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	09/04/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and review of the facility reported incident (FRI) investigation, the facility failed to ensure residents remained free from abuse for 1 of 1 closed record (Resident #40) who experienced sexual abuse from another resident. Failure to protect residents from sexual abuse resulted in fear, anxiety, and mental anguish. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include:The survey team determined a deficient practice existed on 04/27/25. The facility implemented corrective action immediately, completed corrective action on 04/28/25, and continued with staff education and monitoring. Review of the facility policy titled Abuse, Neglect and Exploitation occurred on 09/03/25. This policy, revised May 2025, stated, Each resident has the right to be free from abuse . Residents must not be subject to abuse by anyone, including . other residents . Sexual Abuse is non-consensual sexual contact of any type .The initial FRI, dated 04/28/25, stated, On 4/28/25 OT [occupational therapy] approached DON [director of nursing] and administrator stating [Resident #40] had reported to her that [Resident #15] had put her [sic (his)] hand down her shirt while she was sitting in the dining room, asked her if she liked it, in which [Resident #40] shook her head no. The 5-day FRI investigation, dated 05/01/25, indicated at the end of a therapy session on 04/28/25 staff asked Resident #40 if she would like to stay in her room or go out to main area. Resident #40 replied, I am kind of scared to go out of my room. When asked why, she explained being left alone in the dining room the night before with Resident #15. Resident #40 stated, He touched me, and it really upset me. He reached his hand down my shirt, between my breast, and began rubbing up and down.I don't ever want it to happen again. The facility's review of the dining room video surveillance showed on 04/27/25 at 6:55 p.m. Resident #15 approached Resident #40, rubbed his hand on her chest, and walked away a few moments later.Review of Resident #40's medical record occurred on 09/03/25. Diagnoses included anxiety and post-traumatic stress disorder. An admission Minimum Data Set (MDS), dated [DATE], identified Resident #40 as cognitively intact. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented correction actions for all resident who may be affected by the deficient practice as follows:* Completed an immediate investigation following the incident. * Notified both residents' families of the incident. * Notified the physician of the incident. * Moved Resident #15 to another hallway of the building, occupied by male residents only.* Implemented one-hour checks on Resident #15's location.* Required staff to ensure Resident #15's is not left alone in same room with a female resident. * Educated all staff present during 04/28//25 shift and each shift thereafter, regarding the incident and monitoring Resident #15's location. * Updated care plans for Resident #15 and Resident #40. * Conducted a staff meeting on 05/01/2025 to further educate regarding abuse, and Responding to Resident's Sexually Inappropriate Behavior.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility procedure, review of manufacturer's use instructions, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #8) who fell from a mechanical lift. Failure to safely use the mechanical lift resulted in a fall with injury. Findings include:Review of the facility procedure Use of Hoyer (Full Body) Lift occurred on 09/04/25. This undated procedure stated, . Mechanical Lift from Bed to Chair . Positioned the lift under the bed and widened the base of the lift.Review of the Volaro Series 4 Lift Operator's Manual occurred on 09/04/24. This manual, dated March 2019, stated, . Safety Notes . Lift legs must be fully extended into the wide position when lifting a patient or resident. Lifting from Bed to Chair using the Divided Leg Sling: . If the base is in the narrow position, adjust it to the widest position once you are clear from the bed and always before turning the lift. General Procedure Guide for Training . 19. Check the legs are in the wide position . If base position must remain in a narrow position, make sure the lift area between the bed and chair are clear of any obstacles. Widen once clear from bed.Review of Resident #8's medical record occurred on all days of survey. Diagnoses included hemiplegia [paralysis of one side of the body]. The current care plan stated, . requires Mechanical Lift (hoyer) with (2) [two] staff assistance for transfers.Review of Resident #8's nurse's notes identified the following:*09/02/25 at 9:10 a.m., . [Resident #8] was in the process of being transferred from the bed to the Broda [tilt-in-space mobile positioning chair] chair. [Resident#8] is tall and his legs do not bend so he needs to be placed in the Broda chair sideways. His legs will hit the bar of the lift if he is put in the chair forward. [Resident #8's] foot became entangled in the Broda chair and as a result the hoyer lift began to tilt sideways. One aid grabbed his feet and the other grabbed his head and [Resident #8] was placed on the ground. RN [registered nurse] was paged to the room patient was laying on his back on the floor. Asked patient from top to bottom if any area was hurting him and he stated 'no'. It was noted that his left great toe had a laceration at the time and was bleeding. ER [emergency room] nurse called and EMS [emergency medical services] called. Family notified of transfer to the hospital.*09/02/25 at 09:18 a.m., . Received report from [name] RN at hospital. [Resident #8] has no injuries from the fall. dermabond [a sterile liquid skin adhesive] on . left great toe and steristrips .