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	355042	A. BUILDING _____ B. WING _____	07/24/2024

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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 07/21/24 and concluded 07/24/24.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess for self-administration of medications for 1 of 1 supplemental resident (Resident #19) observed with medications at bedside. Failure to evaluate the resident's ability to safely self-administer medications may result in medication errors and/or harm to the resident. Findings include: Review of the facility policy "Resident Self-Administration of Medication" occurred on 07/24/24. This policy, dated August 2017, stated, ". . . Each resident who desires to self-administer medication may be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. Self-administration should be written in the care plan once safety has been established. . . ." Observation on 07/21/24 at 3:09 p.m., showed one bottle of Visine [eye drop], one bottle of Clear Eyes [eye drop] and one small container of Vicks	F 554	1. For Resident #19, the medication that was being self-administered will be removed from the resident's room. Resident #19's physician will be requested to order the medications for the resident. If orders are obtained for the medications and the resident indicates no desire to self-administer the medication, this will be documented in the resident's medical record. If resident desires to self-administer the medication, an assessment will be conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility. The results of the interdisciplinary team assessment are recorded on the Self-Administration Form, which is placed in the resident's medical record. Once competency of resident is determined an order shall be obtained from the physician. Following the physician's orders, the policy and procedure of "Resident Self-Administration of Medication" will be followed.	8/21/24

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

Electronically Signed | 08/15/2024

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F 554	Continued From page 1 [vapor rub] in an open bedside dresser drawer, all the containers were unlabeled. Review of Resident #19's medical record occurred on all days of survey. The record lacked an assessment and a physician's order for Resident #19 to self-administer medications and lacked orders for all three medications. During an interview on 07/24/24 at 12:17 p.m., an administrative nurse (#1) confirmed the facility failed to complete an assessment and obtain a physician's order for Resident #19 to self-administer medications, and stated she would expect the facility to assess the resident's ability to independently administer these medications.	F 554	2. All residents who have medications in their room/on their person who have not been assessed and conducted per the "Resident Self-Administration of Medication" policy or lack physician orders have the potential to be affected. 3. The current policy and procedure of "Resident Self-Administration of Medication" will be updated and in-serviced with all CMAs and Nurses during a meeting scheduled for August 20th and 21st, 2024 regarding the policy and procedure of "Resident Self-Administration of Medication". 4. The interdisciplinary team will be responsible to audit the presence of medications in a resident's room or person and verify that the policy is being followed. The DON will monitor to assure that audits will be implemented by 7/30/24. Audits will be completed for 8 residents, rotating, once per week for 4 weeks. Following 4 weeks, audits will ensure on a quarterly basis for 1 year. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 582 SS=D	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-	F 582		8/16/24

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F 582	Continued From page 2 (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 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	F 582		

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F 582	Continued From page 3 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 record review and review of Medicare Part A letters/notices, the facility failed to ensure the resident and/or their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for 1 of 3 residents (Resident #40) reviewed for termination of Medicare Part A services. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights regarding Medicare Part A services. Findings include: Review of Medicare Part A beneficiary notices identified Resident #40 discharged from Medicare Part A on 03/20/24. The SNFABN failed to identify if the resident/her representative chose to continue services, discontinue services, or request a demand bill. Review of Resident #40's medical record occurred on 07/24/24. The record lacked documentation indicating whether the resident/resident representative wanted services to continue with the understanding they would be responsible for payment or wanted services to discontinue when the Medicare Part A coverage ended.	F 582	1. For Resident #40, documentation was lacking to provide indication of the resident/representative choice to continue services, discontinue services, or request a demand bill. 2. All residents have the potential to be affected. 3. A new policy has been developed to address Beneficiary Notices and how to properly document the notices and beneficiary decisions. 4. The MDS Nurse or Designee will be responsible to audit the presence of appropriate documentation of beneficiary notices and beneficiary decisions to verify that the policy is being followed. The MDS Nurse or Designee will monitor to assure that audits will be completed starting by 8/16/24. Audits will be completed for all residents who meet the standards for a beneficiary notice twice per month for 3 months. Following 3 months, audits will ensue on a quarterly basis for 1 year. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The MDS Nurse or Designee will submit a report of the monitoring results to the QA Committee at	

