STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1031	A. BUILDING: _____ B. WING _____	C 08/29/2023

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) COMPLETE DATE
L1200	33-07-03.2-12 EDUCATION PROGRAMS The facility shall design, implement, and document educational programs to orient new employees and keep all staff current on new and expanding programs, techniques, equipment, and concepts of quality care. The following topics must be covered with all staff annually: 1. Safety and emergency procedures, including procedures for fire and other disasters. 2. Prevention and control of infections, including universal precautions. 3. Resident rights. 4. Advanced directives. 5. Care of the emotionally disturbed and confused resident. This State Licensing Rule is not met as evidenced by: Based on review of contract staff orientation records, review of the Licensing Rules for Nursing Facilities in North Dakota, and staff interview, the facility failed to ensure 2 of 2 contracted certified nurse aides (CNAs) (B and C) received the required state mandated education and facility orientation as per facility orientation check list. Failure to ensure all contract staff received the necessary training regarding the state mandated education and facility orientation check list, limited the facility's ability to ensure employees are familiar with the facility's policies and procedures, and educated on safety and emergency procedures, infection control, resident rights, advanced directives, and	L1200	1. On 8/16/2023 these two staff received appropriate orientation and training. 2. All residents have the potential to be affected by this deficiency. 3.Orientation process has been changed and standardized on 9/18/2023. There is a checklist to which the orientee and orientator will complete prior to any staff going onto the floor which also was in effect on 9/18/2023. A person has been hired to complete these and ensure that they are up to standards, they were hired and started on 9/11/2023. In the absence of the orientator, DON will direct and delegate onboarding as necessary.	10/6/23

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

Electronically Signed | 09/15/23

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L1200	Continued From page 1 emotionally disturbed and confused residents. Findings include: The Licensing Rules for Nursing Facilities in North Dakota: North Dakota Administrative Code Chapters 33-07-03.2-12, update: July 2004, stated, "33-07-03.2-12 EDUCATION PROGRAMS The facility shall design, implement, and document educational programs to orient new employees and keep all staff current on new and expanding programs, techniques, equipment, and concepts of quality care. The following topics must be covered with all staff annually: . . . Safety and emergency procedures . . . Prevention and control of infections . . . Resident rights . . . Advanced directives . . . Care of the emotionally disturbed and confused resident. . . ." Review of contracted CNA (B's) orientation record occurred on 08/15/23. The facility failed to completed an orientation check list for contracted CNA (B). During an interview on 08/15/23 at 2:55 p.m., two administrative staff members (#1 and #2) confirmed the facility staff failed to complete the new employee orientation process for contracted CNA (B). Review of contracted CNA (C's) orientation record occurred on 08/16/23. The facility failed to complete orientation check list for contracted CNA (C). During an interview on 08/17/23 at 8:45 a.m., an administrative staff member (#1) stated both contracted CNAs (B and C) started on the same	L1200	Orientation process includes policy and procedure on all recent deficiencies, facility policies, building review, competency quiz and additional information specified to position. 4. An audit of all staff files to ensure orientation has been completed by 9/22/2023. Any files with missing information will be completed prior to staffs next scheduled shift. 4.Audits will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, QA nurse will notify DON and Administrator. DON will be in charge of creating a performance improvement plan. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. The QA nurse will submit a report to the QA committee and board members. 5.Corrective action will be completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	

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L1200	Continued From page 2 date and confirmed the facility failed to complete the new employee orientation process for both contracted CNAs.	L1200		

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 08/14/23 and concluded on 08/17/23. Based on the results of the recertification survey, an extended survey was completed on 08/29/23.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		10/6/23

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident representative interview, and staff interview, the facility failed to notify the resident's representative for 1 of 1 resident (Resident #29) treated for an infection. Failure to promptly notify the resident representative of the infection limited their ability to make informed decisions regarding medical care. Findings include: Review of Resident #29's medical record occurred all days of survey. A clinic/consultant referral, dated 08/12/23, stated, "open areas on feet, possible cellulitis, edema. Bactrim [an antibiotic] x [times] 7 days; Elevation of extremities; Continue Ace [an elastic wrap] @ [at] night."	F 580	1.Nursing administration called resident #29 representative on 8/17/2023 to notify of infection and pain. All residents have the potential to be affected by this deficiency. 2.DON provided education to nurses, about when to notify families, on 9/20/2023 at a mandatory nurses meeting. A departmental and managers meeting was be held 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. Attendance and competency will be tracked and placed into employee files. Policy and procedure will be reviewed and revised by 10/6/2023. 3.The QA nurse will be responsible to audit weekly successful notifications to	

