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 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and complaint survey started on 12/16/19 and concluded 12/19/19.	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 policy and procedure, and staff interview, the facility failed to assess the safety of self-administration of medication for 1 of 1 sampled resident (Resident #21) observed with medications left on an overbed table in her room. Failure to determine whether self-administration of medications is a safe practice has the potential to result in a medication error and/or adverse health effects to a resident. Finding include: Review of the facility policy titled "Resident Self-Administration of Medication" occurred on 12/19/19. This policy, reviewed/revised October 2019, stated, ". . . 3. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team . . . 4. The results of the interdisciplinary team assessment are recorded on the Self-Administration Form, which is placed in the resident's medical record. . . . 6. Once competency of resident is determined an order shall be obtained from the physician. 7. Upon	F 554	1. The IDT Team met to review medications that Resident #21 is receiving. Since she is receiving opioids, it was deemed not appropriate or safe for this resident to self administer medications on 1/2/2020. The self administration evaluation form in PCC is utilized for all residents including new admissions. 2. All other residents and any new residents have the potential to be affected. All residents were reviewed to determine which residents are self administering medications. There are no residents currently in this facility that are self administering medications. 3. Self Administration of Medications Policy was updated on 1/6/2020. All nurses and CMAs were educated on the Self Administration of Medication Policy which states to observe all residents who do not self administer their medications take their medications on 1/21/2020 by	1/23/20

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

Electronically Signed | 01/15/2020

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F 554	Continued From page 1 notification of the resident who can self-administer . . . this shall be recorded on the MAR [medication administration record] . . ." Observation on 12/16/19 at 11:07 a.m. showed a plastic medication cup containing pills on Resident #21's overbed table. When asked, Resident #21 stated she did not feel well and "will take them [the pills] later." Review of Resident #21's medical record occurred on all days of survey. The record lacked an assessment and a physician's order for self-administration of any medications. During an interview on 12/18/19 at 11:34 a.m., an administrative nurse (#2) confirmed staff had not assessed Resident #21 for self-administration of medications and stated, "I would expect the nurse to take them [the medications] back with her" when the resident stated she would take them later.	F 554	DON. 4. DON/designee will audit all residents that are self administering medications to determine if Doctor's orders are in place, initial and quarterly assessments are completed, IDT approval, and self administration of medications is care planned. Audits will be performed weekly X4, monthly X2, and quarterly X3 by DON/designee. Audit results will be reported at the monthly QAPI meetings, quarterly QA meetings, and the monthly board meetings by the DON/designee. All new residents will be assessed to determine if self administration of meds is appropriate. Audits include evaluation of new residents, medication desired, & IDT decision. Audits will include observation to ensure nurses are not leaving medications with residents who have not been evaluated. 5. Corrective action will be completed by 1/23/2020.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		1/23/20

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F 584	Continued From page 2 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, review of resident council minutes, review of facility task schedule, anonymous interviews, and staff interview, the facility failed to ensure the cleanliness of residents' wheelchairs for 2 of 11 sampled residents (Resident #15 and #30) and 2 residents	F 584	1. Resident #15 and #30's wheelchairs were cleaned on 12/26/2019. Resident #15 and #30 were added to the wheelchair task list on 12/26/2019. 2. All residents and any new residents that require the use of a wheelchair or	

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F 584	Continued From page 3 from the group interview (Resident C and F). Failure to ensure personal equipment is kept clean does not provide a safe, comfortable living environment for the residents. Findings include: Information provided by the complainant indicated the facility failed to clean wheechairs/walkers on a regular basis. Resident council minutes, dated 12/02/19, identified, ". . .Wheelchairs and walkers are not being cleaned. . . ." - During a resident group interview on 12/17/19 at 4:00 p.m., Resident F reported staff washed her/his wheelchair three times in the last year. Resident C stated she/he asked staff to clean her/his wheelchair approximately six months ago and it has been cleaned once since the request. - Review of Resident #15's medical record occurred on all days of survey. The record showed the resident required a wheelchair in September 2019. Observation on all days of survey showed Resident #15 self propelling in the hallway and lounge area. Review of the facility task schedule showed staff failed to add Resident #15's wheelchair to the cleaning schedule. - Review of Resident #30's medical record occurred on all days of survey. Observation on all days of survey showed Resident #30's wheelchair soiled with dust, food particles and a glue-like substance. Review of the facility task schedule showed staff failed to add Resident	F 584	walker have the potential to be affected. Wheelchair and walker cleaning task lists were reviewed and updated on 12/23/2019 to ensure that all residents using a wheelchair or walker are on the task list for cleaning. 3. Wheelchair and walker cleaning policy was updated on 12/20/2019. Nursing staff was educated on the wheelchair and walker policy which states that each resident using a walker or wheelchair washed weekly prior to bath day on 1/21/2020 by DON & QA/IC. 4. DON/designee will audit wheelchair and walker task list and will visibly inspect walkers and wheelchairs 3 times a week for 1 week and will continue with this schedule if deemed necessary, weekly X3, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly at the board meetings by QA/IC. 5. Corrective action will be completed by 1/23/2020.	

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F 584	Continued From page 4 #30's wheelchair to the cleaning schedule. During an interview on 12/18/19 at 4:15 p.m., an administrative nurse (#2) stated night staff clean wheelchairs the night before a resident's scheduled bath. She reviewed the facility task schedule and confirmed staff failed to add Resident #30's wheelchair to the cleaning schedule.	F 584		
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 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	F 623		1/23/20

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F 623	Continued From page 5 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; (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	F 623		

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F 623	Continued From page 6 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 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 residents, their representative/guardian, and/or the State Long Term Care Ombudsman a written notice of transfer as soon as practicable for 2 of 4 sampled residents (Resident #9 and #31) and 1 closed record (Resident #40) transferred to the hospital from the facility. Failure to provide notice of transfer and/or a written copy of the transfer form	F 623	1. WHCC provided a completed written copy of the transfer form which was faxed to the Ombudsman for residents #9 and #31 on 1/15/2020. Resident #40 no longer resides in this facility. 2. All current residents and new admissions have the potential to be affected if the resident is being	

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F 623	Continued From page 7 does not allow residents and/or their representative/guardian to make informed decisions or inform the Ombudsman of all transfers. Findings include: - Review of Resident #9's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 09/17/19. The record lacked evidence the facility completed and provided a written copy of a transfer form for Resident #9. - Review of Resident #31's medical record occurred on all days of survey and identified the facility transferred Resident #31 to the hospital on 08/31/19 and on 11/07/19. The record lacked evidence the facility notified the Ombudsman about the 08/31/19 transfer and lacked evidence the facility provided a written copy of the transfer form to Resident #31's guardian for the 08/31/19 and 11/01/19 transfers. During an interview on 12/18/19 at 10:52 a.m., an administrative nurse (#2) confirmed the facility could not provide a copy of the transfer form for Resident #9's hospital transfer on 09/17/19. The nurse (#2) also confirmed the facility failed to notify the Ombudsman for Resident #31's 08/31/19 transfer and to provide written copies of the transfer forms to Resident #31's guardian for both transfers. - Review of Resident #40's medical record occurred on 12/19/19 and identified the facility transferred the resident to the hospital on 09/26/19. The record lacked evidence the facility	F 623	transferred from the facility. 3. The policy Before Transfer/Discharge and Fax to Ombudsman was updated on 12/20/2019. Education will be provided to the nursing staff and medical records on 1/21/2020 by DON. The policy update states that the Charge Nurse will provide written notice to the personal representative regarding the transfer or discharge, if unable to review in person, a copy will be mailed to the personal representative within 24 hours. 4. Medical records/designee will audit to ensure written transfer forms are being completed and sent to resident/personal representative and that a copy is faxed to the Ombudsman weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI meetings, quarterly QA, and monthly Board meetings by QA. Charge nurse will fax transfer/discharge to ombudsman within 24 hours. 5. Corrective action will be completed by 1/23/2020.	

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F 623	Continued From page 8 notified the ombudsman, completed a transfer form, or provided a written copy of the transfer form to Resident #40 or the responsible party. During an interview on 12/19/19 at 1:50 p.m., an administrative nurse (#2) confirmed the facility failed to provide the documentation or paperwork for the hospital transfer or notify the ombudsman of the hospital transfer.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		1/23/20

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F 625	Continued From page 9 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, review of facility policy, and staff interview, the facility failed to provide residents or their representative/guardian a written bed-hold notice upon transfer to the hospital for 3 of 4 sampled residents (Resident #9, #31, and #39) and 1 closed record (Resident #40). Failure to complete a bed-hold and/or provide a written copy of the facilities bed-hold policy does not allow residents or their legal representative/guardian to make informed choices. Findings include: Review of the facility policy titled "Notice of Bed Hold Policy" occurred on 12/19/19. This policy, dated July 2017, stated, "The notice of Bed Hold Policy is provided to the resident / Power of Attorney (POA) for Health Care and/or Finance and/or resident's representative upon admission, time of emergency transfer . . . At the time of transfer for hospitalization . . . the facility will provide the resident and/or the resident's above mentioned contact written notice which specifies the duration of the bed-hold policy. . . ." - Review of Resident #9's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 09/17/19. The record lacked evidence the facility completed and provided a written copy of a bed-hold notice for Resident #9. - Review of Resident #31's medical record	F 625	1. Written bed hold notice was provided for Resident #9/PR for transfer (on 9/17/2019) on 1/15/2020, Resident #31 for transfer (on 9/31/2019 and 11/7/2019) on 1/15/2020, and Resident #39 for transfer (on 8/19/19) on 1/15/2020. 2. All current residents and new admissions that may be transferred from this facility have the potential to be affected. 3. Bed Hold policy reviewed and updated on 12/26/2019. Nursing staff and Medical Records will be educated on 1/21/2020 by DON. Policy update states a copy of the bed hold will be mailed to personal representative or POA if they are unable to review in person within 24 hours. 4. Medical records/designee will audit written bed hold records regarding any transfers outside the facility weekly X4, monthly X2, and quarterly X3. Audit results will be reported at monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective action will be completed on 1/23/2020.	

