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 _____	03/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 03/15/21 and concluded on 03/17/21.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		4/21/21

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

Electronically Signed | 04/09/2021

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, review of the CNA's (certified nurse aide) Pocket Kardex (care guide), and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 7 of 16 sampled residents (Resident #3, #11, #15, #21, #22, #34, and #89), and 1 closed record (#40) reviewed for advanced directives. Failure to ensure all methods of communication and/or documentation of code status for each resident accurately reflected the resident/resident representative wishes has the potential to limit his/her access to life-sustaining services or result in unwanted treatment. Findings include: Review of the policy titled, "Communication of Code Status" occurred on 03/17/21. This undated policy, stated, ". . . When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. . . . The nurse who notated the physician order is responsible for documenting the directions in all relevant sections of the medical record. The designated sections of the medical record are: The EMAR [electronic	F 578	1. The corrective action accomplished related to ensuring the medical record contains signed Advanced Directives and consistent documentation that accurately reflects residents wishes is that Resident #3, #11, #15, #21, #22, #34, and #89 now have a singular signed Advanced Directives for CPR Form in place. Since Resident #40 is deceased, no corrective action can be accomplished. All other code status documentation will be removed from duplicative locations. 2. The facility recognizes that all residents with advanced directives have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur are that the facility has revised its policy titled “Communication of Code Status” and also educated facility staff on these updates at an in-service on 04/14/2021 by the co-Directors of Nursing Services. Code status was added to the admission form that the Physician will sign on the day of the Resident’s admission. If a resident	

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F 578	Continued From page 2 medical administration record], Resident Face Sheet, and Care Profile. Additional means of communication of code status include: a. DOT system: Green for Full Code [CPR]; Red for Do Not Resuscitate [DNR]. b. DOT system located outside resident room by their nameplate. c. Pocket Kardex and nurse report sheets. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code. The resident's code status will be reviewed on admission and PRN. The changes will be documented in the designated sections of the medical record, by the resident's nameplate outside their door, on the Resident Pocket Kardex, and the nurse report sheets." Review of a form titled "[Facility Name] Advanced Directive For CPR" offered the following options for resident code status and required a signature and date from the resident/resident representative, a facility representative, and a physician: * "Yes. In the event that I would experience a cardiac emergency and have no pulse, it is my wish for staff to start CPR/use the defibrillator [a machine to restart the heart] [Full Code] . . ." * "No. I do not want CPR started or have the defibrillator used on me in the event that I am experiencing a cardiac emergency and have no pulse [DNR - do not resuscitate]." During an interview on 03/17/21 at 11:15 a.m., an administrative nurse (#2) stated the Advanced Directive for CPR form is used as the physician order for code status and the resident is considered a full code until the form is signed by the physician.	F 578	requests a change in code status during his/her stay at the facility, a verbal order will be obtained from the Physician. Nursing staff were also educated on 4/14/21 that each resident's current Advance Directives order within PCC should always be referenced as the current physicians order in the event of a medical emergency. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that resident medical records accurately reflect their current code status. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 04/12/2021. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 04/21/2021.	

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F 578	Continued From page 3 - Review of Resident #3's medical record occurred on all days of survey. The resident's face sheet and electronic physician's order [EMR] showed CPR. The Advanced Directive for CPR form, signed and dated by the resident's representative on 02/01/21, identified "No" for CPR. The physician signed and dated the form on 03/16/21 (44 days later). Observation on 03/15/21 showed Resident #3's nameplate lacked a dot for code status and review of the CNA Kardex on 03/16/21 identified Resident #3 as DNR. According to the facility policy, Resident #3 was a full code, until the facility obtained the physician's signature. During an interview on 03/16/21 at 2:12 p.m., a CNA (#11) stated she was unsure what the colored dots (red and green) represented. The CNA then pulled a kardex from her pocket and identified Resident #3's code status as a DNR. During an interview on 03/17/21 at 11:15 a.m., an administrative nurse (#2) confirmed the facility considered Resident #3 a full code unitl 03/16/21 when the physician signed the Advanced Directive for CPR form. - Review of Resident #11's medical record occurred on all days of survey. The resident's EMR showed DNR. The Advanced Directive for CPR form, signed and dated by Resident #11 on 02/25/21, identified Resident #11 as "No" for CPR. The physician signed and dated the form on 03/16/21 (19 days later).	F 578		