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F 580	Continued From page 2 Physician orders included the following: * 08/12/23, "Bactrim Oral Tablet 400-80 MG [milligrams] . . . Give 1 tablet by mouth two times a day for BLE [bilateral lower extremities] infection for 7 Days give two tablets initially then 1 tablet every 12 hours" * 08/14/23, "traMADol HCL Oral Tablet 50 MG [pain medication] . . . Give 1 tablet my mouth two times a day for Pain for 7 Days." During an interview on 08/16/23 at 9:40 a.m., Resident #29's representative (A) stated they were not notified of treatment for an infection and pain. During an interview on 08/17/23 at 12:50 p.m., two administrative staff members (#1 and #2) confirmed staff should have notified the representative of changes to Resident #29's status and treatment.	F 580	resident representatives. Audits will be preformed on a weekly basis for 4 weeks. after 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If ever found in an audit that creating a performance improvement plan for the employee who failed to comply with notifying a resident's representative. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. The QA nurse will submit a report of audit results to the QA committee and board members monthly. 4. QA Nurse will review all residents charts to ensure no one was missed in the immediate timeframe along with the audits mentioned above. 5.Corrective action will be completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623		10/6/23

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

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F 623	Continued From page 4 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who	F 623		

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F 623	Continued From page 5 is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident or the resident's representative a written notice of transfer for 3 of 3 residents (Resident #14, #15 and #29) reviewed for hospital transfers. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights or inform the Ombudsman of the transfer. Findings include: Record review identified the following hospital transfers: Resident #14 on 06/30/23 Resident #15 on 11/29/22, 07/02/23, and 07/05/23 Resident #29 on 07/13/23 The residents' medical records lacked documentation the facility provided the resident and/or representative with a written transfer notice. During an interview on 08/17/23 at 12:50 p.m., two administrative staff members (#1 and #2) indicated they were not aware the transfer notice	F 623	1.Copy of notice before transfer / discharge will be sent out to family members of those who did not receive it on 9/21/2023. 2.All residents have the potential to be affected by this deficiency. 3.A departmental and managers meeting was held on 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. Policy and procedure will be reviewed and updated by 10/6/2023. Nurses are to be educated on 9/20/2023 at the mandatory nurses meeting. Attendance and competency will be tracked. 4.Transfer / discharges will be given to HIM to scan in and mail out. 5.Transfer packet are being made up and will be ready by 9/29/2023, will include fax coversheet to ombudsman transfer / discharge, bed hold, checklist for nurses to follow to ensure policies and procedures are being followed. 6. The HIM will be responsible to audit. Audits will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly	

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F 623	Continued From page 6 needed to be provided in writing and confirmed the facility failed to send a copy to the family/representative.	F 623	for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, HIM will notify DON and Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to comply with notifying a residents representative in writing. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. HIM personnel will submit a report of audit results to the QA committee & board members monthly. 7. Corrective action will completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	
F 625 SS=C	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	F 625		10/6/23

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F 625	Continued From page 7 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 facility failed to provide the resident or resident's representative a written bed hold notice for 3 of 3 residents (Resident #14, #15 and #29) reviewed for hospital transfers. Failure to provide a written copy of the bed hold notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Record review identified the following hospital transfers: Resident #14 on 06/30/23 Resident #15 on 11/29/22, 07/02/23, and 07/05/23 Resident #29 on 07/13/23 The bed hold notices for the hospital transfers identified facility staff obtained verbal consent to hold the bed. The residents' medical records	F 625	1.A copy of notice before transfer / discharge will be sent out to family members of those who did not receive it on 9/21/2023. 2.All residents have the potential to be affected by this deficiency. 3.A departmental and managers meeting was held on 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. Policy and procedure will be reviewed and updated by 10/6/2023. Nurses are to be educated on 9/20/2023 at the mandatory nurses meeting. Attendance and competency will be tracked. 4.Bed hold policies will be given to HIM to scan in and mailed out once the facility receives one. 5.Transfer packet are being made up and will be ready by 9/29/2023, will include fax coversheet to ombudsman transfer /	