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F 625	Continued From page 10	F 625		

occurred on all days of survey and identified the facility transferred Resident #31 to the hospital on 08/31/19 and on 11/07/19. The record lacked evidence the facility provided Resident #31's legal guardian a written copy of the bed-hold notice for both hospital transfers.

During an interview on 12/18/19 at 10:52 a.m., an administrative nurse (#2) confirmed the facility could not provide a copy of the bed-hold notice for Resident #9's hospital transfer on 09/17/19 and failed to provide Resident #31's legal guardian a written copy of the bed-hold policy for the hospital transfers on 08/31/19 and 11/07/19.

- Review of Resident #39's medical record occurred on all day of survey and identified a hospital admission on 08/19/19. The record lacked evidence the facility completed a bed hold notice and provided Resident #39 and/or her legal representative with the information. A progress note, dated 08/22/19 at 12:02 p.m., stated, ". . . [family member] informed and agreed for Bed Hold Policy over phone to be held. . . ."

During an interview on 12/17/19 at 11:35 a.m., an administrative staff member (#2) identified the only bed hold for Resident #39 is the statement written in the progress note.

- Review of Resident #40's medical record occurred on 12/19/19 and identified the facility transferred the resident to the hospital on 09/26/19. The record lacked evidence the facility completed a bed-hold notice for Resident #40.

During an interview on 12/19/19 at 1:50 p.m., an administrative nurse (#2) confirmed the facility

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F 625	Continued From page 11 failed to provide a copy of the bed-hold notice to Resident #40 or the responsible party for the hospital transfer on 09/26/19.	F 625		
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" 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, staff interview, 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 1 sampled resident (Resident #15) who experienced a significant change in status. 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 identify and implement appropriate care approaches. Findings include: - Review of Resident #15's medical record occurred on all days of survey. A quarterly	F 637	1. Significant change assessment for resident #15 will be completed by 1/23/2020. 2. All current residents and new admissions have the potential to be affected. 3. Significant Change Assessment policy was reviewed and updated on 12/24/2019 to include monitoring the following to determine significant change: mood change, behavior change, ADL function change, incontinence change/foley, weight change, pressure ulcer stage 2 or higher, restraints, and new unstable condition. Education will be provided to	1/23/20

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F 637	Continued From page 12 Minimum Data Set (MDS), dated 07/08/19, identified the resident as independent with walking in the corridor; independent with set up help for transfers, toileting, personal hygiene, eating, walking in the room, and locomotion on and off the unit; and supervision with one person assist for bed mobility and dressing. The record identified Resident #15 experienced unwitnessed falls on 09/12/19 and 09/14/19 resulting in nondisplaced rib fractures and a nondisplaced pelvic fracture. A quarterly MDS, dated 10/08/19, identified the resident required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene; and did not walk in the corridor. The facility failed to document or complete a SCSA following Resident #15's decline. During an interview on 12/18/19 at 2:54 p.m., an administrative nurse (#2) confirmed the facility failed to complete a significant change MDS for Resident #15 after his/her pelvic fracture.	F 637	the MDS IDT on 1/21/2020 by QA/IC, regarding the requirements for a Significant Change Assessment. 4. MDS Coordinator/designee will audit MDS' for significant change status weekly X4, monthly X2, quarterly X3, and will compare to prior assessments to ensure changes are monitored. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly Board Meetings by QA. 5. Corrective actions will be completed by 1/23/2020. IDT meets daily to discuss & determine whether significant change is appropriate.	
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 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 2 of 17 sampled residents (Resident #9 and #30). Failure to accurately complete Section K	F 641	1. Section K on 9/17/2019 Discharge Return Anticipated Assessment MDS will be corrected by 1/23/2020 for resident #9. Section M on 11/20/2019 MDS will be corrected by 1/23/2020 for resident #30. 2. All current residents and new admissions have the potential to be	1/23/20

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F 641	Continued From page 13 (Swallowing/Nutritional Status) and Section M (Skin Conditions) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION K: SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI User's Manual, revised October 2019, page K-3, stated, ". . . Steps for Assessment for K0200B, Weight 1. Base weight on the most recent measure in the last 30 days. 2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). . . . 5. If the resident's weight was taken more than once during the preceding month, record the most recent weight. . . ." - Review of Resident #9's medical record occurred on all days of survey. The resident's discharge return anticipated MDS, dated 09/17/19, for section K0200 B., showed a weight of 170 pounds. Review of Resident #9's weight record showed the following entries: * 09/17/2019 at 10:26 a.m., 182.2 pounds * 09/17/2019 at 11:54 a.m., 170.2 pounds * A note written in the weight record on 09/18/2019 at 11:25 a.m. identified the weight of 170.2 pounds as inaccurate.	F 641	affected. 3. Accuracy of Assessments policy was reviewed regarding accuracy of the MDS in regards to refreshing the MDS prior to completion to ensure data is correct data collected will reflect the 7 day lookback period and updated on 12/27/2019. MDS IDT will be educated on 1/21/2020 by QA/IC. 4. Accuracy of section M and section K will be audited by the MDS Coordinator/designee for compliance weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI meetings, quarterly QA, and monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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F 641	Continued From page 14 The MDS indicated section K0200 B. electronically signed by the dietary manager (#1) on 09/19/19 at 11:11 a.m. with the inaccurate weight of 170 pounds. During an interview on 12/18/19 at 3:29 p.m., the dietary manager (#1) agreed section K0200 B. on the 09/17/19 discharge return anticipated MDS contained the incorrect weight. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2019, page M-33 through M-37, stated, ". . . Steps for Assessment: 1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. . . ." - Review of Resident #30's medical record occurred on all days of survey. An admission MDS, dated 11/20/19, for section M1200 H. "Skin and Ulcer/Injury Treatments" showed application of ointments/medications administered in the seven day look back period; however, the resident's medical record and treatment record lacked evidence of ointment/medication administration during that time. During an interview on 12/19/19 at 10:30 a.m., an administrative nurse (#3) agreed she failed to code section M of the MDS accurately.	F 641		
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	F 657		1/23/20

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F 657	Continued From page 15 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. (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 ensure staff reviewed and revised comprehensive care plans to reflect the residents' current status for 4 of 17 sampled residents (Resident #3, #16, #24, and #30) and 1 closed record (Resident #40) reviewed. Failure to review and revise the care plans limited the staffs' ability to communicate needs and ensure continuity of care.	F 657	1. Resident #3's care plan was updated to include denture care on 1/14/2020. #16's care plan was updated to include: Resident will be encouraged and helped brushing her teeth 2 times a day concentrating on along her gum tissue and floss or use proxy brush to clean between teeth on 1/14/2020. Resident #24's care plan was updated from assistance with transfers and ambulation using 1 assist, gait belt, and walker to	

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F 657	Continued From page 16 Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 12/19/19. This undated policy stated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. . . ." - Review of Resident #3's current care plan and "Bedside Kardex Report" utilized by certified nurse aides (CNAs) showed no entry under Personal Hygiene/Oral Care regarding denture care. Staff failed to include denture care on the resident's care plan. - Review of Resident #16's current care plan and "Bedside Kardex Report" stated, "Set up supplies for oral cares bid [twice daily]. Assist if necessary. [Resident] has her own teeth." Physician orders, dated 11/21/18, stated, "[Resident] should be encouraged and helped brushing her teeth 2 times a day concentrating on along her gum tissue and floss or use proxy brush to clean between teeth." Staff failed to update the care plan to reflect the 11/21/18 physician's order for additional oral care. - Observation during all days of survey showed Resident #24 ambulated independently with a cane. Review of Resident #24's current care plan and "Bedside Kardex Report" stated, ". . . Mobility	F 657	independent with cane. Resident #30's care plan was updated to include an antiplatelet medication and interventions related to impaired skin integrity and risk for bleeding/bruising. Resident #40 no longer resides in the facility. 2. All residents including new admissions have the potential to be affected. 3. Comprehensive care plan policy was reviewed and updated on 12/24/2019 to ensure compliance, education will be provided to nursing staff regarding care plans on 1/21/2020 by DON and QA/IC. 4. 5 care plans will be audited per week by the MDS Coordinator & on an ongoing basis & it will take 9 weeks to review all residents care plans. Audit results will be reported at the monthly QAPI meetings, quarterly QA meetings, and monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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F 657	Continued From page 17 * Assist [Resident] with transfers and ambulation using 1 assist, gait belt and walker." During an interview on 12/18/19 at 9:55 a.m., an administrative nurse (#2) verified the resident's mobility was upgraded to independent with a cane on 11/14/19, and staff failed to update the care plan. - Review of Resident #30's medical record occurred on all days of survey. Diagnoses included cerebrovascular disease, coronary artery disease with aortocoronary bypass graft. The physician orders included Plavix (antiplatelet drug) 75 milligrams daily. Observation on all days of survey show resident to have bruises and scabs on both hands, right wrist/forearm, and a skin tear on the left forearm. The nursing documentation showed the following: * 11/26/19 at 3:13 p.m., ". . . notified this nurse of blood to the top of right hand. . . ." * 11/29/19 at 2:35 p.m., ". . . skin tear quarter size on left forearm. . . . skin tear with blood the size of quarter. . . ." * 12/06/19 at 2:13 p.m., ". . . Resident already has skin tears on both arms, and some of the dressing came off . . ." Staff failed to update the care plan addressing Resident #30's need for an antiplatelet medication and interventions related to the impaired skin integrity and risk for bleeding/bruising. - Review of Resident #40's medical record	F 657		