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F 578	Continued From page 4 Observation on 03/15/21 showed Resident #11's nameplate lacked a dot for code status. According to the facility policy, Resident #11 was a full code, until the facility obtained the physician's signature. - Review of Resident #15's medical record occurred on all days of survey. The resident's face sheet and EMR showed CPR. An updated Advanced Directives for CPR form, signed and dated by the resident's representative on 02/08/21, identified a change from full code to DNR. The physician signed and dated the updated form on 03/16/21 (36 days later). Observation on 03/15/21 showed Resident #15's nameplate had a green dot for code status and review of the CNA Pocket Kardex on 03/16/21 identified Resident #15 as DNR. According to facility policy, Resident #15 continued as a full code, until the facility obtained the physician's signature. - Review of Resident #21's medical record occurred on all days of survey. The resident's EMR showed DNR. The Advanced Directive for CPR form, signed and dated by the resident's power of attorney on 01/08/21, identified "No" for CPR. The form lacked a physician signature. Observation on 03/15/21 showed Resident #21's nameplate lacked a dot for code status. According to the facility policy, Resident #21 is a full code, until the facility obtains a physician's signature.	F 578		

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F 578	Continued From page 5 - Review of Resident #22's medical record occurred on all days of survey. The resident's face sheet and EMR showed DNR. The Advanced Directives for CPR form, signed and dated by the resident's guardian/representative on 01/14/21, identified "No" CPR. The form lacked a physician's signature. Observation on 3/15/21 showed Resident #22's nameplate lacked a dot for code status and review of the CNA Kardex on 03/16/21 identified Resident #22 as DNR. According to the facility policy, Resident #22 is a full code, until the facility obtains a physician's signature. - Review of Resident #34's medical record occurred on all days of survey. The resident's face sheet and EMR showed DNR. The Advanced Directives for CPR form, signed and dated by the resident's representative on 02/08/21, identified "No" for CPR. The physician signed and dated the form on 03/16/2021 (37 days later). Observation on 03/15/21 showed Resident #34's nameplate lacked a dot for code status and review of the CNA Kardex on 03/16/21 identified Resident #34 as DNR. According to the facility policy, Resident #34 was a full code, until the facility obtained the physician's signature. - Review of Resident #40's medical record occurred on 03/17/21. The resident's face sheet	F 578		

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F 578	Continued From page 6	F 578		

and EMR showed DNR. The Advanced Directive for CPR form, signed and dated by the resident representative on 01/25/21, identified "No" for CPR. The form lacked a physicians signature.

According to the facility policy, Resident #40 was a full code during his/her entire facility stay (15 days) as the facility failed to obtain a physician's signature.

- Review of Resident #89's medical record occurred on all days of survey. The resident's EMR showed DNR. The Advanced Directive for CPR form, signed and dated by the resident's representative on 03/01/21, identified, "No" CPR. The form lacked a physician's signature.

Observation on 03/15/21 showed Resident #89's nameplate lacked a dot for code status.

According to the facility policy, Resident #89 is a full code, until the facility obtains a physician's signature.

During an interview on 03/16/21 at 2:18 p.m., a CNA (#12) stated to check a resident's code status he/she would first look at the resident's nameplate for the appropriate dot color.

During an interview on 03/16/21 at 3:39 p.m., an administrative staff member (#1) confirmed CNA Pocket Kardex forms contained current resident information.

During an interview on 03/17/21 at 9:00 a.m., an administrative staff member (#2) stated the dots by the resident's name outside the door represents their code status: a green dot

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F 578	Continued From page 7 represents a full code and a red dot represents a DNR. The staff member (#2) also stated staff use the dots if a resident is having difficulty, as it takes too much time for staff to "run" to the resident's chart. The facility failed to obtain a physician's signature on the Advanced Directives for CPR forms in a timely manner and/or at all, and failed to ensure all methods of communication and/or documentation accurately reflected resident representative code status wishes. These failures placed Residents #3, #11, #15, #21, #22, #34, #40, and #89 at risk for limited access to life-sustaining services and/or may have resulted in unwanted treatment.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		4/21/21

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F 584	Continued From page 8 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interview, and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment for 1 of 16 sampled resident's (Resident #30). Failure to maintain clean, comfortable resident rooms may result in resident discomfort. Findings include: Review of the policy titled "Resident Rights" occurred on 03/17/21. This policy, dated 10/31/17, stated, ". . . [Facility Name] will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or	F 584	1. The corrective action accomplished related to ensuring that residents have a safe, clean, comfortable, and homelike environment is that Resident #30's thermometer was immediately turned down, visible dust removed from room fans, and the window repaired. These actions all took place on 03/18/2021. 2. The facility recognizes that all residents' rooms have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur. Maintenance/Environmental staff will	