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F 625	Continued From page 8 lacked documentation the facility provided the resident and/or their representative with a written bed hold notice. During an interview on 08/17/23 at 12:50 p.m. two administrative staff members (#1 and #2) indicated they were not aware the bed hold needed to be provided in writing.	F 625	discharge, bed hold policy, checklist for nurses to follow to ensure policies and procedures are being followed. 6. The HIM will be responsible to audit. Audits will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, HIM will notify DON and Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to comply with notifying a residents representative in writing. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. HIM personnel will submit a report of audit results to the QA committee & board members monthly. 7. Corrective action will completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"	F 637		10/6/23

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F 637	Continued From page 9 means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 12 sampled residents (Resident #34). Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily	F 637	1. Amended MDS has been started with an ARD date of 9/26/2023. 2. All residents have the potential to be affected by this deficiency. 3.A departmental and managers meeting was held on 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. Policy and procedure were reviewed and updated by 10/6/2023. Nurses are to be educated on 9/20/2023 at the mandatory nurses meeting about the significance of completing a significant change and need to communicate issues noticed. Attendance and competency will be tracked. 4. QA nurse will be responsible to audit successful significant change MDS. Audits will be preformed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. if 100% compliance is successful, audits will be moved to quarterly basis. If ever found in an audit that compliance is not met, QA nurse will notify DON and Administrator. DON will be in charge of creating a performance	

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F 637	Continued From page 10 Living] decline or improvement mobility, transfers, walking in corridor and toileting." Review of Resident #34's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 04/12/23, identified the resident required limited assistance with walking in the room and corridor, locomotion on and off the unit, limited assistance with bathing, occasionally incontinent of urine, and no evidence of delirium (sudden confusion). A quarterly MDS, dated 07/12/23, identified the resident did not walk in the room and the corridor, required total assistance with locomotion on and off the unit, extensive assistance with bathing, always incontinent of urine, and the presence of delirium. The medical record identified Resident #34 had a fall on 05/13/23 that resulted in a patella (kneecap) fracture. The record lacked evidence the staff identified and/or completed a SCSA following Resident #34's decline in activities of daily living.	F 637	improvement plan for the MDS nurse. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. The QA nurse will submit a report of audit results to the QA committee and board members monthly. 5. QA and MDS nurse will review all residents to ensure a significant change has not been missed outside of the audits. 5. Corrective action will completed by 10/6/2023.	
F 657 SS=E	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	F 657		10/6/23

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F 657	Continued From page 11 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revised comprehensive care plan to reflect the current status for 6 of 12 sampled residents (Resident #4, #13, #14, #29, #34, and #39) and one supplemental resident (Resident #35). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 08/17/23. This revised policy, dated 07/20/22, stated, ". . . 6. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Date Set] assessment, and any significant changes. . . . 10. Following	F 657	1.Care plans have since been updated on the sampled residents to reflect correct care plan needs on 9/13/2023. 2.All residents have the potential to be affected by this deficiency. 3.Education provided to MDS coordinator on 9/13/2023 by DON about priority of having care plans updated in real time. Policy to be reviewed and updated on 9/22/2023 to reflect such need. 4.Different departments will be assigned sections of MDS to audit for monthly QAPI meetings. 5. QA Nurse will review all residents to ensure their care plans are up to date. 6.Audits, on care plans by multiple departments, will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed	

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F 657	Continued From page 12 hospitalization, the care plan will be updated to reflect the changes in care that is needed. 11. When there is a change in cares needed, staff noting the change will report this to the designated staff member(s) that will make the changes on the care plan." - Review of Resident #4's medical record occurred on all days of survey. The care plan stated, "Eating/Nutrition: . . . [Resident #4] chooses also to pick up foods like pancakes with syrup and etc. with his hands . . ." Observations during the noon meal on 08/14/23 and 08/15/23 showed facility staff served a pureed diet and assisted the resident with eating. Resident #4 would drink from a glass independently, after staff handed it to him. - Review of Resident #13's medical record occurred on all days of survey. The care plan stated, ". . . Moon boots (pressure relieving boots) on while in bed. . . 4 oz (ounce) Arginaid Liquid Supplement TID (three times daily)." Observations on all days of the survey showed staff failed to apply Resident #13's moon boots while in bed and failed to give the Arginaid liquid supplements. During an interview on the morning of 08/17/23 a Medication Aide (#9) stated Resident #13's Arginaid was discontinued on 07/18/23. - Review of Resident #14's medical record occurred on all days of survey. The care plan stated, "Transfer: [Resident #24] uses a sit to stand x [times] 2 staff for assistance with	F 657	monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, QA nurse will notify DON and Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to comply with this audit. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. QA Nurse will audit MDS care plans and modifications will be completed when necessary. Department managers will review sections of different care plans for monthly QAPI meetings. QA nurse will report audit findings at the monthly QAPI meetings for review. 7.Corrective action will completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	