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F 657	Continued From page 18 occurred on 12/19/19. Diagnoses included dementia, osteoarthritis, and pneumonia. The care plan indicated, ". . . Pressure Ulcers/Skin issues: [Resident #40] may be at risk related to decreased mobility. . . . check all skin areas with am and pm cares and with showers for reddened or open skin areas. If noted, report to charge nurse. . . . selan cream to buttocks and coccyx after each incontinent episode. . . ." Nursing documentation showed the following: * 09/08/2019 10:47 p.m., ". . . CNA called nurse to resident's room while she was performing AM [morning] cares. A skin tear to right inferior upper arm was evident . . . Wound measured 3cm [centimeters] x 2cm. . . ." * 10/09/2019 at 6:16 p.m., ". . . staff was getting resident up for dinner and noticed a skin tear on her upper right arm. Nurse was called and cleansed the area . . ." * 10/19/2019 at 2:40 p.m., ". . . discovered a small pressure ulcer on the sacrum area. [Nurse] came in and measured the area, which was 1.5 inches x 1 inch . . ." * 10/20/2019 at 6:34 a.m., ". . . Called to resident's room by CNA to assess skin tear to inner right forearm. Area measures 0.4 cm x 2.4 cm . . ." * 10/28/2019 at 2:13 p.m., ". . . changing the brief of the resident and noticed a pressure sore in the sacrum area. I went in to measure it. It was 6x4 inches. . . ." Staff failed to update the care plan addressing Resident #40's need for specialized skin care and interventions related to her skin tears and pressure ulcer.	F 657		
F 658	Services Provided Meet Professional Standards	F 658		1/23/20

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F 658 SS=D	Continued From page 19 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, manufacturer's instruction, and staff interview, the facility failed to ensure facility staff followed professional standards of practice for 1 of 1 observation of insulin administration. Failure to prime the insulin pen in an upright position may result in a resident receiving an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Insulin Pens" occurred on 12/18/19. This policy, dated February 2018, stated, ". . . Remove air from the pen. Air may cause pain during injection. Turn the dial to 2 units. For most pens, you will hear a click for each unit of insulin that you dial. Hold the pen and point the needle up. Gently tap the pen to move air bubbles to the top of the pen. Press in injection button. You should see a drop of insulin on the tip of the pen. . . ." Review of online manufacturer's "Instructions for Use HUMALOG KwikPen," dated December 2018, stated, ". . . To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. . . . Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops. . . ."	F 658	1. Nurse #4 was educated and observed regarding correct priming of an insulin pen by holding the insulin pen with the needle pointing up by DON on 12/20/2019. 2. All residents and new admissions requiring the use of insulin pens have the potential to be affected. All residents requiring the use of insulin pens were identified. 3. Insulin Pen policy was reviewed on 12/26/2019. Each nurse was educated individually on how to prime insulin pens by the DON. 4. Since there are only a limited number of insulin pens which are given all on 1 shift, each nurse will be observed during the preparation of the pen prior to administration. Audits will be completed 3X per week for first week until compliance is achieved & then weekly X3, monthly X2, and quarterly X3 by the DON/designee. Audit results will be reported at monthly QAPI, quarterly QA, and monthly board meetings by QA.	

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F 658	Continued From page 20 Observation on 12/18/19 at 11:30 a.m. showed a nurse (#4) prepared a Lispro (Humalog) KwikPen for injection. The nurse (#4) held the pen sideways to prime the pen. During an interview on the morning of 12/19/19, an administrative nurse (#2) verified the policy stated to prime insulin pens with the needle pointed up.	F 658	5. Corrective action will be completed by 1/23/2020.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of facility policy and staff education, and resident, staff, and family interviews, the facility failed to provide Activities of Daily Living (ADL) assistance to 1 of 1 confidential resident/family interview (Resident A) and 5 of 7 sampled residents (Resident #9, #16, #22, #30 and #31) who required staff assistance for ADLs (oral cares, dining, and/or grooming). Failure to provide appropriate assistance to residents who cannot independently complete ADLs may result in poor oral hygiene, unkempt fingernails, increased anxiety during meals, and decreased self-esteem. Findings include: Information provided by the complainants	F 677	1. All care plans were updated & staff educated to reflect the following changes for each resident: Resident #9: care plan was updated to reflect denture care preferences, assistance with dining, & fingernail care. Staff educated on updated care plan & resident's dentures were cleaned on 12/20/2019 & two times daily going forward as allowed by the resident. Nails were trimmed on 12/20/2019 & will be trimmed every two weeks or as needed. Staff assistance for all meals will be provided. Resident #26: care plan was updated to reflect oral cares & fingernail care. Staff were educated on the updated care plan and teeth were cleaned on 12/20/2019 & two times daily going forward if allowed.	1/23/20

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F 677	Continued From page 21 indicated the facility failed to provide the following: * Proper oral care assistance including denture care * Prompt assistance with trimming fingernails on bath day * Assistance during meals with eating and drinking Review of the facility policy titled "Assistance With Meals" occurred on 12/19/19. This policy, dated May 2009, stated, ". . . Nursing staff and/or Feeding Assistants will serve resident trays and will help residents who require assistance with eating. c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. . . ." Review of the facility's Certified Nurses Aide Education for Oral Hygiene and Denture Care stated, ". . . Brushing and flossing removes plaque and may prevent bacteria from infecting the gums and teeth. . . Check the care plan to make sure you identify what the resident can do for him or herself. . . ." Review of the facility's Certified Nurses Aide Education for Nail Hygiene stated, "Routine nail care prevents disease and infection. Nails that are too long or jagged can tear a resident's skin. . . ." - Review of Resident #22's medical record occurred on all days of survey and included diagnoses of traumatic brain injury, anxiety disorder, vascular dementia with behavioral disturbance, contracture right hand, quadriplegia, blindness one eye (right), and aphasia. The	F 677	Fingernails were trimmed on 12/20/2019 & will be trimmed every two weeks or as needed. Resident is independent with eating. Resident #22: requires sedation with teeth cleaning. Appointment scheduled in Bismarck. Oral cares will be performed two times a day as resident allows by staff. Assistance with meals provided by staff. Fingernails were trimmed on 12/20/2019 and will be trimmed every two weeks or as needed. Resident #30: teeth were cleaned on 12/20/2019 and will be performed two times daily as resident allows. Fingernails were trimmed on 12/20/2019 and will be trimmed every two weeks or as needed. Independent with eating after set up. Resident #31: teeth were cleaned on 12/20/2019 and will be cleaned two times daily as resident allows. Fingernails were trimmed on 12/20/2019 and will be trimmed every two weeks as necessary. Independent with eating after set up. 2. All current and new admissions have the potential to be affected. 3. Oral Care policy was updated on 12/26/2019 to include flossing & brushing the gums. Hydration policy was updated on 12/24/2019 to include offering fluids per task list and to all residents prior to leaving the resident's room. Nail policy will be updated by 1/23/2020 to include the frequency of nail care. Dining/Nutrition policy was updated on	

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F 677	Continued From page 22 current care plan stated, ". . . Stay out of [Resident's] personal space as much as possible since [resident] can become very aggressive physically. [Resident] is very strong . . . will get physically aggressive and attempt to grab staff's hand or arm very hard . . . If [Resident] is upset/agitated, ask [resident] if he is hungry, thirsty . . . Supervise and cue [Resident] at each meal. . ." Review of the quarterly Minimum Data Set (MDS), dated 10/25/19, identified physical and verbal behavior directed toward others and extensive assist of one with eating. Observation on 12/16/19 at 5:34 p.m. showed Resident #22 at the dining room table seated in the wheelchair and grabbing at tablemate's shirt and arm. An unidentified certified nurse aide (CNA) poured the tablemate's fluids into cups, repositioned Resident #22 away from the tablemate, and left. Resident #22 propelled over and began grabbing and pushing at tablemate's wheelchair. Again a staff member intervened and repositioned Resident #22 at the table. After the CNA left, Resident #22 again propelled over to tablemate and grabbed and pushed at wheelchair. Another CNA intervened and again repositioned Resident #22 at the table. At 5:45 p.m. a CNA offered Resident #22 a beverage in a nosey cup. After the CNA left, the resident propelled to another resident's wheelchair and proceeded to grab and push at the handle and armrest. At 5:50 p.m. a CNA (#7) intervened, sat down at the table, and assisted the resident with fluids. When the supper tray arrived, the resident's anxiety decreased while the CNA assisted the resident with the meal. Staff failed to provide consistent supervision and dining assistance during the meal as care planned for	F 677	12/26/2019 to include cueing and supervision at meals. Nursing staff will be educated on the updated policies and appropriate care plans for all residents related to their needs on 1/21/2020 by DON and QA/IC. 4. Nursing/dietary will observe 3 times a week and will continue with that schedule if deemed necessary and then weekly X3, monthly X2, and quarterly X3. We will intermittently interview residents and/or families to ensure cares are completed. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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F 677	Continued From page 23 Resident #22. Observation on 12/17/19 at 7:00 a.m. showed Resident #22 in the wheelchair in front of the television near the dining room area. At 7:50 a.m. staff positioned the resident at the dining room table. The resident grabbed and pounded a closed beverage carton on the table. At 8:00 a.m. a licensed nurse (#9) sat down with the resident, poured three beverages into nosey cups, and offered and placed them in front of the resident. When the nurse left the table the resident placed the milk cup inside the water cup which spilled on the table. When the breakfast tray arrived at 8:15 a.m., the resident's anxiety decreased when a staff member assisted the resident with the meal. Staff failed to provide consistent supervision and assistance with eating/fluids as care planned. Observation on 12/17/19 at 5:17 p.m. showed two CNAs (#7 and #8) transferred the resident from the bed to the wheelchair and transported the resident to the dining room table. Resident #22 grabbed the tablemate's arm and shirt, pushed at wheelchair, grabbed at tableware, and threw hat on the table. Staff repositioned the resident at the dining table and walked away. The resident promptly propelled back to tablemate and continued to repeat the previous behaviors. When the supper tray arrived at 5:50 p.m., the resident's anxiety decreased when a staff member assisted the resident with the meal. Staff failed to provide consistent supervision and assistance with eating/fluids as care planned. During an interview on the morning of 12/19/19, an administrative nurse (#2) verified Resident #22 needed supervision and cueing at meals.	F 677		