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F 584	Continued From page 9 enhancement of his or her quality of life, recognizing each resident's individuality. This facility will protect and promote the rights of each resident. . . . SAFE ENVIRONMENT. The resident has a right to a save [sic], clean comfortable and homelike environment, including but limited to receiving treatment and supports for daily living safely. The facility will provide: . . . Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior . . . Comfortable and safe temperature levels. . . ." Review of Resident #30's medical record showed diagnoses of Parkinson's disease and rhinitis. During an interview on 03/16/21 at 3:40 p.m., Resident #30 stated, "My room is so dam hot I can barely breathe in here. Can't they regulate the heat around here? . . . I have two fans blowing on me. . . . This dam window has been broken for a long time." The resident also stated he spends a majority of his time in his recliner. Observations in Resident #30's room showed the following: * 03/16/21 at 3:40 p.m., a thermometer hanging on the resident's wall read 86 degrees. * 03/17/21 at 8:49 a.m., the thermometer on the wall and a thermometer the surveyor placed in the room showed 84 degrees. * 03/17/21 at 10:46 a.m. and at 2:59 p.m., the thermometer read at 86 degrees. Observations showed both fans with visible dust, the handle on the window broken, and the window open approximately 4 inches.	F 584	receive education on 4/14/21 by the Director of Environmental Services. This education will ensure comfortable and safe temperature levels will exist and a pleasant, sanitary, orderly and comfortable environment. The co-directors of nursing services will provide additional education to all staff on 4/14/21. WHCC has purchased “TELS”, a web based building management tool that has three functions: Compliance with life safety regulations, work orders and asset management. This program will enable staff to electronically place concerns on to the web based program. Prior to the electronic program being in place, all staff will complete a maintenance/environmental work order and notify their supervisor if they have any concerns regarding resident room temperatures, window repair or any general environmental needs. Educated on 4/14/21 at the all staff meeting. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that resident room temperatures are maintained between 71 and 81 degrees Fahrenheit. Additional random audits will be performed to ensure resident room fans are free from visible dust and that windows are operational in nature. These random audits will be done weekly x 4, monthly x 2, and then for one quarter beginning the week of 04/12/2021.	

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F 584	Continued From page 10 During an interview on 03/17/21 at 1:36 p.m., maintenance staff (#3) stated he was aware that the temperature in Resident #30's room is "a major concern" for the resident, stated he fixes windows when he receives a work order, and when told of the dirty fans, stated, "That I can believe."	F 584	Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 04/21/2021.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: BLOOD SUGAR LEVELS 1. Based on record review and staff interview, the facility staff failed to follow professional standards for 1 of 1 sampled resident (Resident #10) who experienced a drop and/or excess of glucose in her bloodstream. Failure to follow standing orders and notify the on-call provider of Resident #10's low and high blood sugar levels (hypoglycemia and hyperglycemia) placed her at risk for adverse health effects. Findings include: Review of Resident #10's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease and diabetic neuropathy [nerve damage]. The quarterly Minimum Data Set (MDS), dated 12/21/20, identified Resident #10 received insulin daily.	F 658	BLOOD SUGAR LEVELS 1. Since the window of time has passed to follow physician□s orders regarding notification of elevated blood sugar readings for Resident #10, the corrective action is that this resident is now having low and high blood sugar readings reported to the provider as ordered. 2. The facility recognizes that all residents with orders for notification of low or high blood sugar readings have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur are that the facility has revised its policy titled Blood Sugar Monitoring and also educated facility staff on these updates at an in-service on 04/14/2021 by the	4/21/21