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F 657	Continued From page 13 transfers." Observation of care on 08/14/23 at 10:54, showed the certified nurse aide (CNA) (#7) transferred the the resident assist of one with a gait belt. - Review of Resident #29's medical record occurred on all days of survey. The record identified a hospitalization in July 2023. The current care plan stated, "Walk to Dine . . . Eating [Resident #29] is able to: eat independently after set up. . . . Toilet Use: [Resident #29] is able to: independently perform toileting tasks, but requires supervision. . . . Transfer: [Resident #29] is able to: independently transfer. Please provide stand by assistance and reminder for [resident] to utilize her walker for ambulation. . . . Locomotion: The resident requires supervision or limited assistance by (1) staff for locomotion using a front wheeled walker. . . ." Observations for Resident #29 showed the following: *08/14/23 at the noon meal, showed CNA (#8) assisted her with dining after resident was brought to the dining table in a wheelchair. *08/14/23 at 12:17 p.m. a CNA (#8) transferred with a gait belt, walker, and assist of one staff. *08/15/23 at 10:45 a.m. two CNAs (#7 and #8) transferred the resident from the wheelchair to the toilet using a gait belt, walker, and assist of two. After toileting the CNAs (#7 and #8) transferred the resident back to the wheelchair with only a gait belt.	F 657		

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F 657	Continued From page 14 During an interview on 08/17/23 at 12:50 p.m., two administrative staff members (#1 and #2) confirmed Residents #4, #14, and #29 care plans had not been reviewed and revised to reflect the resident's current status. - Review of Resident #34's medical record occurred on all days of survey. The care plan stated, ". . . Wander Alert: check daily for accurate functioning . . . Ace wrap right leg daily-on in AM and off at HS [hour of sleep]. . . ." Observations on all days of the survey showed Resident #34 without a wander alert bracelet or an ace wrap. During an interview on the afternoon of 08/16/23, an administrative nurse (#1) reported staff discontinued Resident #34's wander alert bracelet. - Review of Resident #35's medical record occurred on all days of survey. Current diagnoses included long term and current use of an anticoagulant (blood thinner). Physician's orders dated 05/24/23, identified Warfarin (blood thinner) 5 milligrams (mg) by mouth 6 days a week and 7.5 mg on Sunday. Resident #35's care plan failed to identify the resident received a blood thinner. - Review of Resident #39's medical record occurred on all days of survey. The care plan stated, ". . . [Resident name] has order for PRN [as needed] psychotropic medications r/t [related to] Behavior management. . . ."	F 657		

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F 657	Continued From page 15 During an interview on the afternoon of 08/16/23 an administrative nurse (#1) stated, the physician discontinued Resident #39's PRN psychotropic medication on 07/20/23.	F 657		
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 record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #35) with orders for a protime (blood clotting test). Failure to follow physician's orders for monitoring a protime may result in bleeding or excessive bruising for the resident. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #35's medical record occurred on all days of survey. Current diagnoses included long term and current use of anticoagulant (blood thinner). Physician's orders dated, 05/24/23, identified Warfarin (blood	F 658	1.The facility has since gotten this test completed on 8/24/2023, physician was made aware this day also. 2. All residents have the potential to be affected by this deficiency. 3.DON provides education to nurses on 9/20/2023 at a mandatory nurses meeting. A departmental and managers meeting will be held 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. 4.DON and AIT met with Lab services on 9/12/2023 and provided education and developed an audit. With that audit, lab requisition forms were created. All residents who are in need of a protime order has since had the requisitions filled out, updated and sent to lab on 9/20/2023. 5. An audit on all residents to ensure another lab has not been missed was completed on 9/18/2023. 6.The QA nurse will be responsible to audit. Audits will be performed on a	10/6/23

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F 658	Continued From page 16 thinner) 5 milligrams (mg) by mouth 6 days a week and 7.5 mg on Sunday. Protime every 6 weeks. Review of Resident #35's lab record showed a protime completed on 05/18/23 (13 weeks ago). The facility failed to do a protime every 6 weeks as ordered. During an interview on 08/17/23 at 11:00 a.m., an administrative nurse (#1) confirmed the facility failed to do the protime as ordered.	F 658	weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, QA nurse will notify DON and Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to comply with the audit. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. The QA Director will submit a report of audit results to the QA committee & board members monthly. 7.Corrective action will be completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 689	1.Follow the care plan to provide	10/6/23

