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 _____	C 05/18/2022

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 and complaint investigations started on 05/16/22 and concluded on 05/18/22.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the	F 625	1. The facility failed to provide a written	6/16/22

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

Electronically Signed | 06/03/2022

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F 625	Continued From page 1 facility failed to provide a written copy of the bed hold notice to the resident or their representative for 1 of 1 sampled resident (Resident #4) with a recent hospital transfer. Failure to provide a written bed hold notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: - Review of Resident #4's medical record occurred on all days of survey and identified a hospitalization from May 16-18, 2022. The record lacked evidence the facility provided the resident and/or the resident's representative a written copy of the bed hold form. During an interview on 05/18/22 at 11:00 a.m., an administrative staff (#9) agreed the medical record lacked a written bed hold form or documentation stating the resident and/or the resident's representative received the form.	F 625	copy of the bed hold notice to resident #4 or their Personal Representative with a recent hospital transfer. Corrective action taken is that resident #4's Personal Representative was notified by phone on 5/18/2022 of the bed hold related to transfer to the hospital on 2/7/2022. Copy of the bed hold was sent to Personal Representative for signature on 6/1/2022. 2. The facility recognized that all residents that are transferred out of the facility have the potential to be affected by the same practice. 3. The current policy for Bed Hold was reviewed and revised on 5/19/2022. In-service training was provided to the nurses and Medical Records on 5/19/2022. 4. Medical Records will be responsible to audit completion of bed hold after each transfer of a resident out of the facility. QA monitoring will be implemented on 5/19/2022. Medical Records will monitor weekly x 1 month and monthly x 11 months. The QA Director will submit a report of audit results to the QA Committee and Board Members monthly.	
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: Based on observation, review of facility policy,	F 658	1. The facility failed to properly prepare	6/10/22

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F 658	Continued From page 2 and staff interview, the facility failed to follow professional standards of practice for 2 of 2 residents (Residents #16 and #32) observed during insulin administration. Failure to properly prepare an insulin pen per facility policy may result in residents receiving an inaccurate dose of insulin. Findings Include Review of the facility policy titled "Insulin Pens" occurred on 05/18/22. This policy, dated 12/26/21, stated, ". . . 7. Remove the needle caps. Remove the outer cap and save. Remove the inner cap and throw it away. . . ." - Observation on 05/17/22 at 7:50 a.m., showed the nurse (#3) obtained two insulin pens for Resident #16. For each pen, the nurse (#3) attached a needle and without removing the caps primed the insulin pens. - Observation on 05/17/22 at 8:05 a.m., showed the nurse (#3) obtained two insulin pens for Resident #32. For each pen, the nurse (#3) attached a needle and without removing the caps primed the insulin pens. During an interview on the afternoon of 05/17/22, an administrative nurse (#2) indicated the nurse (#3) should have removed the caps before priming the insulin pens.	F 658	an insulin pen per policy for resident #16 & #32. Corrective action taken is that all Nurses were educated on facility policy related to insulin pen usage on 5/19/2022. 2. The facility recognized that all residents with an order for insulin pen usage have the potential to be affected by the same practice. 3. The current policy for insulin pen usage was reviewed and revised on 5/19/2022. Return demonstration of insulin pen usage will be completed on 6/10/2022 for all nurses. 4. Administrative Nurse will be responsible to audit Nurse competency of insulin pen usage. QA monitoring will be implemented on 6/10/2022. Administrative nurse will monitor weekly x 1 month, monthly x 3 months, and quarterly thereafter for 1 year. The QA Director will submit a report of the audit results to the QA Committee and Board Members monthly.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		6/1/22

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F 686	Continued From page 3 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to provide the necessary treatment/services to prevent the occurrence and promote the healing of pressure ulcers for 1 of 3 sampled residents (Resident #8) identified with pressure ulcers. Failure to clarify physician orders to heal the resident's pressure ulcer may result in deterioration of the ulcer and result in further skin breakdown and/or ulcers. Findings include: Review of the facility policy titled "Pressure Ulcer Staging" occurred on 05/18/22. This policy, revised February 2022, stated, ". . . Protect skin of incontinent patients from exposure to moisture. Use protective dressings. . . . " Review of the facility policy titled "Notifying Clinicians" occurred on 05/18/22. This policy, revised 03/21/22, stated, ". . . If there is any question, the Physician, Physician assistants, and/or Nurse Practitioner, the order must be clarified. "	F 686	1. The facility failed to clarify Physician orders to heal resident #8's pressure ulcer. Corrective action taken is that the nurse clarified the Physician's order with the Physician related to the pressure ulcer treatment on 5/18/2022. 2. The facility recognized that all residents with a pressure ulcer have the potential to be affected by the same practice. 3. The current policy for clarification of Physician's orders was reviewed and revised on 5/19/2022. Nurses will be in-serviced regarding clarification of Physician's orders to heal pressure ulcers by 5/20/2022. Night Charge Nurse will be responsible for double checking all orders nightly to determine if clarification is necessary. Licensed Nurse will be responsible to notify resident's physician if current treatment is not effective or if order obtained requires clarification. 4. QA/Designee will be responsible to audit orders related to pressure ulcer treatment to determine if clarification is necessary which will be implemented on	