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F 658	Continued From page 11 The physician's orders identified the following: * Lantus SoloStar Solution Pen-injector 100 unit/milliliter (ml) inject 50 units subcutaneously at bedtime * Lantus Solution 100 unit/ml inject 30 units subcutaneously one time a day * NovoLOG Solution 100 unit/ml inject 14 units subcutaneously before meals * AM blood sugar one time a day The facility's standing orders identified the following: * "HYPOGLYCEMIA (BS [blood sugar] < [less than] 70) * If resident is symptomatic, conscious and able to swallow . . . administer 6 oz [ounces] of fruit juice, milk, regular soda, or other high carbohydrate beverage . . . * Repeat BG [blood glucose] after 15 minutes: If < 70 repeat above intervention * If after 2 attempts to treat and BG is still < 70, notify provider . . . * HYPERGLYCEMIA (BS > [greater than] 400) * Call provider on call." The "Vitals: Blood Sugar" summary identified the following: * 02/16/21, 401 milligrams per deciliter (mg/dL) * 02/23/21, 433 mg/dL * 02/28/21, 402 mg/dL * 03/04/21, 44 mg/dL * 03/06/21, 449 mg/dL * 03/10/21, 442 mg/dL, 485 mg/dL * 03/11/21, 405 mg/dL * 03/13/21, 495 mg/dL * 03/14/21, 455 mg/dL	F 658	co-Directors of Nursing Services. Emphasis will be put on the need for staff to notify providers regarding blood sugar readings outside of identified parameters and document accordingly. Residents with specific parameters for notification will be identified and have those orders entered separately into Point Click Care, in order to allow for enhanced monitoring and easier identification of individualized parameters. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that blood sugar readings outside of specified parameters are reported to the providers as ordered. These random audits will be done weekly x 8, monthly x 2, and then for one quarter beginning the week of 04/12/2021. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 04/21/2021. WEIGHTS 1. Since the window of time has passed to identify the accuracy of previous weights for Residents #10, #22, and #32, the corrective action is that these residents are now having their weights obtained in accordance with the facilities policy.	

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F 658	Continued From page 12 The progress notes failed to identify the staff's response to Resident #10's low and high blood sugar levels listed above. During an interview on 03/17/21 at 3:38 p.m., two administrative staff members (#1 and #2) reported the nurse failed to document the correct blood sugar level on 03/04/21. The administrative staff members (#1 and #2) spoke to one of their nurses and she indicated "she does call the physician when blood sugars are greater than 450 [mg/dL]." The facility failed to ensure staff notified the on-call provider of Resident #10's low and high blood sugar levels (hypoglycemia and hyperglycemia) placing her at risk for adverse health effects. WEIGHTS 2. Based on observation, record review, policy review, and staff interview, the facility failed to consistently document weights according to physician's orders for 3 of 16 sampled residents (Resident #10, #22, and #32) reviewed for weights. Failure to consistently weigh residents as ordered may delay needed treatment for weight loss or gain and not allow residents to maintain a sufficient health/nutritional status. Findings include: Review of the facility policy titled Guidelines for Weighing" occurred on 03/17/21. This policy, dated 01/15/20, stated, ". . . 2. Residents are weighed per standing orders which is weekly or per Practitioner's orders that may indicate more	F 658	2. The facility recognizes that all residents who are weighed have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur are that the facility has revised its policy titled Guidelines for Weighing and also educated facility staff on these updates at an in-service on 04/14/2021 by the co-Directors of Nursing Services. Emphasis will be put on the need for staff to notify the charge nurse if a variance of 5 pounds or more is noted and also to obtain a timely reweigh if indicated. Nursing staff will be responsible for obtaining resident weights and recording them in the weight binder. The Administrative Assistant will be assigned to review for accuracy and enter all weights into the medical record. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that resident□s weights are accurate and timely reweigh occurs if warranted. These random audits will be done weekly x 8, monthly x 2, and then for one quarter beginning the week of 04/12/2021. Results will then be reported to the QA committee with corrective action implemented as deemed necessary.	

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F 658	Continued From page 13 often than weekly. 3. If any resident has a 5# [pound] increase or decrease, the resident will be reweighed. 4. If a practitioner has ordered parameters for a resident's weight, the Practitioner will be notified per orders when there is an increase or decrease regarding parameters. . . . Document the resident's weight in POC [point of care]. . . ." - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included hypertensive heart and chronic kidney disease with heart failure (CHF). The quarterly Minimum Data Set (MDS), dated 12/21/20, identified Resident #10 experienced weight loss. A physician's order, dated 06/22/20, identified, ". . . Assess edema to lower extremities every am every day shift related to . . . (congestive) heart failure. . . ." The "Vitals: Weights" summary identified the following: * 11/22/20, 172.6 lbs [pounds] * 11/29/20, 180.2 lbs (+ 7.6 lbs) * 01/17/21, 184.8 lbs * 01/24/21, 179.8 lbs (- 5 lbs) * 03/07/21, 183.2 lbs * 03/14/21, 174.8 lbs (- 8 lbs) The summary failed to show staff re-weighed Resident #10 when she gained/lost 5 or more pounds as per facility policy. - Review of Resident #22's medical record occurred on all days of survey. Diagnoses included malignant lung cancer and anxiety.	F 658	5. Corrective action will be completed by 4/21/21.	