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F 689	Continued From page 17 facility policy, review of manufacturer's instructions, and staff interview, the facility failed to provide appropriate and sufficient supervision and/or assistive devices for 3 of 4 sampled residents (Resident #19, #23, and #29) observed during a transfer. Failure to provide adequate assistance and/or use the assistive devices appropriately during transfers placed the residents at risk for accidents, falls, and/or injuries. During the standard survey, the team determined an Immediate Jeopardy (IJ) situation existed on 08/15/23 at 7:55 a.m. The IJ resulted from staff failure to provide sufficient supervision and use the assistive device (mechanical lift) in a manner to avoid a fall and/or potential injury. * 08/15/23 at 8:12 a.m., The survey team contacted the State Survey Agency (SSA) to report the findings and discuss potential immediate jeopardy (IJ). * 08/15/23 at 8:25 a.m., The SSA contacted the survey team after discussion with the CMS (Centers for Medicare & Medicaid Services) location and verified the presence of IJ. *08/15/23 at 8:35 a.m., The survey team notified the administrator, the administrator in training (AIT), and the director of nursing (DON), of the IJ situation, provided them with the IJ template, and requested they develop a plan for removal of the immediate jeopardy. * 08/15/23 at 2:55 p.m., The AIT, and the DON presented the IJ removal plan for the survey team to review.	F 689	sufficient supervision and assistance with transferring and toileting a resident. Secure the safety straps on the mechanical lift device appropriately which resulted in a near fall from the mechanical lift. 2. All residents have the potential to be affected by this deficiency. 3.Inservice and education on facility policy/procedure for mechanical lifts, appropriate actions/interventions to ensure resident safety and dignity with the staff member directly involved in the deficient practice, and proper communication to residents for all nursing staff on duty, and on-coming staff on 8/15/2023. Review of each resident's transfer requirements as outlined in their individual care plans on 8/15/2023 and ongoing. Review of facility policies and resources for questions/concerns on 8/15/2023. Review and revision of staff orientation with clear and defined roles/responsibilities defined to ensure all staff receive the necessary orientation in a timely manner on 9/18/2023. 4.When new staff arrive they will go through an appropriate training process of how to use all of the lifts in the facility. Orientation packet was updated on 9/18/2023. All nursing staff have gone through additional training on the lifts and audits. Mandatory all staff meeting to be held on 9/20 where education of lifts will be gone over by all staff and signed off on with competencies. Attendance and competency will be tracked and placed into employee file.	

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F 689	Continued From page 18 The removal plan contained the following: * Inservice and education on facility policy/procedure for mechanical lifts, appropriate actions/interventions to ensure resident safety and dignity with the staff member directly involved in the deficient practice, all nursing staff on duty, and on-coming staff. * Review of each resident's transfer requirements as outlined in their individual care plans. * Review of facility policies and resources for questions/concerns. * Review and revision of staff orientation with clear and defined roles/responsibilities defined to ensure all staff receive the necessary orientation in a timely manner. * 08/15/23 at 4:15 p.m., The survey team reviewed and accepted the facility's removal plan for the IJ. The survey team verified the implementation of the removal plan. The deficient practice remained at an "E" scope and severity following the removal of the IJ. Findings include: Review of the facility policy titled "Transferring a Resident Using a Mechanical Lift" occurred on 08/15/23. This policy, dated July 2018, stated, ". . . General Guidelines At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift. . . . Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. . . . Before using the lift device, assess the resident's current condition, including: . . . Does the resident express fear or appear anxious about the use of a lift? Is the resident agitated,	F 689	5.Nursing staff will have competencies of how to use each kind and style of lift in the facility. These will be completed upon arrival to facility and annually after, along with as needed. 6.Staff use of lifts will be audited by assigned personnel at the direction of the DON, this will be completed by viewing the use of transfers with staff and residents along with additional education provided as needed. Audits will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, QA nurse will notify DON and Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to complete these tasks as educated on. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. Audit findings will be reported at the monthly QAPI meeting by the QA nurse for review. 7.Corrective action will be completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	