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F 582	Continued From page 4	F 582	each scheduled meeting.	
F 641 SS=D	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: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 13 sampled residents (Resident #11 and #32). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-6 to N-7 stated, ". . . N0415: High-Risk Drug Classes: Use and Indication . . . Coding Instructions . . . N0415B1. Antianxiety: Check if an antidepressant medication was taken by the resident at any time during the 7-day look-back period . . . N0415C1. Antidepressant: Check if an antidepressant medication was taken by the resident at any time during the 7-day look-back period . . . N0415D1. Hypnotic: Check if a hypnotic medication was taken by the resident at any time during the	F 641	1. The coding errors will be corrected and a modification of the MDS for resident #11 & #32 will be updated to reflect correct coding. Significant Correction to Prior Comprehensive Assessment will be completed for resident #11. SCPA will be completed within 14 days of discovery of uncorrected significant error. The SCPA assessment reference date is scheduled for 8/23/2024. 2. All residents have the potential to be affected. 3. The facility will utilize two experienced, and appropriately trained Registered Nurses to assist in the reconciliation of these past MDS submissions. Additionally, these two MDS nurses will be utilized to complete and assist in completion of accurate MDS assessments and submission until staff can be appropriately trained to complete the MDS assessments accurately. The job description for the MDS Coordinator position will be modified to require no less than 12 continuing education hours, specific to minimum data set, on a biannual basis. 4. The MDS nurse or designee will be	8/27/24

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F 641	Continued From page 5 7-day look-back period . . . . . N0415F1. Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period. . . ." - Review of Resident #11's medical record occurred on all days of survey. The annual MDS, dated 06/16/24, showed the facility coded N0415C1 and N0415F1, indicating the resident received an antidepressant and antibiotic during the seven-day look back period. The medical record failed to identify an antidepressant or an antibiotic administered in the look-back period. - Review of Resident #32's medical record occurred on all days of survey. The quarterly MDS, dated 05/31/24, showed the facility coded N0415B1 indicating the resident received an antianxiety during the seven-day look back period. The medical record failed to identify an antianxiety administered during the look-back period. The Resident's #32's Medicare five-day MDS, dated 06/11/24, showed the facility coded N0415B1 and N0415D indicating the resident received a hypnotic during the seven-day look back period. The medical record failed to identify an antidepressant or hypnotic administered during the look-back period. During an interview on 07/24/24 at 12:17 p.m., an administrative nurse (#1) confirmed staff coded Section N of the MDS's incorrectly for Resident #11 and Resident #32.	F 641	responsible to audit MDS reports to ensure accuracy. Monitoring and audits will be implemented on 08/01/2024. The Director of Nursing will monitor the completion of these audits. The audits will include review of 3 MDS assessments monthly for 3 months, and 1 MDS assessment monthly thereafter for 1 year. Results will be reported to the Director of Nursing and the Quality Committee. If concerns are identified, immediate corrective action will be implemented.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		8/16/24

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F 645	Continued From page 6 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

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F 645	Continued From page 7 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure an accurate Pre-Admission Screening and Resident Review (PASARR) for 1 of 2 sampled residents (Resident #31) reviewed with PASARR services. Failure to accurately complete the PASARR screening created the potential for not identifying/providing needed mental health services.	F 645	1. Resident #31 and #32 had the potential to be affected by this deficient practice. Both residents will have a new PASAAR completed to include accurate diagnoses and will have a trauma informed care assessment completed. 2. All residents who are considered to have an intellectual disability have the	