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F 677	Continued From page 24 - Observations on 12/16/19 of Resident #30 seated in the dining room showed the following: * 11:45 a.m., attempted to drink liquid from a cup with plastic wrap across the opening, attempted to drink from a carton with the cap attached, sucked on a sealed mustard packet, used his fork to scoop water from the water glass, attempted to drink from the nosey cup and contents from the cup dripped on the table. * 11:50 a.m., spilled the serving of cubed jello onto the table and licked the empty container. An unidentified staff person approached the table and used a napkin to scoop the jello off the table, then placed it back into the container, put the napkin on top of the jello contents, and placed it out of Resident #30's reach. * 11:52 a.m., an unidentified staff person brought the resident his meal. * 12:19 p.m., resident retrieved the portion of jello from earlier and began to eat it. - During an anonymous interview on 12/17/19, Resident A's family verified sometimes the resident's dentures remained in his/her mouth all night and were not cleaned. Further interview revealed family requested the resident's fingernails trimmed, but staff failed to do this for several weeks. Staff had not trimmed Resident A's fingernails for several weeks after family had requested it. After receiving a bath earlier in the day, observation on the afternoon of 12/17/19 showed Resident A's fingernails at varying untrimmed lengths. Review of Resident A's medical record occurred	F 677		

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F 677	Continued From page 25 on all days of survey. The annual MDS, dated 11/30/19, identified moderately impaired cognition, personal hygiene including oral care with extensive assist of one staff, no natural teeth, and the Care Area Assessment (CAA) Summary triggered for dental care and identified as not addressed in the care plan. The current care plan showed no goals or interventions regarding oral and/or denture care. Resident A's progress notes stated the following: * 09/03/19 - ". . . Resident is total care transfer with hoyer [full body mechanical] lift assist per staff x2 [requiring 2 staff], ADL's, dressing, combing hair, showering, and brushing teeth. . . ." * 09/18/19 - ". . . Family would like to remind us of nail care. . . ." * 11/25/19 - ". . . Resident is extensive to total assist with all ADLs. . . ." - Review of Resident #9's medical record occurred on all days of survey. A significant change MDS, dated 09/25/19, identified personal hygiene, including oral care, with extensive assist of one staff and no natural teeth. The current care plan stated, ". . . Set up supplies for oral care bid [twice a day]. Assist as necessary . . ." Resident #9's progress notes stated the following: * 09/02/19, ". . . Resident requires assist of one per staff with total hygiene, dressing, brushing teeth, and combing hair. . . ." * 12/13/19, ". . . [Resident] is total assist for all ADLs like bathing, dressing, hygiene, and meals. . . ."	F 677		

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F 677	Continued From page 26 Observation on 12/17/19 at 8:23 a.m. showed thick sticky oral secretions when Resident #9 opened her mouth to speak. During morning cares, a CNA (#10) cleansed the resident's oral cavity with a mouth swab, removed the dentures, and stated, "She [Resident #9] must have slept with them [the dentures] in." - Review of Resident #16's medical record occurred on all days of survey. The quarterly MDS, dated 10/10/19, identified moderately impaired cognition and personal hygiene including oral care with extensive assist of one staff. The current care plan stated, "Personal Hygiene/Oral Care . . . Set up supplies for oral cares bid [twice daily]. Assist if necessary. [Resident] has . . . own teeth. . . . Bathing * ADL - Bathing Tuesday & Friday (Prefers: Shower) Nail care every Tuesday. . . . " Observation on the mornings of 12/16/19 and 12/17/19 showed Resident #16's teeth heavily coated with a plaque-like substance and discolored. The resident's fingernails were long and uneven. During observation of morning cares on 12/17/19, Resident #16 requested staff trim his/her fingernails. When questioned on the afternoon of 12/18/19 about brushing teeth, the resident stated staff frequently failed to provide assistance with oral care, and at this time showed staff had not trimmed the resident's fingernails. A physician's order, dated 11/21/18, stated, "[Resident] should be encouraged and helped brushing her teeth 2 times a day concentrating on along her gum tissue and floss or use proxy brush to clean between teeth." The dental clinic's	F 677		

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note, dated 11/21/18, identified "quite a bit of plaque and debri tissue irritated in some areas . . . 6 mo [month] recall. . . ." The record failed to document any further dental appointments, and staff failed to include the current dental care order on the care plan.

During an interview on the morning of 12/19/19, an administrative nurse (#2) verified the care plan failed to include the updated care and assistance needed for staff to complete correct dental care for Resident #16. The nurse manager stated residents' nailcare is completed during the first assigned bath day of the week.

- Review of Resident #31's medical record occurred on all days of survey. The annual MDS, dated 03/14/19, indicated no natural teeth and the quarterly MDS, dated 11/14/19, identified personal hygiene, including nail and oral care, with extensive assist of one staff. The current care plan stated, ". . . Set up supplies for oral care bid. Assist as necessary . . ."

Resident #31's progress notes stated the following:
* 09/08/19, ". . . Resident is extensive assist with all ADLS, grooming, hygiene, and dressing, and bathing. . . ."
* 09/09/19, ". . . Resident is ext. [extensive] assistance for ADL's, dressing, showering, combing hair, and brushing teeth. . . ."

Observation on 12/17/19 at 11:11 a.m. showed two CNAs (#10 and #11) in Resident #31's room performing morning cares. While applying an edema glove to the resident's right hand, a CNA (#10) stated, "He needs nail care." While

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F 677	Continued From page 28 assisting the resident with oral cares, the CNA (#10) asked Resident #31 if he slept with his dentures in last night. The resident responded, "Yes." The facility failed to provide consistent assistance with ADLs which effected residents' hygiene, grooming, and feelings of well-being resulting in frustration/anxiety during meals as well as effecting other residents.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide necessary treatment and care for 2 of 2 sampled residents (Resident #16 and #30) and 1 closed record (Resident #40) with skin injury. Failure to assess, monitor, and implement interventions may result in delayed healing of skin or the development of additional skin issues. Findings include: Review of the facility policy titled "Physician Standing Orders 2019-2020" occurred on 12/19/19. This policy, stated, ". . . Physicians	F 684	1. Resident #30's skin tear to the right wrist and left forearm are healed. Resident #16's bilateral boots to feet were placed on the aide task list on 10/26/2018. On 1/15/2020 it was also placed on the nurses TAR to check for boot placement. Resident #40 is no longer residing in the facility. 2. All residents and new admissions have the potential to be affected. 3. Wound Care and Skin policy was reviewed and updated on 1/2/2020. This	1/23/20

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F 684	Continued From page 29 must be notified for all standing orders activated either by memo or phone call. . . . Superficial wound care: cleanse with normal saline, skin tears may apply steri-strips, abrasions may use telfa dressing or leave open to air, for signs of infection may apply bacitracin ointment BID (twice a day) x 1 week . . ." - Review of Resident #30's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated 11/20/19, identified Resident #30 with severe cognitive impairment and identified extensive assistance of two staff for all activities of daily living. Observation on 12/17/19 at 6:59 a.m. showed Resident #30 to have a dressing on his left forearm and right wrist. Review of physician's orders and the treatment administration record for the months of November and December 2019 lacked any skin care or treatment orders. A nursing note, dated 11/29/19 at 2:35 p.m., stated, "skin tear quarter size on left forearm. . . . skin tear with blood the size of quarter. Treatment: cleaned with saline solution and applied bacitracin gauze and kerlex." During an interview on 12/19/19 at 8:55 a.m., when asked if an investigation of the skin tear was completed and what is the expected treatment/monitoring when a skin tear is identified, an administrative nurse (#5) stated, "the investigation on the skin tear was completed, the standing order for skin treatment is to be written for physician signature and the order transcribed onto the treatment record for ongoing skin/wound treatment/monitoring." The	F 684	policy includes: Notification and treatment orders per practitioner, assessment, staging, description, and measurements of the skin issue. We will notify the provider and expect a response within 24 hours and any skin breakdown will be monitored daily for signs and symptoms of infection. Education was provided to the nursing staff by DON and QA. 4. Skin assessments will be performed weekly by the nurse. If a skin issue is noted, it will be assessed daily, the provider will be notified within 24 hours and orders will be obtained if changes are needed. Treatment will be placed on the TAR and interventions will be included on the care plan. DON/QA will perform audits weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI meetings, quarterly QA meetings, and monthly at the board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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administrative nurse (#5) confirmed the standing order for wound care was not written or transcribed onto the treatment record, and routine skin care was not provided for Resident #30.

- Review of Resident #40's medical record occurred on 12/19/19.

A nurse's note, dated 09/08/19 at 10:47 p.m., stated, ". . . A skin tear to right inferior [sic] upper arm was evident but of unknown etiology as it was present prior to cna [certified nurse assistant] beginning care. Resident unable to articulate how injury occurred. Wound measured 3 cm [centimeters] x 2 cm. Nurse tried to rehydrate edges in order to re-approximate but was unsuccessful. Bacitracin applied to wound bed and secured with a non-adhering dressing. . . . physician notified via fax."

The record lacked documentation of any physician response or skin treatment orders for the skin tear identified on 09/08/19 and lacked documentation of ongoing assessment and monitoring of the skin tear.

During an interview on 12/19/19 at 9:45 a.m., when asked if an investigation of the skin tear was completed, an administrative nurse (#5) stated "The investigation on the skin tear was completed" and confirmed facility staff failed to implement skin assessment, monitoring, or treatment for Resident #40.