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F 689	Continued From page 19 resistant, or combative? . . ." The manufacturer's instructions for the "Volaro Series 5 Stand" stated, ". . . The most important part of the lifting experience is applying the SLING properly. . . . Position the wings of the sling under the arms and make sure they are centered. . . . Be sure the person's arms are located outside the fabric. . . . Attaching Sling to Lift . . . The shin rest has a built-in safety support strap. The strap helps those who need the added security and support. This will keep their shins and feet securely in place. . . ." - Review of Resident #23's medical record occurred on all days of survey. The current care plan stated, ". . . ADL [activity of daily living] performance deficit r/t [related to] Dementia, Pain (chronic back pain), and SOB [shortness of breath] due to diagnosis of COPD [chronic obstructive pulmonary disease]. . . . Toilet use: [resident name] requires extensive assistance of (2) staff for toileting. Transfer: [resident name] is able to: use sit to stand lift and staff assistance x's 2 to complete transfers. . . . behavior problem of exhibiting s/s [signs and symptoms] of physical aggression and verbal abuse directed at staff. . . . Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. . . ." Observation on 08/14/23 at 3:11 p.m. showed a certified nurse aid (CNA) (#3) utilized the sit-to-stand lift to toilet Resident #23. The CNA attempted to maneuver the lift into the resident's bathroom. Resident #23 stated, "No, it's not going to work, No, No, No!" The CNA realized she could not get the lift into the bathroom and	F 689		

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F 689	Continued From page 20 the resident stated, "I told you so." The CNA transferred Resident #23 into the wheelchair and instructed the resident to lift his feet as she pushed the wheelchair. The wheelchair foot pedals remained out to the sides of the chair and caught on the door frame as the CNA (#3) exited the room, the left foot pedal caught on a cart located in the hallway. The CNA stopped, adjusted the foot pedals, placed Resident #23's feet onto the pedals, and continued to the main bathroom located adjacent to the nurse station. The CNA utilized the sit-to-stand lift and placed Resident #23 onto the toilet, the resident stated, "I don't want to be in here." At 3:24 p.m., the CNA (#3) utilized the sit-to-stand lift to transfer Resident #23 off the toilet. With the upper body sling in place, the CNA raised the resident to a standing position without applying the shin/leg strap. With the resident in a standing position on the lift, the CNA proceeded to remove the incontinent product and tore the side seam of the product. Resident #23 yelled, "Don't tear that! Don't tear that!" The CNA continued to remove the product. Resident #23 released his hands from the handle grips and brought both arms inside the sling and held onto the bar directly in front of him. The CNA instructed Resident #23 she needed to remove his pants, the CNA attempted to lift the residents' left leg out of the pant leg. Resident #23 yelled, "Don't do that!" as he made a fist with his left hand and hit the CNA on her shoulder two to three times. The resident's upper body began to slide out from under the sling. The CNA (#3) stood behind the resident and wrapped her arms around the resident's upper body and under his arms to hold him up until a wheelchair was placed under the resident and additional staff arrived to provide assistance.	F 689		

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F 689	Continued From page 21 During an interview on 08/15/23 at 2:55 p.m., two administrative staff members (#1 and #2) confirmed staff are expected to follow the resident care plans and stated it is facility policy for two staff to assist with all mechanical lift transfers. Facility staff failed to: * Communicate with the resident in a manner that maintained and enhanced the resident's individuality which resulted in psychosocial distress for the resident. * Follow the care plan to provide sufficient supervision and assistance with transferring and toileting a resident. * Secure the safety straps on the mechanical lift device appropriately which resulted in a near fall from the mechanical lift. - Review of Resident #19's medical record occurred on all days of survey. The care plan stated, ". . .Transfers . . . requires 2 assistance using the sit to stand lift. . . ." Observation on 08/14/23 at 2:20 p.m. showed two CNAs (#4 and #6) transferred Resident #19 from the wheelchair to the bed by each CNA lifting under the resident's axilla and pulling up on her pants. The CNAs failed to use the sit to stand lift to transfer Resident #19. - Review of Resident #29's medical record occurred on all days of survey. The care plan stated, ". . . Transfer: . . . able to: independently transfer. Please provide stand by assistance . . ." Observation on 08/15/23 at 10:45 a.m. showed	F 689		