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F 645	Continued From page 8 Findings include: Review of Resident #31 medical record occurred on all days of survey. Admission diagnoses included dementia, anxiety, dissociative identity disorder, major depression, PTSD [post-traumatic stress disorder], and bipolar disorder. A Level 1 PASARR screening completed by the facility prior to admission failed to include Resident #32's diagnoses of PTSD and bipolar disorder. During an interview on 07/24/24 at 12:17 p.m., an administrative staff (#1) stated he/she would expect provider diagnoses to be reviewed and entered correctly on the PASARR screening.	F 645	potential to be affected. 3. The social service designee and MDS nurse will be in serviced on 8/16/2024 regarding PASARR screening completion and trauma informed care completion. A template for trauma informed care has been identified in the electronic health record and will be utilized to capture this information. 4. The social services designee will be responsible to audit all new PASAAR screenings to ensure accurate diagnoses and the presence of a trauma informed care assessment if deemed necessary by results of PASAAR. The social services designee will monitor these screenings on a monthly basis for 1 year. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The social services designee will submit a report of the monitoring results to the QA committee at each scheduled meeting.	
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.	F 657		8/21/24

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F 657	Continued From page 9 (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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans for 3 of 13 sampled residents (Resident #3, #9 and #36). Failure to review and revise the care plan limited staff's ability to communicate needs, ensure the continuity of care, and may negatively impact the care provided to residents. Findings include: Review of the facility policy titled "COMPREHENSIVE CARE PLANS" occurred on 07/24/24. This policy, dated 01/30/18, stated, "The facility will develop and implement a baseline care plan for each resident . . . 6. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment, and any significant changes. 7. The comprehensive care plan will	F 657	1. Resident #3, #9, and #36 will have care plans updated to be comprehensive and include measurable objectives and timeframes to meet their individual needs. 2. All residents have the potential to be affected. 3. All nurses and members of the interdisciplinary team will be in serviced at a meeting scheduled for August 20th and 21st, 2024 regarding comprehensive care plans and how to properly document. 4. The Director of Nursing or designee will be responsible to monitor comprehensive care plan completion and maintenance. The Director of Nursing or designee will monitor to assure care plans are updated appropriately and as needed and will be implemented on 8/15/2024. The Director of Nursing or designee will monitor and audit 3 care plans per month for 3 months and quarterly thereafter for 1	

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F 657	Continued From page 10 include measurable objectives and timeframes to meet the resident's needs. . . . " - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included malignant neoplasm of unspecified site of right female breast cancer. An admission Minimum Data Set (MDS) dated 07/03/24, identified a weight loss of 5% or more in the last month or 10% or more in last 6 months. A nutrition/dietary Note, dated 07/03/24, stated, ". . . Nutr. [nutrition] Dx [diagnosis]: Unintentional wt. [weight] loss r/t [related to] poor appetite, nausea & [and] vomiting w/ [with] reduced oral intake secondary to chronic medical condition (cancer) as evidenced by approximate 20 lb [pound] or 9.5% unintentional wt. loss in 6 months or less per patient report and confirmed via past weight records . . . " Resident #3's care plan lacked a problem, goals, and interventions related to weight loss. During an interview on 07/24/24 at 9:09 a.m. an administrative staff member (#1) confirmed staff failed to update Resident #3's care plan with a problem, goals, and interventions related to weight loss. - Observation on all days of survey showed Resident #9 without dentures. Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Bipolar Disorder, Anxiety Disorder, Mood Disorder, Spinal Stenosis, and Weakness. The current care plan stated: "Focus: [resident name] has an	F 657	year. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 657	Continued From page 11 ADL (Activities of Daily Living) self-care performance deficit . . . Interventions: ORAL CARE: [resident name] has upper dentures . . . needs substantial assistance to complete oral care. . . . Coordinate arrangements for dental care. . . ." A Mini Nutritional Assessment completed on 05/06/24 showed a score of 5.0 which indicated Resident #9 malnourished. The care plan lacked nutritional interventions. During an interview on 07/22/24 at 9:30 a.m., Resident #9 stated she has upper dentures which do not fit right and would like to have "new shiny ones that work." During an interview on 07/24/24 at 10:30 a.m., a certified nurse aide (CNA) (#2) stated Resident #9 did not have dentures for a long time. - Review of Resident #36's medical record occurred on all days of survey. Diagnoses included Chronic Kidney Disease, Hypertension, Edema, Diabetes, Altered Mental Status, and Anemia. The care plan lacked problems, goals and interventions related to diabetes, diuretic use, anemia, and excessive weight loss. During an interview on 07/24/24 at 11:45 a.m., an administrative staff member (#1) confirmed resident's care plans have not been reviewed/or revised timely.	F 657		
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 -	F 689		8/5/24

