STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING _____ B. WING _____	C 11/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on November 14, 2024. During the report investigation the facility was found noncompliant with regulatory requirements	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interviews, the facility failed to ensure residents remained free from resident to resident abuse for 1 of 1 sampled residents (Resident #3) who experienced unwanted sexual contact with another resident. Failure to identify sexual abuse placed residents at risk for mental and emotional distress. Findings include: Review of the facility policy titled "Abuse, Neglect	F 600	1. For Resident #1 care plan was updated to reflect sexual behaviors towards female residents. Will keep Resident #1 separated from Resident #3. Resident #1 and Resident #3 live on opposite wings of the facility. Resident #1 and Resident #3 will not sit near or adjacent to one another during activities or community gatherings. Resident #1 is receiving hourly behavior monitoring daily and is assessed by nursing department staff for increased inappropriate	11/21/24

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

Electronically Signed | 12/04/2024

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F 600	Continued From page 1 and Exploitation" occurred on 11/14/24. This policy, revised 03/02/22, stated, ". . . Each resident has the right to be free from abuse . . . Residents must not be subject to abuse by anyone, including, but not limited to; . . . other residents . . . 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. . . .'Sexual Abuse' is non-consensual sexual contact of any type with a resident . . . The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents: . . . Provide education on what constitutes abuse . . . Assess, monitor and develop appropriate plans of care for residents with inappropriate sexual behavior, whether towards staff or other residents. . . ." - Review of Resident #1's medical record occurred on 11/14/24. Diagnoses included dementia, adjustment disorder, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS), dated 10/05/24, identified moderate cognitive impairment and independent for ambulation with an assistive device. The care plan, dated 04/11/24, stated, ". . . has also been sexually inappropriate to female staff. . . . Intervene as necessary to protect the rights and safety of others. . . ." Review of progress notes identified the following: * 11/20/23 at 2:57 p.m., ". . . [provider name] saw resident r/t [related to] female staff reports of resident's continued inappropriate behavior towards them . . . new order as follows: 'Start Paxil [an antidepressant used to treat sexual inhibition]. . .'" * 01/05/24 at 11:31 p.m., ". . . Resident does	F 600	behaviors towards female residents. If Resident #1 attempts to make contact with Resident #3 staff will intervene. 2. All female residents have the potential to be affected. 3. The current policy/procedure for Abuse and Neglect has been reviewed. All staff were in-serviced regarding Abuse & Neglect and Behavior Reporting/Response on November 20th and 21st. All female residents will be assessed for any behavior concerns. If any concerns are identified related to inappropriate sexual behavior by another resident, the care plan of that resident and any other residents that have the potential to be affected will be updated using input from individual resident, staff, and resident representatives. 4. The DON or designee will be responsible to monitor/audit resident-specific behavior charting. The DON or designee will monitor to assure all behaviors are charted and to assure all behaviors are followed-up on appropriately. QA will be implemented by 11/21/24. The DON or designee will monitor weekly for three months and then monthly for six months. If concerns are identified, immediate corrective action will be implemented. The QA/IP Coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 600	Continued From page 2 have sexually inappropriate behaviors to female resident/staff at times. . . ." * 06/20/24 at 2:48 p.m., "Resident was sitting next to a female resident [Resident #3] and put his hand on the upper part of her leg. I removed it and placed it on his knee. later [sic] he again had it on her crotch. I removed his hand and put her at the front table." - Review of Resident #3's medical record occurred on 11/14/24. Diagnoses included depression, and anxiety. A quarterly MDS, dated 10/10/24, identified severe cognitive impairment. Resident #3's medical record lacked documentation of the interaction with Resident #1 on 06/20/24. During an interview on 11/14/24 at 1:20 p.m., administrative nurse (#2) reported being unaware of the incident of touching between Resident #1 and #3, and confirmed she expected staff to report it. During an interview on 11/14/24 at 1:47 p.m., staff member (#4) confirmed she witnessed the touching between Resident #1 and #3, stated she separated the residents, and explained to Resident #1 that the touch was inappropriate. The staff member (#4) identified Resident #3 as "uncomfortable" with Resident #1's touch and unsure if she reported it to anyone.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		11/21/24

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F 609	Continued From page 3 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview the facility failed to report an incident of resident-to-resident abuse to the State Survey Agency (SSA) for 1 of 1 sampled residents (Resident #3) who experienced abuse. Failure to report resident-to-resident abuse allegations and the results of the facility's investigation to the SSA placed all residents at risk for possible abuse. Findings include:	F 609	1. For Resident #1 care plan was updated to reflect sexual behaviors towards female residents. Will keep Resident #1 separated from Resident #3. Resident #1 and Resident #3 live on opposite wings of the facility. Resident #1 and Resident #3 will not sit near or adjacent to one another during activities or community gatherings. Resident #1 receives hourly behavior monitoring daily and is assessed by nursing department staff for increased inappropriate	

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F 609	Continued From page 4 Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 11/14/24. This policy, revised 03/02/22, stated, ". . . Each resident has the right to be free from abuse . . . Residents must not be subject to abuse by anyone, including, but not limited to; . . . other residents . . . 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. . . .'Sexual Abuse' is non-consensual sexual contact of any type with a resident . . . Anyone in the facility can report suspected abuse . . . When abuse, neglect or exploitation is suspected . . . Notify the Director of Nursing and Administrator . . . In response to allegations of abuse . . . the facility must: . . . Ensure that all alleged violations involving abuse . . . are reported . . . not later than 24 hours . . . to the administrator of the facility and to other official (including the State Survey Agency . . .) in accordance with State law . . ." - Review of Resident #1's medical record occurred on 11/14/24. Diagnoses included dementia, adjustment disorder, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS), dated 10/05/24, identified moderate cognitive impairment and independent for ambulation with an assistive device. The care plan, dated 04/11/24, stated, ". . . has also been sexually inappropriate to female staff. . . . Intervene as necessary to protect the rights and safety of others. . . ." A progress note, dated 6/20/24 at 2:48 p.m., stated, "Resident was sitting next to a female resident [Resident #3] and put his hand on the upper part of her leg. I removed it and placed in	F 609	behaviors towards female residents. If Resident #1 attempts to make contact with Resident #3 staff will intervene. 2. All residents have the potential to be affected. 3. The current policy/procedure for Abuse and Neglect has been reviewed. All staff will be in-serviced regarding Abuse & Neglect and Behavior Reporting/Response on November 20th and 21st. All residents will be assessed for any behavior concerns. If any concerns are identified related to inappropriate sexual behaviors by another resident, the care plan of that resident and any other residents that have the potential to be affected will be updated using input from the individual resident, staff, and resident representatives. Non-direct care staff have been educated to immediately report resident behaviors to the charge nurse who will then complete any necessary documentation. This action should be followed up with notification to the DON or administrator either verbally or via writing to ensure any further investigation is completed in a timely manner. 4. The DON or designee will be responsible to monitor/audit resident-specific behavior charting. The DON or designee will monitor to assure the safety of all residents and to assure all behaviors are followed-up on appropriately. QA will be implemented by	

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