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F 658	Continued From page 14 Review of Resident #22's "Vitals: Weights" summary identified the following: * 01/24/21, 153.8 lbs * 02/07/21, 155.6 lbs (no weight for 14 days) * 03/03/21, 153.4 lbs (no weight for 24 days) The summary failed to show staff obtained weekly weights for Resident #22 per facility policy. - Review of Resident #32's medical record occurred on all days of survey. The "Vitals: Weights" summary identified the following: * 02/11/21, 158.1 lbs * 02/14/21, 196.0 lbs (+ 37.9 lbs) * 02/18/21, 195.8 lbs * 03/03/21, 156.0 lbs (- 39.8 lbs) * 03/07/21, 196.6 lbs (+ 40.6 lbs) * 03/10/21, 197.2 lbs The summary failed to show staff re-weighed Resident #32 when she gained/lost 5 or more pounds as per facility policy. During an interview on 03/17/21 at 4:32 p.m., two administrative staff members (#1 and #2) confirmed weights "should be redone" if greater or lesser than 5 pounds per policy.	F 658		
F 689 SS=D	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	F 689		4/21/21

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F 689	Continued From page 15 §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, and staff interview, the facility failed to provide the assistance necessary to prevent a fall with minor injury for 1 of 1 sampled resident (Resident #10) who experienced a fall in the facility van. Failure to ensure staff safely transported Resident #10 in the facility van resulted in a fall. Findings include: Resident #10's medical record, reviewed March 15-17, 2021, identified diagnoses including anxiety, osteomyelitis [an infection of the bone], type 2 diabetes mellitus, and right below-knee amputation. The quarterly Minimum Data Set (MDS), dated 12/21/20, identified intact cognition and total dependence on two or more persons for transfers. A fall note, dated 09/22/20, identified, "Resident has a small bruise on buttock were [sic] she landed on the foot rest. No other new signs of injury. Will continue to monitor for changes." An incident report, dated 09/22/20, identified, ". . . During transport back from [Hospital], van was forced off the road into the ditch. Resident slid out of chair onto foot rest. Chair was locked into place in the van. Seat belt in place. Resident stated van was forced off the road. 2 staff members in van assisted [Resident #10] back into w/c [wheelchair] and secured w/c and resident. When [Resident #10] arrived to facility,	F 689	1. The corrective action accomplished related to ensuring residents receive the care and services necessary to attain the highest degree of safety possible while being transported in the facility van is that Resident #10 is now receiving all transportation via Southwest Transit Services while the facilities van is being upgraded. 2. The facility recognizes that all residents who are being transported by the facility van have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur are that the facility has revised its “Transport Van Checklist” and also educated facility van drivers on the updates at an in-service on 04/14/2021 by the co-Directors of Nursing Services. A facility policy titled “Resident Transportation” was developed and also shared with staff at the 04/14/2021 in-service. The facility van is currently having a new seat belt system installed and will remain out of service until that update is completed. Just-in-time education and corresponding competencies will be performed with facility staff who are designated to assist with the transportation of residents following installation of the new seatbelt	

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F 689	Continued From page 16 nurse did full assessment. Bruise to L [left] buttocks noted, however, nurse did not know if bruise occurred during the incident or prior to in the hospital. . . . Recently underwent below knee amputation. . . ." During an interview on 03/17/21 at 1:55 p.m., an environmental services staff member (#3) and a certified nurse assistant (CNA) (#4) reported picking Resident #10 up from the hospital following her amputation. They described being forced off the road by a semi truck during their return trip to the facility. The environmental services staff member (#3) and the CNA (#4) stated, "[Resident #10] was belted in." They secured her wheelchair with four hooks attached to the floor. Resident #10 was strapped in with a belt that crossed from shoulder to hip and attached to the floor hook. They reported Resident #10 slid out of her wheelchair when they were forced off the road, sustaining "a little road burn to her coccyx area." The environmental services staff member (#3) revised the manner in which they secured residents' in their wheelchairs following the accident. When asked if he re-educated staff on the revisions, he (#3) stated, "Right, we do. We did. [CNA (#4), maintenance, housekeeping, laundry staff members (#5 and #6), and a name of an unidentified staff member]." During an observation/interview on 03/17/21 at 2:49 p.m., the environmental services staff member (#3) demonstrated how he secured Resident #10's wheelchair in the van. The environmental services staff member (#3) then pulled the belt across the wheelchair (shoulder to hip) and attached it to the floor hook. When the	F 689	system. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that facility staff is currently utilizing the facility van and new seat belt system correctly, in order to ensure safe transport of residents to/from appointments and/or outings. These random audits will be done weekly x 8, monthly x 2, and then for one quarter beginning the week of 04/12/2021. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 04/21/2021.	