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	355042	A. BUILDING _____ B. WING _____	07/24/2024

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F 689	Continued From page 12 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident and staff interviews, the facility failed to ensure an environment free of accident hazards for 1 of 1 supplemental resident (Resident #19) observed with a torn and raised strip of flooring. Failure to ensure flooring is in good repair may result in falls and/or injury. Findings include: Review of the facility policy titled "Falls" occurred on 07/24/24. This policy, dated October 2018, stated, ". . . [Facility name] provides an environment free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. . . ." Observation on 07/21/24 at 2:04 p.m., showed an approximately 15 inch length, torn and raised strip of laminate flooring in front of Resident #19's recliner. During an interview on 07/21/24 at 3:09 p.m., Resident #19 stated that the floor had been like that for some time. Resident #19 state that he should ask for assistance, as he has a history of falls, but will self-transfer from the recliner to the wheelchair.	F 689	1. Resident #19 had to potential to be affected by the deficient practice. The flooring was repaired in Resident #19's room on 8/5/2024. 2. All residents of the facility have the potential to be affected. 3. A new policy and procedure is being developed to address the deficient practice. 4. The Environmental Services Manager will be responsible to monitor and audit. The Environmental Services Manager will monitor to assure that the implemented policy is being followed. The Environmental Services Manager will monitor the environment to ensure it is free of accident hazards weekly for one year. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The Environmental Services Manager will submit a report of the monitoring results to the Quality Committee at each monthly scheduled meeting.	

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F 689	Continued From page 13 During an interview on 07/24/24 at 12:17 p.m., an administrative staff member (#1) confirmed the flooring will need replacement as soon as possible.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify a history of trauma, and/or trauma triggers for 2 of 2 sampled residents (Resident #4 and #31) reviewed for Post-Traumatic Stress Disorder (PTSD) and/or Trauma. Failure to identify a resident's history of trauma and/or trauma triggers may cause re-traumatization. Findings include: Reviewed of a facility policy titled "Trauma-Informed Care" occurred on 07/23/24. This policy, implemented 05/01/19, stated ". . . WHCC [West Horizen Care Center] will have sufficient staff with the appropriate competencies and skill sets to provide nursing and related services. . . These competencies and skill sets will include . . . Develop a care plan to address past trauma which is driven by triggers for trauma	F 699	1. For Residents #4 and #31, a trauma assessment will be completed to assure the identification of potential triggers and completion of a trauma care plan. 2. All residents who have an unidentified history of trauma and/or trauma triggers have the potential to be affected. 3. The interdisciplinary team will be in serviced regarding trauma care assessments and care plans on August 20th & 21st, 2024. A trauma informed care assessment has been identified in our electronic health record and will be utilized to track and document trauma informed care assessments. 4. The Director of Nursing or designee will be responsible to monitor and audit the completion of trauma informed care assessments and care plans. Quality Assurance and monitoring will be	8/21/24

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F 699	Continued From page 14 (per resident and family). . . If a resident has experienced trauma in the past, interventions will be put in place on the care plan to assist in coping with the triggers of a past trauma. Care plan will be updated as necessary to include interventions if new triggers arise. . . " - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included PTSD. A physician's order stated "Venlafaxine HCl ER [hydrochloride] [extended release] (an antidepressant medication) Give 150 mg [milligrams] by mouth in the morning for depression, anxiety related to POST TRAUMATIC STRESS DISORDER, CHRONIC." A psychiatry provider note, dated 04/22/24, stated, ". . . Recheck of Anxiety disorders. . . Onset followed traumatic event (TBI) [Traumatic Brain Injury]. Currently the symptoms occur monthly and last for hours. . . Associated symptoms include poor concentration, irritability, and depression symptoms . . ." Resident #4's medical record lacked a trauma assessment, identification of potential triggers, and a trauma care plan. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included PTSD. The admitting MDS [Minimum Data Set] dated 12/04/23 identified a diagnosis of PTSD. The current care plan included PTSD as a diagnosis but failed to identify triggers and interventions to prevent re-traumatization. A psychiatry provider note, dated 11/09/23, stated, ". . . Past Medical History . . . PTSD. . ."	F 699	implemented by 8/15/2024. The Director of Nursing or designee will monitor and audit all new admissions for the presence of a trauma informed care assessment and trauma care plan if necessary per the assessment. This will be completed on a monthly basis for 3 months, and quarterly thereafter for 1 year. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 699	Continued From page 15 Resident #31's medical record lacked a trauma assessment, potential triggers, and a trauma care plan. During an interview on 07/24/24 at 9:09 a.m. an administrative staff member (#1) confirmed they would have expected staff to interview family and/or the resident, if applicable, and review psych notes for potential triggers related to the resident's diagnosis of PTSD.	F 699		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;	F 790		8/31/24