- Observation on the morning of 12/17/19 showed Resident #16's padded foot boots laying on the floor. When asked if the resident had the

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F 684	Continued From page 31 boots on before starting morning cares, the CNA (#7) stated no. Resident #16's current care plan stated, "Resident Care . . . Bilateral boots * Boots to bilateral lower extremities while in bed to prevent skin breakdown. . . ." During an interview on the morning of 12/19/19, an administrative nurse (#2) verified staff should place the boots on Resident #16 each night.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on closed record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment and services to prevent the occurrence and promote the healing for 1 of 1 resident (Resident #40) reviewed who developed a pressure ulcer after a decline in health condition. Failure to evaluate risk factors that may impact the development/healing of a	F 686	1. Resident #40 is no longer a resident in this facility. 2. All residents and any new admissions that are at risk for pressure ulcers have the potential to be affected. All residents were assessed using the Braden scale and skin assessments (if a new resident),	1/23/20

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F 686	Continued From page 32 pressure ulcer, implement, monitor, and modify interventions to reduce risk factors, and/or provide treatment to prevent and/or heal the development of new pressure ulcers resulted in Resident #40 developing an avoidable, facility-acquired pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" occurred on 12/19/19. This policy, revised October 2010, stated, "Assessment and Recognition: The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss . . . the nurse shall assess and document/report the following: . . . full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue . . . Resident's mobility status, current treatments, including support surfaces, . . . The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc). and application of topical agents. . . . During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated . . ." Review of Resident #40's medical record	F 686	by the nurse. Assessment forms are in Point Click Care. All nurses complete the assessments, typically during the day. Measurements will be documented on the TAR to ensure continuing of care. Descriptions will be placed in a progress note. 3. Skin and Wound Care policies were updated on 1/2/2020 by DON to include that the physician will be notified of a developing pressure ulcer and a response will be received within 24 hours. Orders will be implemented when received. Residents pressure site will be monitored weekly and measurements taken at that time. Education will be provided to the nursing staff on 1/21/2020 by DON and QA/IC. 4. Audit includes: observation, location of wound, stage, length, width, depth, exudate, signs and symptoms of infection, description, and treatment orders. Description will be documented in progress notes and care plan. Appropriate documentation will include everything in the audit. DON/QA will audit weekly X4, monthly X2, and quarterly X3 to determine if interventions and appropriate documentation are in place for those residents at risk or those residents with a pressure ulcer. Audit results will be reported at the monthly QAPI meetings, quarterly QA meetings, and monthly board meetings by QA. 5. Corrective actions will be completed by	

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F 686	Continued From page 33 occurred on 12/19/19. Diagnoses included dementia, chronic obstructive pulmonary disease, osteoarthritis, and a hospitalization from 09/26/19 to 10/04/19 for pneumonia. The Minimum Data Set (MDS), dated 10/10/19, identified severe cognitive impairment and extensive assistance of one to two staff for all activities of daily living. The care plan stated, ". . . Focus: Pressure Ulcers/Skin Issues: [name of resident] may be at risk related to decreased mobility . . . Interventions: . . . check all skin areas with am and pm cares and with showers for reddened or open skin areas. If noted, report to charge nurse . . . selan cream to buttocks and coccyx after each incontinent episode . . ." A dietary note, dated 10/04/19, stated, "Nutrition/Dietary note: nutrition screening indicates malnutrition . . . weight has decreased from 105-108 % range last year to 88# [pounds] on hospital admission this week. She has significant weight loss and underweight status. Patient was hospitalized with pneumonia and readmitted to Care Center today. . . " A Restorative Program note, dated 10/05/19, stated, "Resident returned from hospital on 10/04/19. Spoke with resident's son [name] today re: [regarding] restorative nursing. He [son] would like walking program discontinued at this time, but would like to cont [continue] the AAROM [assisted active range of motion] / PROM [passive range of motion] program to her B [bilateral] UE [upper extremities]/LEs [lower extremities]. Also spoke with resident's granddaughter who is a nurse, and she would like a w/c [wheelchair seating] evaluation for resident, as she is not sitting well when eating	F 686	1/23/2020.	

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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 686	Continued From page 34 and up in w/c. . . ." The Occupational Therapy (OT) documentation showed the following: * 10/08/19 at 1:10 p.m., ". . . has been experiencing a significant decline and was recently hospitalized for pneumonia. She has also had a significant weight loss recently. . . . OT recommended device for neck positioning. A small soft cervical collar was trialed by OT . . . which did provide improved neck and head position. Resident did not voice any concerns, pain, behaviors, or behaviors indicating discomfort. . . ." * 10/15/19 at 11:55 a.m., ". . . has improved position with her neck during meals with the use of the soft cervical collar. She is eating better due to this. . . ." The nursing documentation showed the following: * 09/26/19 at 10:56 a.m., ". . . Resident admitted to hospital for pneumonia/observation. . . ." * 10/04/19 at 6:31 p.m., "Resident returned from the hospital to facility @ [at] 10:30 via wheelchair. . . " * 10/05/19 at 10:46 p.m., "Resident on Cefuroxime Axetil antibiotic for pneumonia. Tolerating the medication well. No rash, nausea, vomiting or diarrhea noted. On 2L [liters] of continuous oxygen per nasal cannula. Turned every 2 hours. . . ." * 10/08/19 at 6:39 p.m., "Resident completed Cefuroxine treatment for pneumonia. There was no adverse reactions noted, . . ." * 10/19/19 at 2:40 p.m., "Resident was being cleaned and changed by aide [name of aide] and discovered a small pressure ulcer on the sacrum	F 686		

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F 686	Continued From page 35 area, Nurse [name of nurse] came in and measured the area, which was 1.5 inches x 1 inch. Barrier cream was applied and we have started a turning sheet for all aides to sign when the resident is repositioned, which will be every 2 hours. There was no depth measured. . . . [name of physician] was notified via fax" * 10/20/19 at 11:38 a.m., ". . . Resident has been refusing to eat or drink over the weekend. . . . Family is aware and wants her to be kept comfortable." * 10/25/19 at 11:52 a.m., "Received a verbal order from provider for comfort measures only. . . ." * 10/28/19 at 2:13 p.m., CNA [certified nurse aide] [name of staff] and CMA [certified medication aide] [name of staff] was in changing the brief of the resident and noticed a pressure sore in the sacrum area. I went in to measure it. It was 6 x 4 inches. The area was cleansed and barrier cream applied. . . ." A physician visit note, dated 10/24/19, stated, ". . . [name of resident] has been placed on comfort care by her family. She is resting quietly. Most of her medications have been stopped. She had a small skin tear on her right arm. This is healing well . . . Weight 95.2 pounds which is stable. She is resting quietly in bed. She moans occasionally when she is examined. Her mucous membranes are slightly dry. The skin is supple. . . ." As per facility policy, the facility failed to: * Assess and document an individual's significant risk factors for developing pressure sores, * Document the stage of the ulcer, characteristics of the ulcer, and presence of pain, * Failed to obtain pertinent orders related to	F 686		

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F 686	Continued From page 36 wound treatments, wound cleansing, dressings, and application of topical agents, * During resident visit, the physician failed to evaluate and document the progress of wound healing of a pressure ulcer, * Update the care plan at the time Resident #40's pressure ulcer was first identified. During an interview on 12/19/19 at 10:20 a.m., when asked what is expected once a pressure ulcer is identified, an administrative nurse (#5) stated, "an order would be placed on the treatment record for skin assessment and wound measurement to be completed weekly." The administrative nurse (#5) confirmed staff failed to implement skin assessments, monitoring, and treatment or modify the plan of care. The record identified staff failed to respond timely to a change in the resident condition and lacked communication with the physician at the time a pressure ulcer was first identified. Staff failed to update the care plan or complete a full assessment of the pressure ulcer to include stage, skin condition, or take measurements from 10/19/19 to 10/28/19 (nine days later) which resulted in deterioration and increase in size of the pressure ulcer to Resident #40.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 687		1/23/20

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F 687	Continued From page 37 medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide foot care for 1 of 4 sampled residents (Resident #30) who required nail trimming by a qualified professional. Failure to provide nail care by qualified professionals may result in the development of foot problems or complications from disease processes. Findings included: Review of Resident #30's medical record occurred on all days of survey. Diagnoses included type 2 diabetes and cerebrovascular disease. The Minimum Data Set (MDS), dated 11/20/19, identified severe cognitive impairment and extensive assistance of one to two staff members required for all activities of daily living. Observation on 12/17/19 at 7:09 a.m. showed a certified nurse assistant (CNA) (#10) removed Resident #30's socks as part of morning cares and observed to have long nails on all toes of both feet. During an interview the afternoon of 12/18/19, an administrative nurse (#2) reported the podiatrist visited the facility every two weeks. The administrative nurse (#2) acknowledged Resident #30 had not been seen by podiatry since his/her admission to the facility in November 2019, as	F 687	1. Resident #30's toe nails were trimmed on 1/23/2020. 2. All current residents and new admissions have the potential to be affected. Review of all residents will be completed by 1/23/2020 to determine if they are on a scheduled podiatrist's list on the TAR for the nurse to perform. 3. Foot care policy was updated on 12/26/2019 to include consultation with podiatrist for residents that have a diagnosis of PVD & Diabetes. Education will be provided to nursing staff on 1/21/2020 by DON and QA/IC. 4. Foot care audits will include: schedule on TAR, date nails were trimmed by the podiatrist or nurse, and through observation. Audits will be performed by QA/designee weekly X4, monthly X2, and quarterly X3. Results of the audits will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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F 687	Continued From page 38 staff failed to add Resident #30 to the podiatry list.	F 687		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 07/11/19. Based on observation, record review, and resident and staff interviews, the facility failed to document consistent weights or to offer fluids for 2 of 2 sampled residents (Resident #9 and #22) who were not offered fluids during cares or had inaccurate weights. Failure to ensure accuracy of	F 692	1. Resident #9 and #22's weights were rechecked on 12/29/2019 to establish a current baseline weight. Resident #9 and #22 were placed on the task list to offer fluids at meals and in between meals (0600, 0930, 1300, 1530, and 2000). 2. All current residents and new admissions have the potential to be affected regarding documentation of	1/23/20

