessary by the team or teams. The PIP team will determine if a goal has been met by utilizing data and monitors on an	3/1/18

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F 867	Continued From page 44 Transfer/Discharge F641 Accuracy of Assessments F657 Care Plan Revision F725 Sufficient Nursing Staff F867 Quality Assessment and Assurance F880 Infection Control During an interview on 01/25/18 at 11:21 a.m., an administrative staff member (#11) stated they monitor many different issues in all the facility departments for the number of incidents, i.e., the number of falls per month, per the consultant's recommendation. The staff member stated the QAA committee compared the number of incidents month to month, but failed to develop action plans to address problem areas. Failure of the facility to effectively utilize QAA resulted in continued noncompliance at F585, F623, F641, F657, F725, F867, and F880.	F 867	ongoing basis. The administrator or designee will audit the QAPI and PIP monthly x 12. QA was initiated on 1/31/18 by the PIP team. PIP audits will be reported at the monthly QAPI/QA meetings. 5. Corrective action will be completed on March 1, 2018.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,	F 880		3/1/18

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F 880	Continued From page 45 identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 46 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE STANDARD SURVEY CONDUCTED ON 10/27/16 AND THE COMPLAINT SURVEY CONDUCTED ON 06/07/17 1. Based on observation, facility policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 2 of 16 sampled residents (Resident #35A and #35B) observed during personal cares. Failure to follow infection control practices related to hand hygiene and glove use has the potential to spread infection within the facility. Findings include: Review of the facility policy titled, "Hand Hygiene" occurred on 01/24/18. This policy, revised August 2017, stated, ". . . Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors . . . Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub	F 880	1. Staff did not provide proper hand hygiene when caring for resident # 35A and 35B. Observation of proper hand hygiene was performed on 1/29/18 by QA. 2. All residents have the potential for improper hand hygiene by staff members. 3. Hand Hygiene Policy was current. Staff education on hand hygiene was provided on 1/31/18 by Sandy White, Infection Control. Hand hygiene hand outs were provided to the staff. Hand hygiene test was completed by on 1/31/18. Staff will be educated on hand hygiene related to resident cares and medication pass yearly during a	

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F 880	Continued From page 47 also know as alcohol-based rub . . . The use of gloves does not replace handwashing. Wash hands after removing gloves . . . a waterless antiseptic may be used between tasks normally requiring hand washing unless hands are visible soiled. . . ." Review of the facility policy titled, "PERSONAL PROTECTIVE EQUIPMENT-GLOVES" occurred on 01/24/18. This policy, dated September 2007, stated, " . . . Gloves must be worn when handling , body fluids, secretions, excretions, mucous membranes and/or non-intact skin . . . Gloves shall be used only one and discarded into the appropriate receptacle located in the room in which the procedure is being performed . . . Wash your hands after removing gloves . . . Employees must receive training relative to the use of gloves and other protective equipment prior to being assigned tasks that involve potential exposure to blood or body fluids and when new or modified protective equipment or procedures have been introduced into the workplace. . . ." - Observation on 01/23/18 at 12:16 p.m. showed two certified nursing assistants (CNAs) (#5 and #6) entered Resident #35B's room. The resident was transferred from her wheel chair (WC) to bed with a full body mechanical lift. The CNAs (#5 and #6) donned (applied) gloves, and gathered a brief, protective cream and wipes. After cleansing the resident of bowel movement (BM) one CNA (#5) discarded her soiled gloves and donned new gloves without performing hand hygiene. The CNA (#5) applied white protective cream to Resident #35B's peri area and then removed her gloves, without performing hand hygiene,	F 880	skills lab by QA director and designee. 4. Staff will be observed performing resident cares and medication passes weekly x4, monthly x5, and quarterly x2. QA was initiated on 2/19/18. QA's will be monitored by QA Director/Designee. Audit results will be reported at the monthly QAPI/QA meeting by QA Director/Designee. 5. Corrective action will be completed on March 1, 2018.	

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	355042	A. BUILDING _____ B. WING _____	01/25/2018

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F 880	Continued From page 48 reapplied gloves, and finished performing cares. - Observation on 01/24/18 at 8:18 a.m., showed two CNAs (#6 and #8) enter Resident #35B's room. The resident was transferred from her WC to bed with a full body mechanical lift. The CNAs (#6 and #8) donned gloves. After cleansing the resident of BM the CNAs (#6 and #8) removed their soiled gloves and donned new gloves without performing hand hygiene. One CNA (#8) applied white protective cream to Resident #35B's peri area. During an interview on 01/24/18 at 03:07 p.m., an administrative nurse (#1) stated, "yes, I expect staff to wash their hands upon entering the room and inbetween glove changes." - On 01/23/18 at 10:43 a.m., observation showed a staff member (#12) entered Resident #35A's room, placed a gaitbelt around the resident's trunk, held on to the gaitbelt while ambulating with Resident #35A out of the room, down the hall, and back to the room. The staff member removed the gait belt after the resident sat on the bed. The staff member (#12) failed to perform hand hygiene after resident contact and before leaving the room. During an interview on 01/25/18 at 8:15 a.m., an administrative nurse (#11) stated staff "should perform hand hygiene before they leave the room" after contact with a resident. 2. Based on observation and review of facility policy, the facility failed to ensure staff followed proper hand hygiene for 1 of 2 staff nurses (#10)	F 880		

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 _____	01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 49 observed during medication administration. Handling resident medications with bare hands has the potential to spread infections. Findings include: Review of the facility policy entitled "Administration of Meds [Medications]" occurred on 01/25/18. This policy, dated August 2017, stated, ". . . Staff shall follow established facility infection control procedure (e.g. [example given], hand washing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. . . ." Observation during medication pass on the morning of 01/24/17 showed a staff nurse (#10) touched two medications with bare hands while placing the medications in a medication cup. The nurse failed to use gloves or other device when touching the resident's medications.	F 880		