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F 790	Continued From page 16 §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. 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 assist in obtaining dental care to meet the needs of 1 of 2 sampled residents (Resident #9) with ill fitting dentures. Failure to assist the resident in making an appointment, may result in chewing difficulties and/or eating difficulties, and unplanned weight loss. Findings include: Review of the facility policy titled "DENTAL SERVICES" occurred on 07/24/24. This policy, dated 09/01/07, stated, "Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care . . . 6. Social Services personnel will be responsible for assisting the resident/family in making dental appointments and transportation as necessary . . . ."	F 790	1. Resident #9 will have a dental appointment scheduled as soon as possible with resident's dental provider to ensure resident has dentures that fit appropriately. If a dental visit cannot be secured by the resident's dental provider by September 15th, 2024, other surrounding dentists will be contacted to secure an appointment. All attempts at scheduling this appointment will be documented. Any resident refusal will be properly documented. 2. All residents have the potential to be affected. 3. The current policy for Dental Services will be revised to include referral timelines and documentation requirements by August 31st, 2024. All nursing staff will be in-serviced regarding this policy update at a meeting scheduled for August 20th and 21st, 2024. 4. The Social Service Designee will be	

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F 790	Continued From page 17 Observation on all days of survey showed Resident #9 without dentures. Review of Resident #9's medical record occurred on all days of survey. A quarterly minimum data set (MDS), dated 06/13/24, identified mouth or facial pain, discomfort or difficulty with chewing. The current care plan stated, ". . . Focus: [resident name] has an ADL (activities of Daily Living) self-care performance deficit . . . Interventions: ORAL CARE: [resident name] has upper dentures . . . needs substantial assistance to complete oral care. . . . Coordinate arrangements for dental care. . . ." An Oral/Dental Assessment, dated 03/20/24, identified Resident #9's last dental exam as 06/05/23. A Mini Nutritional Assessment, dated 05/06/24, identified a score of 5.0 which indicated Resident #9 is malnourished. A weight change note, dated 05/06/24, identified Resident #9 triggered for a 10% weight loss in 180 days. During an interview on 07/22/24 at 09:30 a.m., Resident #9 stated she has upper dentures which do not fit right and she would like to have "new shiny ones that work." During an interview on 07/24/24 at 10:30 a.m., a certified nurse aide (CNA) (#2) stated Resident #9 did not have dentures for a long time. During an interview on 07/24/24 at 11:40 a.m., an administrative staff member (#1) stated Resident	F 790	responsible to monitor and audit the timeliness of dental referrals and documentation regarding resident refusal. Monitoring will be implemented by August 23rd, 2024. The Social Service Designee will monitor all dental service referrals for appropriate documentation and policy adherence on a weekly basis for 8 weeks, then monthly thereafter for one year. Results will be reported to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The social services designee will submit a report of the monitoring results to the QA Committee monthly at each scheduled meeting.	