*09/04/25 at 2:25 a.m., . resident moaned in pain. Knee has some swelling now to it, and he complained of pain upon ROM [range of motion] of Left knee and leg. Will continue to evaluate this leg. Will offer resident an ice pak [sic] to knee.*09/04/25 at 6:55 a.m., . Resident has swelling in his left knee which is migrating up to his Left hip. Ice was applied x2 [two times] which did not offer reduced swelling. Patient c/o [complained of] 10/10 pain upon moving him. This nurse called his son . who requested him being sent to ER for evaluation that may have not been noted on his last ER visit.*09/04/25 at 11:11 a.m., . This nurse spoke to nurse . at [critical access hospital] who stated resident would be transferred out due to left hip fracture .Interviews with staff identified the following:*09/02/25 at 10:50 a.m. a certified nurse aide (CNA) (#3) confirmed the resident fell while she and another CNA (#4) transferred the resident from the bed to the Broda chair. The CNA (#3) confirmed the base/legs of the mechanical lift were closed while they moved Resident #8 from the bed to the Broda chair, the resident's leg caught on the chair, and the lift tipped on it's left side with the resident landing on the floor. The CNA (#3) confirmed staff kept the base/legs closed in order to get the lift under the Broda chair. *09/03/25 at 3:35 p.m., two CNAs (#5 and #6) confirmed they approach Resident #8's Broda chair from the side and the base/legs of the mechanical lift stay closed during transfers. The facility failed to ensure staff widened the base/legs of the mechanical lift while transferring Resident #8. The facility implemented corrective actions for all residents who may be affected by the deficient practice as follows:*Completed an investigation into Resident #8's fall.*Assessed and transferred Resident #8 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	for treatment.*Educated CNAs and nurses on proper mechanical lift use.*Sent an educational message to all CNAs and nurses via the HomeBase scheduling app regarding proper mechanical lift use on 09/04/25.*Educated all CNAs and nurses working 09/04/25 on proper mechanical lift use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, and staff interview, the facility failed to store meds and biologicals appropriately in 2 of 4 medication storage and supply areas (West Wing medication cart and [NAME] Wing medication room). Failure to secure medications in the medication cart and to dispose of expired needles has the potential for unauthorized access of medications and has the potential for inaccurate laboratory results. Findings include:Review of the facility policy titled Expiration of Medications and Supplies occurred on [DATE]. This policy, dated [DATE], stated, . 2. Weekly on every Wednesday, the CMA [certified medication aide]/nurse working on the East and [NAME] Nurses' station will check . the medication room . for . supply expiration dates . Any expired . supplies will be disposed of after removal from . medication rooms .The facility failed to provide a policy regarding locking the medication cart.-Observation on [DATE] of the [NAME] wing medication cart showed the cart unlocked and unattended from 11:51 to 11:56 a.m. and from 12:30 to 12:34 p.m. with residents nearby. -Observation of the [NAME] wing medication storage room occurred on [DATE] at 1:44 p.m. and showed the following:* Three boxes of needles used for lab draws expired in [DATE].* Three individually wrapped needles used for lab draws expired in [DATE].During an interview on [DATE] at 4:20 p.m., two administrative staff members (#1 and #2) stated they expected staff to close and lock the medication carts when unattended and audit the medication rooms for expired supplies.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview, the facility failed to promote privacy and confidentiality of the electronic medication administration record (EMAR) on 1 of 2 units (West Wing) observed. Failure to promote resident privacy and lock computer screens may result in unauthorized viewing of resident records by other residents, visitors, or unlicensed staff. Findings include:A review of facility policy titled Violation Sanctions HIPPA Policies occurred on 09/04/25. This policy, dated June 2020, stated, . Confidentiality: It is the right of an individual to have personal, identifiable information kept private . Violations are defined into categories . failure to properly sign off from or lock computer when leaving a workstation.Observation on 09/02/25 of the [NAME] wing medication cart showed the EMAR open and visible to visitors and residents at 11:51 a.m. and 12:30 to 12:34 p.m. without a nurse present.During an interview on 09/03/25 at 4:20 p.m., two administrative staff members (#1 and #2) stated they expected staff to close and lock the EMAR when unattended.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or their representative and the State Long Term Care Ombudsman a written notice of transfer and bed-hold notice for 1 supplemental resident (Resident #10) reviewed for hospitalizations. Failure to provide a notice of transfer and a bed-hold notice does not allow the resident and/or their representative to make informed decisions regarding their rights, or inform the Ombudsman of the transfer. Findings include:Review of the facility policy titled Bed Hold Policy occurred on 09/04/25. This policy, dated 05/15/25, stated, . will provide written information to the resident or resident's representative regarding the bed hold policy prior to a transfer . the resident or resident's representative will be provided written information regarding the bed hold policy. will be notified in writing the reasons for the move in a language and manner they understand. The facility will send a copy of the notice to a representative of the Office of the State Long term Care Ombudsman.Review of Resident #10's medical record occurred on 09/03/25. A nurse's note, dated 04/28/25 at 3:09 p.m., stated, . Clinic called at 1500 [3:00 p.m.] and stated that [Resident #10] was admitted for hyponatremia and hypoxia. The medical record lacked a written notice of transfer, a written notice of bed-hold, and notification of the transfer to the State Long Term Care Ombudsman.During an interview on 09/03/25 at 9:15 a.m., two administrative staff members (#1 and #7) confirmed the facility failed to complete a written notice of transfer form, a written bed-hold, and notify the Ombudsman.