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F 689	Continued From page 22 two CNAs (#6 and #7) assisted Resident #29 with toileting. The CNAs (#6 and #7) used the walker, a gait belt, and assist of two onto the toilet. When finished, the two CNAs (#6 and #7) assisted the resident to stand, without using the walker, one CNA (#6) lifted under the resident's right axilla, and one (#7) used the gait belt. The CNA (#6) grabbed the back of Resident #29's pants, pushed the resident around to line up with the wheelchair and the resident sat down in the wheelchair.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/6/23

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F 880	Continued From page 23 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 24 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 6 of 12 sampled residents (Resident #4, #10, #13, #23, and #39) and 1 supplemental resident (#35) observed during personal cares or transfers. Failure to practice infection control standards related to hand hygiene, glove use, and multiple resident use equipment (mechanical lifts) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene Policy and Procedure" occurred on 08/16/23. This policy, dated 03/12/22, stated, ". . . Indications for handwashing . . . When moving from a contaminated body site to a clean body site during resident care . . . AFTER REMOVING GLOVES . . . Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces . . ." HAND HYGIENE - Observation on 08/14/23 at 12:56 p.m. showed two certified nurse aides (CNAs) (#4 and #6) performed perineal care for Resident #13. The CNA (#6) cleansed the frontal area of stool, removed her gloves, failed to perform hand hygiene, and donned clean gloves. Both CNAs (#4 and #6) continued to clean stool from the	F 880	1.Since, each mechanical lift has been disinfected after every use and daily by different departments effective on 8/18/2023. 2. All residents have the potential to be affected by this deficiency. 3.DON provided education on hygiene to nursing staff on 9/20/2023 at a mandatory nursing staff meeting. A departmental and managers meeting was held 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. Attendance and competency will be tracked. Policy and procedure will be reviewed and given to all staff by 10/1/2023. 4.The QA nurse will be responsible to audit. Audits will consist of observation of each of the following events: hand hygiene, glove use, and multiple resident use equipment. Audits will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, QA nurse will notify DON an Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to comply with appropriate hand hygiene and disinfecting	

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F 880	Continued From page 25 resident, failed to remove their gloves, and perform hand hygiene before dressing, repositioning, adjusting the pillows, and giving Resident #13 the call light. - Observation on 08/14/23 at 1:58 p.m. showed a CNA (#8) donned gloves and assisted Resident #10 to change a wet brief and pants. The CNA removed the brief, cleansed the perineal area, applied a skin protectant cream, applied a clean brief, used a disposable wipe to cleanse the seat of the wheelchair and removed the gloves. The CNA failed to perform hand hygiene and assisted the resident to sit in the wheelchair. The CNA donned gloves, emptied the garbage, placed the resident's wet pants and socks in a bag, assisted the resident to put on clean pants, used the walkie-talkie to page housekeeping, turned the bathroom light off, closed the door, and removed the gloves. - Observation on 08/15/23 at 9:41 a.m. showed two CNAs (#6 and #7) donned gloves and assisted Resident #10 with toileting. The CNA (#7) completed perineal cleansing after a bowel movement, removed gloves, failed to perform hand hygiene, applied a clean brief, adjusted the waist band of the resident's pants, assisted the resident to sit in the wheelchair, removed the mechanical lift sling and leg strap, and opened the door for the resident to exit the room. - Observation on 08/15/23 at 10:01 a.m. showed two CNAs (#6 and #7) donned gloves and assisted Resident #23 with toileting. The CNA (#7) cleansed the resident's back side, applied a clean brief, adjusted the resident's pants, removed the gloves, failed to perform hand	F 880	the lift between uses. Additionally, if noncompliance is found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. The QA nurse will submit a report of audit results to the QA committee. 5.Corrective action will be completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	

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F 880	Continued From page 26	F 880		

hygiene, positioned the resident into the wheelchair and adjusted the back of the resident's shirt.

- Observation on 08/15/23 at 2:11 p.m. showed two CNAs (#7 and #10) donned gloves and assisted Resident #23 with toileting. The CNA (#7) cleansed the perineal area, failed to change gloves and perform hand hygiene, applied a clean brief, adjusted the resident's pants and shirt, and assisted the resident into the recliner chair.

- Observation on 08/16/23 at 10:32 a.m. showed two CNAs (#7 and #8) donned gloves and assisted Resident #23 with toileting. The CNA (#8) completed perineal cares, applied a clean brief, adjusted the resident's pants, removed the gloves, failed to perform hand hygiene, assisted the resident to the wheelchair, and removed the lift sling and leg strap.