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F 790	Continued From page 18 #9 often refused appointments and confirmed the record lacked documentation of the refusals.	F 790		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of resident council meeting minutes, and staff interview, the facility failed to ensure resident allergens/preferences were communicated to dietary staff for 2 of 13 sampled residents (Resident #6 and #31). Failure to ensure resident allergens/preferences were communicated to staff may result in residents experiencing an intolerance to a specific food, a moderate-to-severe allergic reaction, and/or inadequate nutrition. Findings include: Review of the facility policy titled "Food Allergies and Intolerances" occurred on 07/24/24. This policy, revised 05/18/09, stated, ". . . Residents with food allergies and/or intolerances will be identified upon admission and steps will be taken to prevent resident exposure to the allergen(s). . . . Food allergies can trigger moderate allergic	F 806	1. For Resident #6, their medical record will be updated by 8/19/2024 to include a food preference to not be served foods they dislike, additionally, their dietary card will be updated to reflect this. Furthermore, Resident #6 was interviewed on 8/19/2024 to ensure that no other food preferences were not listed. For Resident #31, their dietary card will be updated to reflect their food allergy by 8/19/2024 and an interview with Resident #31 will occur on 8/26/2024 to ensure that the dietary card is updated to list any further preferences. 2. All resident□s who have food preferences, allergies, or intolerances have to potential to be affected. 3. New dietary cards were purchased on 8/08/2024 to allow additional space for notation of food preferences, allergies, and intolerances. The dietary lead,	8/27/24

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F 806	Continued From page 19 reactions . . . or can be severe and life threatening. . . . Food intolerances are unpleasant reactions to specific foods . . ." Review of the facility policy titled "Resident Food Preferences" occurred on 07/24/24. This policy, revised 09/01/07, stated, ". . . nursing staff will identify a resident's food preferences. . . . The resident's clinical record . . . will document the resident's likes and dislikes and special dietary instructions . . ." - Review of the Resident Council Meeting Minutes, dated 06/25/24, stated, ". . . [Resident #6] requested not being served asparagus or broccoli . . ." Review of Resident #6's medical record occurred on 07/24/24. The record identified an allergy to medications and no food preferences. Review of Resident #6's diet card occurred on 07/22/24 at 10:25 a.m. The diet card failed to include any known food preferences. - Review of Resident #31's medical record occurred on 07/24/24. The record identified an allergy to mushrooms and no food preferences. Review of Resident #31's diet card occurred on 07/22/24 at 10:25 a.m. The diet card failed to include any known food allergies or preferences. During an interview on 07/22/24 at 10:25 a.m., when asked if any of the residents had a known food allergy, a dietary staff member (#4) reported, "[Resident #31] is allergic to mushrooms." The dietary staff member (#4) confirmed Resident #31's diet card failed to include any food allergies or preferences.	F 806	resident council facilitator, and nursing staff will be in serviced on August 20th and August 21st, 2024 to review the policy Resident Food Preferences to ensure documentation and communication is occurring appropriately. All Residents will be interviewed quarterly, on or around their care conference date, to ensure no preferences have changed. If food preferences have changed, the resident's dietary card will be updated immediately. 4. The Director of Nursing or designee will be responsible to monitor and audit resident food preferences and documentation. Quality assurance monitoring will be implemented on 8/19/2024. The Director of Nursing or designee will audit all admissions for 3 months and then 25% of all admissions quarterly thereafter for one year. A secondary audit of food preferences for all current residents will also be started on 8/27/2024. The Director of Nursing or designee will audit 100% of all resident food preferences following their care conference date to ensure the interview outlined in #3 above was conducted and any necessary updates to the dietary card have been made. Subsequent to the first quarter, audits will be decreased to 25% of residents quarterly for the next year. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing or designee will submit a report of the monitoring results to the QA committee at each monthly	

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F 806	Continued From page 20	F 806	scheduled meeting.	
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 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, review of facility policy, and staff interview, the facility failed to prepare and/or store food in a sanitary manner in 1 of 1 kitchen and 2 of 2 kitchenettes. Failure to ensure proper concentration of the sanitizer solution and failure to apply an identifying label and/or open date to food items has the potential to affect food quality/preparation and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include:	F 812	1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected. 3. The sanitizer solution has been repaired by maintenance staff. Staff were educated to the process to request maintenance assistance and to notify the administrator if sanitation dispenser were not functioning appropriately in the future. Additionally, all dietary staff will be in-serviced on August 20th and 21st,	8/21/24