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, and staff interviews, the facility failed to obtain a physician's order for 1 of 1 supplemental resident (Resident #17) observed receiving crushed medications. Failure to notify the provider regarding the resident's ability to swallow whole medications and obtain an order for crushed medications may result in an inconsistency in care and choking. Review of a nurse's report sheet occurred on 09/04/25. This form, dated 08/15/25, showed Resident #17 takes her medications Whole.Observation of medication administration occurred on 09/02/25 at 12:42 p.m. and showed a nurse (#11) crush Resident #17's medication, placed them in pudding, and administered them to the resident. The medication administration record (MAR) lacked documentation indicating staff were to crush the resident's medications. During an interview on 09/02/25 at 12:43 p.m. a staff nurse (#11) stated, We have been crushing her meds for a couple of weeks now since she (Resident #17) came back from the hospital after her stroke.During an interview on the morning of 09/04/25, two administrative staff members (#1 and #10) confirmed Resident #17's medical record lacked an order to crush Resident #17's medications.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, review of a dietary document, and staff interview, the facility failed to provide food in a form to meet individual needs for 2 of 2 sampled residents (Resident #15 and #20) with a physician's order for a minced and moist diet. Failure to provide minced and moist food as ordered may result in reduced meal intake, choking, and aspiration pneumonia. Findings include: Review of a document titled Hormel Health Labs Checklists for IDDSI [International Dysphagia Diet Standardization Initiative - standardized system for classifying food and drink textures for individuals with swallowing difficulties] Levels 7, 6, 5, and 4 provided by the dietary manager (#14) occurred on 09/04/25. This undated document described Level 5 Minced and Moist requirements as Soft and moist particle size - very small pieces ([less than] 1/8 inch - adults); Pieces fit between fork tines; Mimics a soft chewed bolus [a soft round mass] . -Review of Resident #20's medical record occurred on all days of survey. Diagnoses included cerebral infarction (stroke) and dysphagia (difficulty swallowing). A physician's order, dated 02/28/25, stated, Regular diet, Minced texture, Honey consistency. Observation of the lunch meal on 09/02/25 showed the facility served Resident #20 cooked peas and diced carrots along with the rest of his meal. Observation on 09/04/2025 at 8:17 a.m. showed Resident #20 ate approximately half of an egg omelet with small pieces of chopped peppers and ham, larger than 1/8 inch. At 8:30 a.m., a dietary manager (#14) attempted to mash the peppers in the eggs and noted the skins did not mash. The dietary manager agreed the peppers were not appropriate for the minced and moist diet. When asked about the cooked peas and carrots served on 09/02/25, she stated staff should have mashed them for Resident #20. -Review of Resident #15's medical record occurred on all days of survey. Diagnoses included dementia and dysphagia, oropharyngeal phase (difficulty transferring food from mouth to throat). A physician's order, dated 07/28/25, stated, Regular diet, Minced texture, Regular consistency. Observation on 09/02/25 of the lunch meal showed the facility served Resident #15 cooked peas and diced carrots along with the rest of his meal.During an interview on 09/03/2025 at 12:40 p.m., a dietary consultant (#15) stated a minced and moist diet required food no larger size than the tine of a fork, and the cooked peas and carrots would not be appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and policy review, the facility failed to follow standards of infection control and prevention for 1 of 6 sampled residents (Resident #19) and 1 of 1 supplemental resident (Resident #17) observed during cares. Failure to practice infection control standards related to hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 09/04/25. This policy, revised December 2024, stated, Hand hygiene is the act of cleaning one's hands to remove potentially harmful substances and organisms. Hand hygiene . highly effective method for preventing the spread of pathogens, such as bacteria and viruses, which can lead to infections. PROCEDURE Indications for Performing Hand Hygiene: Before moving from work with a soiled body site . to a clean body site . After contact with . body fluids . -Observation on 09/02/25 at 10:18 a.m. showed two certified nurse aides (CNAs) (#8 and #9) applied gloves and provided perineal cares for Resident #17. The CNAs removed their soiled gloves and provided perineal cares for Resident #17. The CNAs removed their gloves and failed to perform hand hygiene before moving on to other tasks. -Observation on 09/02/25 at 11:33 a.m. showed two CNAs (#8 and #9) transferred Resident #19 from the wheelchair to the bed. With gloved hands, the CNAs provided perineal cares, removed the soiled gloves, applied clean gloves, replaced clothing, transferred the resident to the wheelchair, and touched various items in the room before removing gloves and performing hand hygiene.