DISINFECTING LIFTS

Review of the facility policy titled "Preventive Maintenance Invacare Policy" occurred on 08/17/23. This policy, dated 07/13/21, stated, ". . . Staff is to clean lift with a Cavi Wipe (disinfecting wipe) between each resident. . . ."

Observation during the survey showed staff failed to disinfect mechanical lifts with a Cavi wipe after or between each resident use as follows:
* 08/14/23 at 12:56 p.m. Resident #13 full body lift
* 08/14/23 at 1:30 p.m. Resident #39 sit to stand lift
* 08/15/23 at 9:41 a.m. Resident #10 sit to stand

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F 880	Continued From page 27 lift * 08/15/23 at 10:01 a.m. Resident #23 sit to stand lift * 08/15/23 at 10:19 a.m. Resident #4 full body lift * 08/15/23 at 2:11 p.m. Resident #23 sit to stand lift * 08/15/23 at 2:30 p.m. Resident #35 sit to stand lift During an interview on 08/17/23 at 11:20 a.m., an administrative nurse (#1) stated she expected staff to remove gloves after perineal care, perform hand hygiene between glove changes, and disinfect the lifts after each resident.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on review of staff's certification, review of	F 882	1.N/A to specific residents.	10/6/23

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F 882	Continued From page 28 facility policy, and staff interview, the facility failed to designate an individual who has completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. Failure to employ an Infection Control Preventionist (ICP) may affect all residents, staff, and visitors, placing them at risk for acquiring infectious diseases. Findings include: Review of the facility policy titled "Infection Preventionist" occurred on 08/17/23. This policy, dated, 11/13/17, stated, Western Horizon Care Center will provide an Infection Preventionist that will be responsible for coordinating the implementation and updating of our established infection prevention and control policies and practices. . . ." During an interview on 08/17/23 at 11:30 a.m., an administrative nurse (#1) confirmed the facility failed to have a staff member with specialized training in infection prevention and control.	F 882	2.The facility has since hired an infection preventionist on 9/5/2023 and has completed the appropriate training on 9/11/2023. 3.DON will become certified also in case of issue with staffing falls upon the facility again within a 3 month time frame. 4.Corrective action completed by 10/6/2023.	
F 948 SS=D	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 948	1.On 8/18/2023, DON and Administrator	10/6/23

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F 948	Continued From page 29 interview, the facility failed to ensure 1 of 1 staff member completed the appropriate training to assist residents with meals. Failure to assure staff have completed a State-approved feeding assistant training program has the potential to cause harm to the residents. Findings include: Observation of dining on 08/14/23 at 11:48 a.m. showed a staff member (#5) feeding Resident #39. During an interview on 08/16/23 at 1:35 p.m., the staff member (#5) confirmed she had not gone through any training program for feeding assistants. During an interview on 08/17/23 at 12:50 p.m., an administrative staff member (#2) stated she failed to check the training of staff member #5.	F 948	met with individuals involved and provided education on who can assist with feeding. 2. All residents have the potential to be affected by this deficiency. 3.DON provides education to nursing staff on 9/20/2023 at a mandatory nurses meeting and will be notified than no staff outside nursing staff, nursing staff includes RN, LPN and CNA's, will have the ability to assist with resident meals. A departmental and managers meeting was held 9/11/2023 & 9/18/2023 to review deficiencies and in-service staff on our plan of correction. Attendance and competency will be tracked. Policy to be reviewed and updated on 9/22/2023 to reflect such need. 4.The QA nurse will be responsible to audit. Audits will consist of ensuring that no staff outside of nursing staff, RN, LPN and CNA's are assisting with resident feeding. (Put in charge nurse on duty if any deficiently will be reported to DON to complete PIP) Audits will be performed on a weekly basis for 4 weeks. After 100% of success of compliance following the 4 weekly audits, audits will be completed monthly for 2 months. If 100% compliance is successful, audits will move to a quarterly basis. If it is ever found in an audit that compliance is not met, QA nurse will notify DON and Administrator. DON will be in charge of creating a performance improvement plan for the employee who failed to comply with audit and worked out of the scope of their practice. Additionally, if noncompliance is	

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F 948	Continued From page 30	F 948	found, the audit process will resume to weekly audits and follow the progress as stated above to resume compliance and return to quarterly audits. The QA nurse will submit a report of audit results to the QA committee & board members monthly. 5.Corrective action will be completed by 10/6/2023. Although, this will remain as a quality measure and will continued to be audited and reported to the Board of Directors, and will be included during onboarding for all new staff members.	