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F 812	Continued From page 21 SANITIZING FOOD PREP AREAS During an interview on 07/22/24 at 10:25 a.m., when asked to test the solution in the sanitizing bucket, a dietary staff member (#4) stated, "EcoLab was here a couple of weeks ago to replace some parts [of the automatic dispenser]. The sanitizer is not working. The sanitizer bucket isn't right. I just have hot water in there." LABELING/DATING FOODS Review of the facility policy titled "Food Receiving and Storage" occurred on 07/24/24. This policy, revised 05/18/09, stated, ". . . Food shall be . . . stored in a manner that complies with safe food handling practices. . . . All foods stored in the refrigerator or freezer will be covered, labeled and dated . . ." Observations on 07/21/24 at 12:15 p.m. and 2:10 p.m. and on 07/22/24 at 10:25 a.m. showed the following: * West Kitchenette Refrigerator - cranberry juice with a resident's name, but no open date - a sandwich and two slices of pie undated * Kitchen Silver Refrigerator - noodles undated * Kitchen Big Chest Freezer - staff identified cod in an unsealed bag undated * Kitchen Little Chest Freezer near Big Chest Freezer - churros undated * Kitchen Chest Freezer near Kitchen	F 812	2024 regarding food receiving and storage best practices. 4. The Dietary Manager or designee will be responsible to audit the function of the sanitizer and proper food storage and labeling. Quality Assurance audits will be implemented by 8/19/2024. The Dietary Manager or designee will monitor both sanitizer function and food storage to include, storage, labeling, and dating, twice weekly for 4 weeks, and weekly thereafter for one year. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The Dietary Manager or Administrator will submit a report of the monitoring results to the QA Committee at each monthly scheduled meeting.	

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F 812	Continued From page 22 - bread dough and garlic bread undated * Kitchen Chest Freezer near Water Heater - donuts undated * Kitchen Upright Freezer - staff identified chicken cordan blue, chicken strips, and fish sticks with no identifying label or date - corn dogs in an unsealed bag - staff identified pork patties with no open date During an interview on 07/21/24 at 12:15 p.m. and 2:10 p.m., a dietary staff member (#3) confirmed she expected staff to label and date food items when opened and throw away outdated food items. During an interview on 07/22/24 at 10:25 a.m., a dietary staff member (#4) also confirmed she expected staff to label and date food items when opened and throw away outdated food items.	F 812		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of the North Dakota Plumbing Code, and staff interview, the facility failed to provide an air gap for 2 of 2 multi-compartment sinks observed in the main kitchen. Failure to provide the required air gap for a multi- compartment sink has the potential to allow contamination of the sink in the event of a sewer back-up.	F 921	1. No residents were affected by the deficient practice. 2. All residents have the potential to be affected. 3. The plumber was called following the identification of the deficiency. Plumber will resolve the deficiency on or prior to DATE placing a back flow stopper to correct the deficiency. All environmental	8/28/24

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	355042	A. BUILDING _____ B. WING _____	07/24/2024

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 921	Continued From page 23 Findings include: Review of the 2018 North Dakota Plumbing Code, Section 801.2 Air Gap or Air Break Required, stated, "Indirect waste piping shall discharge into the building drainage system through an air gap or air break as set forth in this code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood-level rim of the receptor shall be not less than 1 inch (25.4 mm)." Section 801.3.3 Food-Handling Fixtures, stated, "Food-preparation sinks, steam kettles, potato peelers, ice cream dipper wells, and similar equipment shall be indirectly connected to the drainage system by means of an air gap. Bins, sinks, and other equipment having drainage connections and used for the storage of unpackaged ice used for human ingestion or used in direct contact with ready-to-eat food, shall be indirectly connected to the drainage system by means of an air gap. Each indirect waste pipe from food-handling fixtures or equipment shall be separately piped to the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall be not less than the drain on the unit and in no case less than 1/2 of an inch (15 mm)." Observations on all days of survey showed the end of a two-compartment sink drainpipe joined with the end of a three-compartment sink drainpipe ending approximately two inches below the rim of a cut out in the tiled flooring that contained the floor drain. The facility failed to provide the required air gap for the	F 921	services staff will be in serviced on 08/19/2024 to provide education on plumbing code as it relates to this deficiency. 4. The Environmental Services Manager will be responsible to provide continuing education to their department. The Environmental Services Manager will review one code as it relates to the regulations related to safety, sanitary environment, building, or plumbing code each week beginning 8/19/2024 for four weeks and monthly thereafter for one year to the environmental services department. Documentation of the education will be reported to the Administrator. If concerns are identified, the Administrator will require additional or more specific education to be provided. The Environmental Services Manager will submit a report of the education training documentation and attendance to the QA Committee at each monthly scheduled meeting.	