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F 692	Continued From page 39 residents' weights (Resident #9) may result in difficulty assessing actual weight loss/gain and failure to ensure staff provided assistance with fluid intake (Resident #22) may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "WEIGHT ASSESSMENT AND INTERVENTION" occurred on 12/19/19. This policy, reviewed November 2018, stated, ". . . The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. . . . 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. . . ." - Review of Resident #9's medical record occurred on all days of survey. Progress notes, dated 10/17/19, 11/16/19, and 11/26/19, indicated the resident had experienced weight loss. The current care plan stated, ". . . Goal: [resident's name] will attempt to maintain a weight of 175 to 185 [pounds] . . ." Review of Resident #9's weight record from September 17 through December 15, 2019 identified the following: * 09/17/19 182.2 lbs (pounds) * 09/22/19 183.4 lbs * 09/29/19 195.2 lbs (6.43% gain from last weight with no reweigh completed) * 10/06/19 181.6 lbs (6.97% loss from last weight with no reweigh completed) * 10/20/19 179.6 lbs * 10/27/19 176.2 lbs	F 692	weights. All current residents and new residents that are dependent for fluid intake and/or at risk for dehydration have the potential to be affected. These residents have been identified. 3. Weight policy was updated to include the resident will be reweighed if weight is above or below 3lbs. Hydration policy was updated to add those residents who are at risk for dehydration to the task list. Dining and nutrition policy was updated to include supplement use. Staff education was provided by the DON. 4. Hydration audit includes: observation during meal times & cares. Review of the task list 3 times a week during all shifts and meals and will continue with schedule if deemed necessary and will be audited by DON/Dietary weekly X3, monthly X2, and quarterly X3. Weight audit includes all weights completed each week and a comparison to the previous weight will be completed. It also includes if the resident was reweighed for a weight loss or gain of 3 pounds and will be audited weekly X4, monthly X2, and quarterly X3. Audits will be reported at the monthly QAPI, quarterly QA meetings, and the monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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F 692	Continued From page 40 * 11/03/19 175.4 lbs * 11/10/19 166.6 lbs (5.02% loss from last weight with no reweigh completed) * 11/24/19 182.4 lbs (9.48% gain from last weight with no reweigh completed) * 12/01/19 180.0 lbs * 12/08/19 181.3 lbs * 12/15/19 208.0 lbs (14.73% gain from last weight with no reweigh completed) During an interview on 12/18/19 at 3:29 p.m., an administrative nurse (#2) confirmed the facility had problems with staff forgetting to deduct the weight of the wheelchair and stated the nurse on duty should have requested reweighs for Resident #9's out-of-range weights. The facility failed to reweigh Resident #9 per facility policy which resulted in inaccurate weight loss/gain assessments. - Review of Resident #22's medical record occurred on all days of survey and included diagnoses of anxiety, vascular dementia with behavioral disturbance, contracture right hand, quadriplegia, blindness one eye (right), and aphasia. The current care plan stated, ". . . Assess for s/s [signs and symptoms] of UTI [urinary tract infection] . . . Assist and encourage fluids before leaving his room and when he is in the common area. . . ." Review of the quarterly Minimum Data Set, dated 10/25/19, identified an extensive assist of one with eating. Observation on 12/16/19 at 5:34 p.m. showed Resident #22 at the dining room table in his/her wheelchair. An unidentified certified nurse aide (CNA) poured a tablemate's fluids into glasses	F 692		

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F 692	Continued From page 41 and left. At 5:45 p.m. another CNA offered Resident #22 a beverage in a nosey cup and left the table. At 5:50 p.m. a CNA (#7) sat down at the table and assisted the resident with fluids and jello. When the meal tray was served, the CNA (#7) continued assisting the resident. Staff failed to provide consistent assistance with fluids/meal. Observation on 12/17/19 at 7:00 a.m. showed Resident #22 in his/her wheelchair in front of the television near dining room area. At 7:50 a.m. staff placed the resident at the dining room table. The resident grabbed and pounded a closed beverage carton on the table. At 8:00 a.m. a licensed nurse (#9) sat down with the resident, poured three beverages into nosey cups, and offered them to the resident. When the nurse left the table, the resident placed the milk cup inside the water cup which spilled on the table. At 8:15 a.m. staff served the resident's breakfast tray, and a staff member sat down to assist the resident with eating/drinking. Staff failed to provide consistent assistance with fluids for at least one hour. Observation on 12/17/19 at 5:17 p.m. showed two CNAs (#7 and #8) transferred the resident from his/her bed to the wheelchair and transported the resident to the dining room table. Staff failed to offer the resident fluids after cares and before serving the supper tray at 5:50 p.m. Staff failed to assist the resident at the dining table. The facility failed to assist with and encourage fluids for Resident #22.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		1/23/20

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F 695	Continued From page 42 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure proper respiratory care for 1 of 2 sampled residents (Resident #9) with orders for oxygen therapy. Failure to ensure oxygen is administered and provided as ordered may complicate a resident's respiratory status. Findings include: Review of facility policy titled "OXYGEN ADMINISTRATION" occurred on 12/19/19. This policy, dated January 2018, stated, ". . . STEPS IN THE PROCEDURE . . . 5. Turn the oxygen to the Practitioner's prescribed flow rate. . . . 7. Adjust the oxygen delivery device so that . . . the proper flow of oxygen is being administered. . . . ASSESSMENT If the resident's Practitioner has ordered continuous oxygen or oxygen to keep sats [saturation - oxygen level in the blood] greater than specific parameters, the following will be assessed and documented in PCC [point click care]: . . . 3. Oxygen flow rate . . ." Review of Resident #9's medical record occurred on all days of survey and indicated a diagnosis of	F 695	1. Resident #9: nurse signed off on the TAR for O2 use and flow rate with O2 sats twice a day prior to survey. On 1/15/2020 it was also added to check four times a day to determine accurate flow rate & that O2 was turned on. 2. All current residents and new admissions that require O2 use have the potential to be affected. All residents orders were checked to determine oxygen use. Oxygen flow rate was placed on the TAR to be checked by the nurse QID and to check if oxygen is turned on for those residents that are also receiving oxygen on 1/15/2020. 3. Oxygen administration policy and procedure was reviewed and updated on 12/26/2019 to check the flow rate by looking at the flow rate monitor at eye level. Nursing staff will be educated on updated policy on 1/21/2020 by DON and QA/IC. 4. Audits will include observation on all	

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F 695	Continued From page 43 hypoxemia. A physician order, dated 09/23/19, stated, "02 [oxygen] sats 2-4 [2 to 4] LPM [liters per minute] to keep sats > [greater than] or = [equal to] 89% every shift for respiratory symptoms." The December 2019 treatment administration record indicated the resident received 2 liters of oxygen with each documented entry. Observation on 12/16/19 at 3:42 p.m., 12/17/19 at 7:10 a.m. and 4:33 p.m., and 12/18/19 at 11:21 a.m. showed Resident #9 resting in bed with oxygen on per nasal cannula and the oxygen concentrator set at 1.5 LPM. Observation on 12/16/19 at 4:06 p.m. showed Resident #9 seated in the dining room with oxygen on per nasal cannula and the oxygen concentrator (brought from the resident's room) set at 1.5 LPM. At 6:09 p.m. an unidentified CNA switched Resident #9 from use of an oxygen concentrator to a portable oxygen tank and failed to turn the tank on. Observation on 12/17/19 at 8:53 a.m. showed Resident #9 seated in the dining room, oxygen on per nasal cannula attached to a portable oxygen tank, and the flow rate set at 2 LPM. Inspection of the portable oxygen tank showed the regulator gauge registered the oxygen tank as empty and not turned on. The facility staff failed to provide Resident #9 oxygen at the ordered flow rate of 2-4 LPM when the oxygen concentrator utilized. The facility staff also failed to turn on the portable oxygen tank when used.	F 695	residents receiving oxygen regarding flow rate and that oxygen is turned on. This will be documented on the TAR. QA/designee will perform audits weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI meetings, quarterly QA meetings, and the monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	
F 700	Bedrails	F 700		1/23/20

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F 700 SS=D	Continued From page 44 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. 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 a resident's risk of entrapment and attempt alternatives for 1 of 4 sampled resident (Resident #90) reviewed for side rail use. Failure to assess the resident's use of the bed rails, when the facility changed the resident's bed, may result in the bed rails being a restraint for the resident. Findings include:	F 700	1. Resident #90 is currently using bedrails and has a consent, assessment, and order in place as of 1/15/2020. Bedrails also checked for care plan on 1/15/2020. Bedrail assessments will be completed by the MDS coordinator quarterly. 2. All residents or new admissions requesting or requiring a side rail have the potential to be affected. All residents were reviewed to determine current side	

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F 700	Continued From page 45 Review of the facility policy titled "Bedside Rails" occurred on 12/19/19. This policy, dated 08/31/17, stated, "Policy: Bedside Rails will only be utilized at residents request, for bed control purposes, or for resident safety. Policy Explanation and Compliance Guidelines: 1. Due to the restraint effect of bedside rails, our facility discourages the use of bedside rails. 2. If a resident requests a bedside rail for bed controls or a positioning aide, the resident requesting a bedside rail will have to undergo an evaluation for a bedside rail. . . ." Review of Resident #90's medical record occurred on all days of survey. The last "Side Rail Evaluation," completed by the facility, dated 12/12/18, identified one side rail utilized to assist Resident #90 to exit the bed. A quarterly Minimum Data Set (MDS), dated 11/12/19, identified Resident #90 did not use side rails. Observations on all days of survey showed Resident #90's bed rails elevated on both sides of the head of the bed. During an interview on 12/19/19 at 12:00 p.m., two administrative staff members (#2 and #3) identified the MDS as correct as the resident requested the prior single rail be removed. Both (#2 and #3) identified the facility changed Resident #90's bed on return from the hospital (11/27/19), and the facility failed to complete the "Side Rail Evaluation." The record failed to show staff completed an assessment for side rail safety and appropriate use of the rails, attempted alternatives to the rails, explained the risks/benefits of the rails,	F 700	rail use on 1/15/2020 which included a consent, assessment, order, and care plan. 3. Bedrail policy was reviewed and updated on 12/26/2019. Education will be provided to nursing staff on 1/21/2020 by DON and QA/IC. 4. Audits will include Physician order for rail, consent received, assessments completed to include observation for safety, and that the bed rails are care planned. DON/Designee will audit the use of bedrails weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective action will be completed by 1/23/2020.	