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F 689	Continued From page 17	F 689		

belt accommodated a forward movement, the environmental services staff member (#3) indicated it would "not tighten unless jerked." The environmental services staff member (#3) was unable to locate the owner's instruction manual.

During an interview on 03/17/21 at 3:52 p.m., a maintenance, housekeeping, laundry staff member (#5) and two activity staff members (#7 and #8) indicated they utilize the van to transport residents to/from appointments and/or outings.

Review of the "Transport Van Checklists" identified the environmental services staff member (#3) re-educated two maintenance, housekeeping, and laundry staff members (#5 and #6) following the accident. The checklists failed to reflect the process changes the facility made when securing residents in the facility van.

During an interview on 03/17/21 at 3:38 p.m., two administrative staff members (#1 and #2) acknowledged pulling the belt across the resident, from shoulder to hip, and attaching it to the floor hook failed to secure the resident properly.

During an interview on 03/17/21 at 5:20 p.m., an administrative staff members (#1) stated, "We don't have a policy on the van; transporting residents."

The facility failed to ensure Resident #10 received the care and services necessary to attain the highest degree of safety possible while being transported in the facility van. They failed to ensure they safely transported Resident #10 in the facility van, failed to revise the "Transport Van

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F 689	Continued From page 18 Checklist" reflecting process changes, failed to re-educate all staff members currently utilizing the facility van to transport residents to/from appointments and/or outings, and failed to develop a policy addressing resident transport via the facility van.	F 689		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/16/20. Based on observation, record review, review of facility policy, review of professional reference, and staff interviews, the facility failed to offer	F 692	1. The corrective action accomplished related to offering fluids and/or supplements during cares is that Resident #21, #32, #89, and #A are now receiving fluids and/or supplements per facility policy.	4/21/21

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F 692	Continued From page 19 fluids to 3 of 16 sampled residents (Resident #21, #32, and #89) and one supplemental resident (#A) observed during cares and requiring staff assistance for fluid intake. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Hydration Management" occurred on 03/17/21. This policy, reviewed 12/24/19, stated, ". . . Staff will provide fluids consistently throughout the day and when awake at night. . . . A picture of a water glass has been placed on the inside of each resident room as a reminder to staff to offer fluids. . . ." Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, page 137, identified, ". . . One of the most difficult challenges when working with patients is getting them to take enough thickened liquids to meet their fluid needs. . . ." - Review of Resident #21's medical record occurred on all days of survey. Diagnoses included dementia and gastro-esophageal reflux disease. The admission Minimum Data Set (MDS), dated 01/14/21, identified Resident #21 required oversight, encouragement, or cuing during meals. The current physician's orders identified, ". . . PER SPEECH THERAPY . . . Mechanical soft . . . Nectar thick, small bites and sips. . . ." Observations identified the following: * 03/15/21 at 1:32 p.m., A certified nurse	F 692	2. The facility recognizes that all residents who are dependent on staff for fluid intake have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur is that nursing staff will be reeducated on the facility policy titled Hydration Management at an in-service on 04/14/2021 which relates to water pass and water within reach of the resident. Emphasis will be put on the need for all staff to offer fluids or supplements to residents with all interactions, especially prior to leaving the room and fluids are always left within resident□s reach. Bedside fluids will be replenished three times daily by nursing staff and also provided at scheduled mealtimes. The Restorative Nursing Department will be responsible for overseeing and championing this process. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that residents who are dependent on staff for fluid intake are provided the necessary assistance. These random audits will be done weekly x 8, monthly x 4, and then for one quarter beginning the week of 04/12/2021. An additional audit will also be performed at the above frequency to ensure that fluids are left within resident□s reach by facility	