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F 686	Continued From page 4 During an interview on 05/16/22 at 10:35 a.m., Resident #8 stated she had a sore spot on her bottom. Review of Resident #8's medical record occurred on all days of survey. Resident #8's current care plan stated, "SKIN ISSUES: [resident] is at risk for skin issues related to incontinence and decreased mobility. . . . [resident] has moisture associated skin damage to her coccyx and buttocks. . . . " A skin assessment dated 05/11/22 stated, "ONGOING OPEN AREA TO SACRUM, BLANCHABLE REDNESS TO BUTTOCKS AREA. NO NEW SKIN ISSUES NOTED." Current physician orders stated: * "SACRAL MEPILEX BORDER DRESSING - CLEAN AREA WITH NS [normal saline], PAT DRY AND APPLY MEPILEX BORDER DRESSING. CHANGE EVERY 3 DAYS AND PRN [as needed] (WHEN SOILED) every 72 hours for open area on buttocks" dated 04/15/2022. * "Apply collagen powder to wounds daily (ok to mix with Vaseline) every day shift related to PRESSURE ULCER OF SACRAL REGION, STAGE 1 apply to wounds on buttocks/sacral area" dated 4/16/2022. Observation on 05/17/22 at 4:02 p.m., showed two CNAs' (#5 and #6) transferred Resident #8 from wheelchair to bed with use of a mechanical lift. During the transfer, the resident repeatedly cried out "oh my butt hurts". The CNAs' (#5 and #6) completed perineal care for urinary	F 686	6/1/2022. QA/Designee will be responsible to audit orders related to pressure ulcer treatment to determine if clarification is necessary which will be implemented on 6/1/2022. QA/Designee will monitor weekly x 1 month, monthly x 3 months, and quarterly thereafter for 1 year. QA/Designee will submit a report of the audit results to the QA Committee and Board Members monthly.	

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F 686	Continued From page 5	F 686		

incontinence. Resident #8's buttocks showed multiple open areas to each buttock and an open area to the resident's sacrum. The resident cried out "that hurts" repeatedly with each peri wipe to the broken skin areas. No dressing observed to the resident's buttocks/sacral area. A facility nurse (#7), completed skin care for Resident #8's buttocks and sacrum, but failed to apply a dressing to the area.

During an interview on 05/18/22 at 8:24 a.m., a nurse (#8) stated Resident #8 is frequently incontinent of urine, requires frequent incontinent cares, and confirmed the Mepilex is to stay on for 3 days but doesn't stay on due to the resident's incontinence. Nurse #8 clarified the Collagen/Vaseline mixtures is to be applied to Resident #8's buttocks/sacral area daily, and when asked how this could be completed when the order is to change the Mepilex every 3 days, nurse #8 replied, "the Mepilex does not stay on".

During an interview on 05/18/22 at 9:27 a.m., an administrative nurse (#1), confirmed staff should be replacing Mepilex to Resident #8's buttocks/sacral site if not on with each wound care.

During an interview on 05/18/22 at 10:15 a.m., an administrative nurse (#2) stated staff failed to discontinue the order for the Mepilex every 3rd day when the new order for the Collagen and Vaseline mixture was received, and stated she understood the order stated to apply a new Mepilex with each dressing change.

The facility failed to clarify physician orders for providing pressure ulcer care for Resident #8.

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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 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, review of facility policy, and staff interview, the facility failed to discard expired medications in 1 of 2 medication storage rooms (West) and 2 of 2 medication carts (East and West). Failure to discard expired medications increases the risk of residents receiving outdated medications with reduced efficacy.	F 761	1. The facility failed to discard expired medications in 1 of 2 medication storage rooms (west) and 2 of 2 med cards (east and west). Corrective action taken is that expired medications were discarded and replaced with medications obtained from Thrifty White Drug on 5/18/2022. 2. The facility recognized that all residents receiving medications have the potential	6/10/22

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F 761	Continued From page 7 Findings include: Review of the facility policy titled "Administration of Meds [Medications]" occurred on 05/18/22. This policy dated August 2017, stated, ". . . The expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the "open" date shall be recorded on the container. . . ." Observation of medication storage on 05/18/22 at 10:30 a.m. with the Certified Medication Aide (CMA) (#4) showed the following: West medication cart: - one bottle acetaminophen 500 mg (milligrams), opened 05/01/22, expired 01/22 - one bottle aspirin 81 mg, opened 04/16/22, expired 01/22 East medication cart: - one bottle aspirin 81 mg, opened 05/13/22, expired 01/22 West Medication storage room: - 25 bottles aspirin 81 mg, expired 01/22 The CMA (#4) stated they had just ordered the aspirin, and she had not checked the expiration date when she placed it in the medication storage room for use.	F 761	to be affected by the same practice. 3. The current policy for expired medications was reviewed and revised on 5/19/2022. Nurses and CMAs will be in-serviced regarding policy for expired medications by 5/19/2022. Nurse/CMA will be responsible to check medications for expiration dates prior to giving medications. Nurse/CMA will be responsible to check medication carts and medication rooms on a weekly basis for expired medications. 4. QA/Designee will submit a report of the audits performed to the QA committee and board members monthly.	
F9999	FINAL OBSERVATIONS Based on record review, the complaint investigation in conjunction with the Standard Medicare/Medicaid survey was not substantiated.	F9999		