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F 700	Continued From page 46 including a risk of entrapment; or obtained consent from the resident/resident representative for the use of the side/bed rails for Resident #90.	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on information provided by complainants, review of facility policy, Resident Council interview, review of staffing schedules,	F 725	1. Care plans were updated for the following residents: Resident #9: care plan was updated to	1/23/20

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F 725	Continued From page 47 anonymous resident, family, and staff interviews, the facility failed to ensure the availability of sufficient nursing staff to promptly respond to residents' needs for 1 of 1 confidential resident/family interview (A), confidential resident group interview (Resident C, E, and F), 7 of 7 sampled residents (Resident #9, #16, #22, #30, #31, #37, and #90), and 1 supplemental resident (Resident #14) interviewed and/or observed during the survey. Failure to provide sufficient staffing for resident needs/assistance may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Information provided by the complainants indicated the facility failed to promptly respond to resident needs including Activities of Daily Living (ADLs) (oral care, trimming fingernails, and dining assistance), answering call lights, refreshing/filling water pitchers, cleaning resident wheelchairs, and ensuring staff members were present during meals. ADLs See F677 regarding ADLs (oral care, fingernail care, dining assistance) for Resident A, #9, #16, #22, #30, and #31. CALL LIGHTS - Review of Resident Council minutes regarding call lights showed: * 10/07/19, ". . . Old Business: . . . CNA's [certified nurse aide] still coming in and shutting off the call lights and forgetting to come back. . .	F 725	reflect denture care preferences, assistance with dining, fingernail care, call light will be within reach and answered in a timely manner. Call light audit to include lights under 5 minutes and lights over 5 minutes. Wheelchairs will be cleaned weekly or PRN if needed. A tag will be added to the wheelchair stating the last date it was cleaned and will be updated with each subsequent cleaning. Resident will be monitored by nursing staff during meal times. This includes a minimum supervision to max assist X1 depending on the day. Water pitcher will be refilled/refreshed per facility schedule and PRN. Resident #16: Oral cares offered twice a day as resident allows by staff. She will have nail cares every two weeks and as needed. She is independent with dining. Her call light will be within reach and will be answered in a timely manner. Her water pitcher will be refilled/refreshed per facility schedule and PRN. Resident #22: requires sedation with teeth cleaning. Oral cares will be performed two times a day as resident allows by staff. Assistance with meals provided by staff. Fingernails were trimmed on 12/20/2019 and will be trimmed every two weeks or as needed. Call light will be within reach and answered in a timely manner. Call light audit to include lights under 5 minutes and lights over 5 minutes. Wheelchair will be cleaned weekly or PRN if needed. Tag will be added to the wheelchair stating the last date cleaned and will be updated with	

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F 725	Continued From page 48 ." * 11/04/19, ". . . Nursing: Shortage is an issue having to wait for staff still . . ." * 12/02/19, ". . . Old Business: . . . Workers are coming in to shut off call light and say to the resident that someone will be right back but 15 to 30 minutes will pass before someone comes back. . . . Nursing: Resident are waiting a long time after pushing their call button, then someone comes into room shuts off call light and says someone will be right back but they have another long wait. . . ." - During a group interview on 12/17/19, at 4:00 p.m., Resident F reported they (the residents) wait 20 minutes for staff to answer call lights. Resident E reported staff come in and say they will return but do not come back. Resident C also reported this happens and takes twenty minutes or more for someone to return. - During an interview on 12/17/19 at 8:51 a.m., Resident #37 reported she activated her call light at 7:10 a.m., and her call light was answered at 7:50 a.m., and staff placed her on the bedpan. Resident #37 reported she turned her call light on twice in the past hour and staff entered her room, turned the call light off, and said they would be back. Observation at 8:57 a.m., showed a CNA (#10) entered Resident #37's room and offered assistance off the bedpan (an hour after staff placed Resident #37 on the bed pan). WATER PITCHERS - Review of Resident Council minutes regarding water pitchers showed: * 10/07/19, ". . . The filled water cups are not	F 725	each subsequent cleaning. Resident will be monitored by nursing staff during meal times. This includes a minimum supervision to max assist X1 depending on the day. Water audit will be completed to include task list observation of thickened water offered. Resident #30: oral cares will be performed two times daily as resident allows. Fingernails will be trimmed every two weeks as necessary. Independent with eating after set up. Call light will be within reach and answered in a timely manner. Call light audit to include lights under 5 minutes and lights over 5 minutes. Wheelchair will be cleaned weekly or PRN if needed. Tag will be added to wheelchair stating the last date cleaned and will be updated with each subsequent cleaning. Resident will be monitored by nursing staff at meal times. The includes a minimum supervision to max assist X1 depending on the day. Water audit will be completed to include task list observation of thickened water offered. Resident #31: oral cares will be performed twice a day as the resident allows. Fingernails will be trimmed every two weeks as necessary. Independent with eating. Call light will be within reach and answered in a timely manner. Call light audit to include lights under 5 minutes and lights over 5 minutes. Water pitcher will be refilled/refreshed per facility schedule and PRN. Resident #37: Oral cares will be completed twice a day if the resident	

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F 725	Continued From page 49 making it back to the night table and if they are put back they are out of reach. . . ." * 12/02/19 ". . . Old Business: Water bottles still an issue and some not being filled overnight. . . ." - During a group interview on 12/17/19 at 4:00 p.m., Resident C reported he/she requested water and it takes two to three hours to get it. Resident E stated he/she sees staff passing water, and they don't give water to everyone. Resident C shared once staff brought the pitcher with only ice and filled it with water from the sink, which tastes bad. Resident C was told it is all the same, and the resident replied, "If it's all the same why is there a filter on the water machine?" - An observation on 12/16/19 at 11:35 a.m. showed an unidentified nurse brought Resident #37's medications to her room. The nurse offered Resident #37 her water mug, and the resident stated, "that water is from last night." The nurse took the water mug and exited the room. Resident #37 reported staff fill her water mug only once a day, but she drinks a lot of water and must ask staff to refill it. - An observation on 12/18/19 at 3:37 p.m. showed Resident #90 put on his call light to ask for water. An unidentified CNA answered the light at 3:39 p.m. At 4:00 p.m. Resident #90 stated he asked for water and had not received it yet. At 4:58 p.m. Resident #90 stated, "I just got my water" and indicated the nurse put ice in it for him. Staff failed to fulfill the resident's request for water until 79 minutes later. WHEELCHAIR CLEANING	F 725	allows. Finger nails will be trimmed every two weeks and prn. Resident is independent with eating. Call light will be within reach and monitored by audited for timeliness of response. Wheelchair will be cleaned weekly and the tag will be updated to reflect the current date it was last cleaned. Water pitcher will be refilled/refreshed per facility schedule and PRN. Resident #90: oral cares will be completed twice a day if the resident allows. Fingernails will be trimmed every two weeks and PRN. Resident does not require dining assistance. The call light will be monitored by audit for timeliness of response. Water audit will be completed to include task list observation of thickened water offered. Wheelchair will be cleaned weekly and tag will be updated to reflect the current date it was last cleaned. Resident #14: deceased. 2. All residents have the potential to be affected. 3. In addition to the above audits: a) weekly finger nail care beauty shop for male & female residents, CNA will be available to trim fingernails. This will be provided by the bath CNA which is in addition to our staffed CNAs on Beauty Shop Day. Each resident has their own 2 fingernail and toenail clippers which are kept in individual holders. These are kept with the manicure table located in the beauty shop. Each container has a	

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F 725	Continued From page 50 - Review of Resident Council minutes regarding cleaning of wheelchairs showed on 12/02/19, ". . . Nursing: . . .Wheel chairs and walkers are not being cleaned. . . ." - During a group interview on 12/17/19 at 4:00 p.m., Resident F reported staff have cleaned his/her wheelchair three times and only once returned it to my room. Resident C reported he mentioned cleaning his wheelchair at a meeting 5-6 months ago and staff have washed it once. See F584 regarding wheelchair cleaning for Resident #15 and #30 SUPERVISION IN DINING ROOM - During a group interview on 12/17/19 at 4:00 p.m., when asked about staff in the dining room, Resident F stated, "No improvement until you came." None of the residents in attendance contradicted the statement and three agreed. - Observation on 12/16/19 at 11:45 a.m. showed Resident #9 seated at the dining room table taking small bites of food. At 12:12 p.m., an unidentified CNA stopped by the resident's table and stated, "[Resident's name], aren't you hungry?" The resident shook head no, and the CNA walked away. The CNA failed to take time to encourage Resident #9 to eat or to address possible reasons the resident was not eating. - Observation on 12/16/19 at 11:59 a.m. showed Resident #14 seated at the dining room table taking small bites of food and dozing off in between. At 12:18 p.m., the resident awakened, pushed her wheelchair away from the table, and	F 725	fingernail clipper, toenail clipper, emery board, and orange stick. These are cleaned using barbiside. b) Dental visits scheduled per insurance parameters. Medicaid residents are allowed 1 cleaning visit per year. All other residents will be scheduled every 6 months for cleaning if resident consents. Visits will be documented in the progress notes and on an audit form. c) The bath aide will monitor residents in the East dining room prior to breakfast and lunch. One CNA will be assigned on rotation for the supper meal. d) Call light audit to determine areas of need e) Water pass three times per day; Activities and Therapy will also offer fluids. Activity staff will offer thin liquids to all but 3 residents. These residents will have thickened liquids that are obtained from nursing staff. f) Wheelchair cleaning audits, nurse will sign off; wheelchairs and walkers will be tagged with date of last cleaning g) Schedule revised to include a bath aide. We have added a bath aide to the schedule. This will fluctuate with census. There are 5-6 CNAs on the floor during the day all week, including the weekend. We are working on obtaining one more CNA. Education was provided in all areas of non-compliance by DON and QA/IC. 4. Audits will include fingernail care, dental visits, assistance with dining, call lights, water pass, wheelchair cleaning,	