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F 692	Continued From page 20 assistant (CNA) (#9) and nurse (#10) assisted Resident #21 into the bathroom and provided toileting cares. After transferring Resident #21 back to her room, the nurse (#10) offered her a drink of water, realized there was no water/fluids available in her room, and exited the room to obtain a water jug. * 03/16/21 at 12:37 p.m., No water/fluids available in Resident #21's room. * 03/17/21 at 8:55 a.m., No water/fluids available in Resident #21's room. Staff had posted a water glass sign on the back of her door. - Review of Resident #32's medical record occurred on all days of survey. Diagnosis included dementia. The admission Minimum Data Set (MDS), dated 02/10/21, identified Resident #32 required oversight, encouragement, or cuing during meals. Observations identified the following: * 03/15/21 at 4:19 p.m., Resident #32 in bed, water jug on bedside table across the room and out of reach. CNA's (#9 and #11) assisted Resident #32 to the wheelchair. Staff failed to offer water prior to leaving the resident's room. * 03/16/21 at 11:12 a.m., Resident #32 in bed, water jug on bedside table across the room and out of reach. * 03/17/21 7:47 a.m., Resident #32 in bed, water jug on bedside table across the room and out of reach. During all three observations the water glass sign present on the resident's door. - Review of Resident #89's medical record occurred on all days of survey. Diagnoses included dementia and dehydration. The	F 692	staff. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 4/21/21.	

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F 692	Continued From page 21 admission Minimum Data Set (MDS), dated 03/05/21, identified Resident #89 required set-up assistance during meals. Observations identified the following: * 03/15/21 at 1:50 p.m., Resident #89 sat on the edge of his bed, water jug on bedside table across the room and out of reach. * 03/17/21 at 8:56 a.m., Resident #89 resting in bed, water jug on bedside table across the room and out of reach. Staff had posted a water glass sign on the back of her door. During an interview on 03/17/21 at 9:15 a.m., an administrative staff member (#2) stated, "The water glass signs were placed as reminders that specific residents need cues/assistance to maintain hydration. Certain people need more reminders than others." During an interview on 03/17/21 at 3:22 p.m., Resident #A reported staff failed to routinely fill ice waters, especially on weekends. Resident #A stated the kitchen staff fill resident room water jugs at noon during the week. He/she stated if you want your water filled on the weekend, you have to put on your call light and request it. He/she also stated this has been an issue discussed during many council meetings. During an interview on 03/17/21 at 5:20 p.m., an administrative staff member (#1) confirmed they expect residents "to have access to water in their rooms and the water should be within their reach."	F 692		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		4/21/21

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F 801	Continued From page 22 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 801		

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F 801	Continued From page 23 (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager fully completed the necessary education to obtain the required qualifications to serve as the director of food and	F 801	1. The corrective action accomplished related to ensuring the facility has a qualified staff with the appropriate competencies and skill sets to carry out	

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F 801	Continued From page 24 nutrition services for 1 of 1 dietary staff. Failure to ensure a qualified staff with the appropriate competencies and skill sets to carry out the function of food and nutrition services has the potential to result in foodborne illness to residents, staff, and visitors. Findings include: During an interview on 03/17/21 at 2:09 p.m., the dietary manager (#14) stated she had completed 120 hours of dietary service training, received a certificate of completion on 09/09/20, and applied to take the exam for the course "just a few days ago." Review of the certificate of completion showed the dietary manager completed the training, but failed to complete the certification. During an interview on the afternoon of 03/17/21, an administrative staff member (#1) agreed the facility currently did not employ a certified dietary manager (CDM).	F 801	the function of food and nutrition services is that the facility now has an interim certified dietary manager in place. 2. The facility recognizes that all residents receiving food and nutrition services have the potential to be affected by the same practice. 3. Measures put into place to ensure this practice will not reoccur are that the facility has hired an interim certified dietary manager consultant while the existing dietary manger takes her examination to become fully certified. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that a certified dietary manager is employed at the facility on a full-time basis. These random audits will be done monthly x 12 beginning the week of 04/12/2021. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 04/21/2021.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		4/21/21

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F 812	Continued From page 25 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, professional reference, facility logs, and staff interview, the facility failed to test and/or consistently test sanitizer solutions in 1 of 1 kitchen. Failure to test and/or consistently test concentration levels of sanitizing solutions may result in unsanitary dishware/surfaces and a sanitizer concentration that is either too weak to sanitize or too strong, which may leave a chemical residue on surfaces. Findings include: The "Food Code, U.S. Public Health Service, Food and Drug Administration," U.S. Department of Health and Human Services, 2013, page 499, stated, ". . . Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: 1. The use of chemical sanitizers requires minimum concentrations of the sanitizer during the final rinse step to ensure sanitization;	F 812	1. The corrective action accomplished related to ensuring a sanitary environment in the kitchen is that sanitizer solution and testing strips were located/labeled and a demonstration of how to test, how often to test, and when to change the solution was provided to the dietary staff on the shift. 2. The facility recognizes that all residents have a potential to be affected by the same practice. 3. Measures put in to place to ensure this practice will not reoccur is that a Competency Verification/Training Checklist will be used for orientation purposes for all current and future staff. Dietary staff will be educated regarding testing of quat and bleach levels, logging,	