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F 921	Continued From page 24 multi-compartment sinks. During an interview on 07/21/24 at 12:15 p.m., a dietary staff member (#3) indicated the three-compartment sink was used to "thaw something in water and to drain vegetables." During an interview on 07/22/24 at 10:25 a.m., a dietary staff member (#4) indicated the two-compartment sink was used for "food prep." During an interview on 07/24/24 at 7:45 a.m., a maintenance staff member (#5) reported a plumber recently worked on the drainpipe and informed him "that's how it has to be."	F 921		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and resident and staff interviews, the facility failed to maintain an effective pest control barrier for 1 of 1 kitchen and 1 of 2 dining rooms (West). Failure to maintain the integrity of the doors has the potential to allow the entrance of mice and other pests. Finding included: Review of the facility policy "Pest Control" occurred on 07/24/24. This policy, dated 01/01/09, stated, ". . . This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. . . .	F 925	1. Resident #31 was affected and will be provided updates to our resolution below. 2. All residents have the potential to be affected. 3. The current policy for pest control is being updated to provide processes for staff to increase the frequency of pest control measures. All staff will be in serviced on August 20th and 21st, 2024 regarding best practice to ensure all measures are taken to handle pest control. The weather strip on the kitchen door will be replaced on or prior to 8/23/2024. EcoLab will be contacted on or prior to 8/23/2024 to review the deficiency	8/28/24

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F 925	Continued From page 25 Windows are screened at all times. . . ." During an interview on 07/21/24 at 1:38 p.m., Resident #31 indicated there is an ant and fly problem in the west dining room and the facility was not doing anything about it. Observations showed the following: * 07/21/24 at 12:15 p.m., Rows of glasses air-drying on a shelved cart in the dishwashing area with two flies walking across the clean glasses and gnats flying in the food prep area in the kitchen. * 07/21/24 at 1:52 p.m., Several dead flies and gnats lying on the window ledge and floor and a large winged bug on the floor near the ice machine in the west dining room. * 07/22/24 10:21 a.m., Ants and a centipede crawling on the west dining room floor. * During the evening meal on 07/22/24, a menu plan located on the hood of the steam table with two flies walking across the paper and flying under the hood and directly above the food. A dietary staff member (#4) attempted to deter the flies from landing on the food. Observation on all days of survey showed: * Several gnats crawling/flying on or near the plants in the plant center near the facility entrance. * An open window with no screen in a glass-enclosed entrance to the dining room with visible gaps between the interior door and door frame. During an interview on 07/21/24 at 12:15 p.m., a dietary staff member (#3) stated, "We have both bugs, flies and gnats, and mice. I haven't seen	F 925	and to provide an updated pest control plan on or before 8/28/2024. 4. The Environmental Services Manager will be responsible to monitor the pest control program. Quality Monitoring will be implemented on 08/19/2024. The Environmental Services Manager will monitor weekly on an ongoing basis. Results will be reported to the Administrator. If concerns are identified, immediate corrective action will be implemented. The Environmental Services Manager will submit a report of the monitoring results to the QA Committee at each monthly scheduled meeting.	

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F 925	Continued From page 26 that many gnats today. We found a mouse in the sticky trap last week. The back door doesn't fit the foundation. You can see dirt coming through." During an interview on 07/22/24 at 7:45 a.m., a maintenance staff member (#5) stated, "The delivery guys don't close the door [kitchen entrance] behind them. I am going to replace the weather strip on the door to the outside. We had one mouse this year."	F 925		