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F 725	Continued From page 51 self-propelled out of the dining room. Staff failed to offer encouragement/assistance during this time. - During an interview on 12/18/19 at 4:25 p.m., an administrative nurse (#2) identified on the West dining room, one CNA is assigned to the area during the meal, and administrative staff supplement the assigned staff member as they can. STAFFING/SCHEDULING - During an interview on the morning of 12/19/19, an administrative nurse (#2) indicated a staffing goal of five CNAs during the day shift. - Review of the facility schedule from December 1 through December 19, 2019 showed five CNAs scheduled during 11 of 19 dayshifts, four CNAs scheduled on seven dayshifts, and three CNAs scheduled on one dayshift. - Anonymous CNA staff interviews (#12, #13, and #14) occurred throughout survey and identified the following: * CNAs' responsibilities included all resident personal cares, getting residents up and assisting them to lie down for naps, walk to dine programs, dining assistance (including feeding), vital signs, passing ice water, restocking supplies, and charting * Usually not enough time to complete all responsibilities/tasks. May not complete stocking supplies, vital signs. Charting has to be completed * Many times CNA shifts are up to 16 hours in length to help cover the evening or night shifts	F 725	staffing, and observations. DON/QA will perform audits weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective actions will be completed by 1/23/2020.	

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F 725	Continued From page 52 * CNA staffing includes three CNAs on the East units and one CNA on the West units * If five CNAs are on the dayshift, one CNA is the bath aide. If less than five CNAs are on the dayshift, then each CNA is responsible for resident baths plus the other tasks. The facility failed to provide sufficient staffing to meet the needs of and assistance required by residents.	F 725		
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; §483.55(a)(4) Must if necessary or if requested,	F 790		1/23/20

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F 790	Continued From page 53 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, and resident and staff interview, the facility failed to assist in obtaining dental care to meet the needs of 2 of 2 sampled residents (Resident #16 and #26). Failure to assist the resident in making an appointment or follow-up appointment may result in delayed dental care and/or dental complications. Findings include: - Observation on the mornings of 12/16/19 and 12/17/19 showed Resident #16's teeth heavily coated with a plaque-like substance and discolored. When questioned on the afternoon of 12/18/19 about oral hygiene, the resident stated staff frequently failed to provide assistance with oral care, and staff have not made a dental appointment for a long time. The resident stated she/he would like to see a dentist. Review of Resident #16's medical record occurred on all days of survey. The quarterly	F 790	1. Resident #16 will be scheduled for a dental appointment by 1/21/2020. Resident #26 was not scheduled for a dental appointment since he refused, Resident #26 will be asked quarterly. Resident's refusals will be documented and will be reevaluated on quarterly oral/dental assessments by MDS Coordinator after oral assessment is completed. 2. All current residents and new admissions have the potential to be affected. All resident records were checked for their last dental appointment. Appointments were scheduled for those residents that consented that did not have an appointment in the last 6 months. 3. Routine and Emergency Dental Services policy was updated on 1/15/2020 and staff were educated on 1/21/2020 by the DON. Quarterly	

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F 790	Continued From page 54 Minimum Data Set, dated 10/10/19, identified moderately impaired cognition and personal hygiene (including oral care) with extensive assist of one staff. The current care plan stated, "Personal Hygiene/Oral Care . . . Set up supplies for oral cares bid [twice daily]. Assist if necessary. [Resident] has . . . own teeth. . . ." A physician's order, dated 11/21/18, stated, "[Resident] should be encouraged and helped brushing her teeth 2 times a day concentrating on along her gum tissue and floss or use proxy brush to clean between teeth." The dental clinic's note, dated 11/21/18, identified, "quite a bit of plaque and debri tissue irritated in some areas . . . 6 mo [month] recall. . . ." The record failed to document any further dental appointments, and staff failed to include the current dental care order on the care plan. During an interview on the morning of 12/19/19, an administrative nurse (#2) verified the care plan and the certified nursing assistant's (CNA) Bedside Kardex Report failed to include the updated care and assistance needed for staff to complete correct dental care, and the facility had made no follow-up appointment after the 11/21/18 dental appointment. - During an interview on the afternoon of 12/16/19, Resident #26 stated, "I haven't seen a dentist since I've come here. I still have a few teeth left." Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, ". . . Arrange for a dental exam when [Resident] requests one. Arrange for	F 790	assessments includes questions about whether residents would like a dental appointment. This assessment will be located under the assessments tab. Dental appointments are documented in the progress notes. This policy includes lost or damaged dentures. 4. Nurse/designee will audit dental appointments and follow up weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective actions will be completed by 1/23/2020.	

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F 790	Continued From page 55 transportation if necessary. . . ." The medical record failed to document if staff periodically discussed the resident's wishes for a dental appointment. During an interview on the morning of 12/19/19, an administrative nurse (#2) verified Resident #26 had not seen a dentist since 2015.	F 790		
F 812 SS=D	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 manufacturers' labeling, and staff interview, the facility failed to properly store protein supplements in 2 of 2 nutrition centers (East and West). Failure to identify the expiration date of a protein based	F 812	1. 9 containers of Plus 2 supplements at the east nutrition center were removed and disposed of on 12/20/2019. 2 cartons of Plus 2 supplements were removed and disposed of on 12/20/2019.	1/23/20

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 12/19/2019

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 812	Continued From page 56 supplement and to dispose of an expired beverage has the potential to result in altered potency of the supplements and/or foodborne illness. Findings include: Review of the Plus 2 manufacturers' label showed the following: "Store Frozen. Thaw at or below 40 [degrees Fahrenheit] Use thawed product within 14 days. Keep refrigerated." Observation during the dietary tour on 12/19/19 at 8:30 a.m. with a dietary staff member (#1) showed the following thawed, undated, and expired items: - East nutrition center refrigerator: nine containers of Plus 2 supplement, thawed and undated. - West nutrition center refrigerator: two cartons of Plus 2 supplement, thawed and undated and one container that identified a thaw date of 11/16/19 (33 days past thaw date). During the tour, the dietary staff member (#1) identified she expected staff to put a thaw date on the Plus 2 supplement and to use it within 14 days.	F 812	2. All residents receiving the supplements have the potential to be affected. 3. Supplement policy will be updated by 1/23/2020. Policy will include Dietary and Nursing staff will be educated on documentation of thaw date, open date, and to use within 14 days of thaw date by Dietary Manager/DON. 4. Dietary/CMA will audit supplements for outdates/no dates in all kitchen areas weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective actions will be completed by 1/23/2020.	
F 880 SS=D	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	F 880		1/23/20

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WESTERN HORIZONS CARE CENTER	**1104 HWY 12 HETTINGER, ND 58639**

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F 880	Continued From page 57 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; §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	F 880		

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F 880	Continued From page 58 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. §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 and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 2 of 2 sampled residents (Resident #9 and #22) observed with an uncleanable area on his/her wheelchair. Failure to ensure resident chairs have an intact surface does not allow for proper cleaning and may result in the spread of infection within the facility. Findings include: - Observation on all days of survey of Resident #9's Broda chair showed a padded head rest and left and right lateral support cushions attached to	F 880	1. #9's broda chair head rest and lateral cushions were ordered on 1/15/2020. #22's rock and go chair armrests were ordered on 1/15/2020. 2. All current and new residents that require use of a wheelchair or other specialty chairs have the potential to be affected. All resident's wheelchairs will be inspected for surfaces that are not intact prior to 1/23/2020 by the CPTA. 3. Maintenance of Wheelchair policy will be updated on 1/20/2020 to include the new tags to be applied with the date they	

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F 880	Continued From page 59 the chair with buckle clip straps. The head rest and both of the lateral cushions had several scattered cracks in the vinyl covering. The seam near the strap of the left lateral cushion showed an approximate 3 inch tear with the inner foam exposed. During an interview the afternoon of 12/19/19, an administrative nurse (#2) agreed Resident #9's head rest and lateral cushions are not washable/cleanable surfaces and need to be replaced. - During an observation on 12/17/19 at 5:10 p.m., Resident #22's Rock and Go chair had a large tear in front and below both armrests. The area showed frayed padding extruding from under the covering exposing the metal bar. During an interview on the morning of 12/19/19, an administrative nurse (#2) indicated Resident #22's chair was sprayed/cleaned on a weekly basis and agreed the frayed areas needed repairing.	F 880	were last cleaned after the wheelchairs are washed. Staff education was provided on 1/21/2020 by the DON. 4. We will observe this task and include on the task list. We will use a check list to report to the DON. We will put a tag on the wheelchairs, walkers, Broda Chair, Geri Chair, and Rock-N-Go chair with the date they were last cleaned. CPTA/Restorative nursing will audit maintenance of wheelchairs and specialty chairs weekly X4, monthly X2, and quarterly X3. Audit results will be reported at the monthly QAPI, quarterly QA, and monthly board meetings by QA. 5. Corrective actions will be completed by 1/23/2020.	