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F 812	Continued From page 26 and 2. Too much sanitizer in the final rinse water could be toxic. . . ." During observation of the kitchen on 03/17/21 at 2:09 p.m., a review of the March 2021 "Dishwasher Sanitizer check range" log showed staff failed to consistently monitor/track sanitizer levels. During observation, a dietary staff member (#15) demonstrated how/what is used to sanitize and wipe down resident tables. The staff member (#15) filled a bucket with water and Ecolab 146-quat sanitizer that automatically dispenses with the water when the water faucet on. The staff member then filled another bucket with plain water, and without measuring, poured bleach from a gallon jug into the bucket of water, and stated, "I was told to add about a tablespoon." The staff then stated, she would wipe the resident tables first with the bucket of quat water and follow with the bleach water. The dietary staff member (#15) stated, "No. Should I?" when asked if she tested the concentration of the quat and bleach prior to wiping the tables. The staff member (#15) further stated she has never tested the concentrations of quat and bleach. A second staff member (#14) tested the quat and the bleach concentrations in the buckets of water. Results: Quat 250 ppm, bleach 100 ppm. Review of the March 2021 "Bucket Sanitizer Readings" log for quat showed staff failed to consistently track quat sanitizer levels. The facility failed to provide a log for tracking bleach	F 812	and troubleshooting per policy at an in-service on 04/14/2021. Emphasis will be put on the need for dietary staff to routinely measure sanitizing buckets to ensure the appropriate amount of chemical is present in accordance with facility policy and regulatory requirements. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using Kitchen Sanitation audits. An additional audit on using the sanitizer correctly will be performed weekly. These audits will be done weekly x4 and then monthly thereafter to ensure ongoing compliance. Results will be reported to the QA team with corrective action implemented. 5. Corrective action will be completed by 04/21/2021.	

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F 812	Continued From page 27 bucket sanitizer levels. During an interview on 03/17/21 at 4:10 p.m., dietary staff members (#14 and #16) stated no device is utilized to measure bleach amounts used in sanitizing buckets and bleach sanitizer levels are not monitored/tracked by the kitchen staff.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Quality Assurance and Performance Improvement (QAPI) program and staff interview, the facility failed to ensure the Medical Director (physician) actively participated on the Quality Assurance (QA) committee for 1 of 4 quarters (October-December 2020). Failure to ensure the medical director participates in the facility's QA	F 868	1. The corrective action accomplished related to ensuring the facilities medical director participates in the facility□s QA activities is that the medical director is now attending quarterly QA meetings in accordance with regulatory requirements. 2. The facility recognizes that all	4/21/21

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F 868	Continued From page 28 activities deprived the committee of the physician's unique contributions for analyzing and correcting problems with identified resident care areas. Findings include: Review of the facility QAPI program titled "Quality Assurance and Performance Improvement" occurred on 03/18/21. The plan, revised 06/23/19, stated, ". . . The QAPI program includes the establishment of a Quality Assessment and Assurance (QA) Committee and a written QAPI Plan. . . . The QA Committee shall be interdisciplinary and shall . . . Consist at a minimum of . . . The director of nursing services . . . The Medical Director . . . At least three other members of the facility's staff . . . The infection control and prevention officer. . . . Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program . . ." The facility provided documentation showing the QA committee met on a quarterly basis between April 2020 and January 2021. The documentation showed the Medical Director failed to attend the October-December 2020 meeting. During an interview on 03/17/21 at 4:30 p.m., two administrative staff members (#1 and #2) confirmed the Medical Director failed to attend one of the four required quarterly QA committee meetings.	F 868	residents have the potential to be affected by this deficient practice. 3. Measures put into place to ensure this practice will not reoccur is that the facilities medical director will be notified prior to the scheduled QA meeting to determine if he or she will be able to attend. If the medical director is not able to attend, the quarterly meeting will be rescheduled to an alternate time in order to allow for their participation and to be compliant with CMS requirements. 4. The facility plans to monitor its performance to make sure solutions are sustained by assigning the QA Coordinator and/or designee to monitor by using random audits that the facilities medical record actively participates in the QA committee each quarter. These random audits will be done quarterly x4 beginning the week of 04/12/2021. Results will then be reported to the QA committee with corrective action implemented as deemed necessary. 5. Corrective action will be completed by 04/21/2021	