STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355103	A. BUILDING _____ B. WING _____ JAN 29 2010	01/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 4, 2010 and completed on January 6, 2010, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. In addition,3 residents were added to the sample to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	F156 Notice of Rights and Services and F492 Administration Due to time constraints unable to send SNFABN letter to families of residents #1, #5, and #12. SSD called and explained to families the mistake that was made and advised that she would send them written notification of their right to appeal. Letters will be sent by 2/1/2010. To insure that correct forms are being used. SSD reviewed, updated and implemented the following on 2/1/2010. 1. CMS 100SS SNFABN 2. CMS 10123 (General denial) 3. CMS 10124 (Detailed explanation of non-coverage) SSD also developed a cover letter explaining CMS 100SS SNFABN. Developed weekly CMS review flow sheet to help keep up with any new information. Develop and implement a Q.A. Demand Bill Flow sheet. Q.A. on Demand Billing will be done quarterly for one (1) year. Business manager or SSD to be responsible for Q.A.	2-10-2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: DeAnne Carlson, RN/A | TITLE: Administrator | (X6) DATE: 01-28-10

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.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156	4.Cover letter explaining CMS 100SS SNFABN 5. Beneficiary Notice Initiative Guide. Developed weekly CMS review flow sheet to insure that the CMS website is being checked weekly for any revised / updated Medicare forms and the instructions on how to complete them. Two (2) staff members from the Medicare Compliance Committee will be attending the Medicare University in Bismarck from March 16-18. Medicare Compliance Committee will meet weekly for one (1) month, than monthly for two (2) years to insure that we are in compliance. The SSD or Business manager will report to Q.A. at the quarterly meetings. addition per T.C. to (with) Lynette Burley DON 2/11/10 at 1 p.m.	2/10/10 per Lynette Burley DON

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/04/08. Based on review of Medicare records, review of professional literature, and staff interview, the facility failed to provide required notices for potential liability of payments for 3 of 3 residents (Residents #1, #5, and #12), and failed to provide Resident #1's representative with a written Medicare Denial Letter following telephone notification on 8/10/09 and 10/09/09. Failure to provide the correct notices is an infringement of	F 156		

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F 156	Continued From page 3 resident rights, and has the potential to hinder their right to appeal and to request a demand bill. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined standards of practice regarding informing Medicare beneficiaries of their rights related to billing. The facility must provide a liability notice using either the Skilled Nursing Facility Advanced Beneficiary Notice or a Denial Letter to the resident or his/her legal representative when the facility believes the skilled services will no longer be covered by Medicare. The facility must provide the notice to the resident/representative in writing, including the reason why they believe the services will no longer be covered. The facility must issue the Notice of Medicare Provider Non-coverage (CMS form 10123, also called an Expedited Appeal Notice or a Generic Notice) when there is a termination of all Medicare Part A services for coverage reasons. This notice informs the beneficiary of his/her rights to an expedited review of Medicare benefit termination by the Quality Improvement Organization . These notices need to be provided to the resident or representative in writing and in a language the resident understands. Review of Medicare records for Resident #1, #5, and #12 occurred on 01/06/10 at 11:30 a.m. Records indicated these residents no longer received Medicare benefits as of the following dates: * Resident #1 on 08/10/09 and on 10/09/09. * Resident #5 on 09/23/09. * Resident #12 on 09/11/09.	F 156		

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F 156	Continued From page 4 The facility listed the reason Residents #1, #5, and #12 no longer qualified for Medicare Part A benefits as "You do not qualify for 'skilled care' under Medicare guidelines. . . ." on the Determination of Benefits for Medicare Coverage form. The facility completed a form titled "Determination of Benefits for Medicare Coverage" (denial letter) on 08/10/09 and 10/09/09 for Resident #1 when the facility determined he no longer qualified for Part A benefits. An administrative staff member (#6) telephoned the resident's representative to notify her verbally on both occasions, but failed to mail a copy of the form to the representative. During an interview the morning of 01/06/10, two administrative staff members (#6 and #8) stated they were not aware of the Medicare Provider Non-coverage form, consequently the form had not been provided with the denial letters.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		

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F 225	Continued From page 5 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to immediately report alleged violations involving abuse or neglect to the State survey and certification agency for 2 of 2 investigations of abuse or neglect reviewed during the survey. Failure to report all alleged violations, and the results of the investigations, to the State survey and certification agency could place all residents within the facility at risk for mistreatment in the event these staff members continued to work in the facility. Findings include: Review of the facility ABUSE AND NEGLECT	F 225	F225 Staff Treatment of Residents All residents residing in the facility have the potential to be affected. Therefore the Abuse investigative team reviewed and revised Abuse Policy. On 2/2/2010 we held an in-service for all staff and reviewed the revised Abuse Policy. We Revised FSHCC First Report to State Form and FSHCC Second Report to State Form. Educated all licensed staff; RN's and LPN's via in-services on 2-2-2010 on the following; the updated Abuse Policy and what to do in the event of abuse from staff to resident. Also reviewed the revised First Report to the State form, Injuries / bruising of unknown source form, and the Incident Report not related to falls form. Developed an abuse orientation for new nurses. To be implemented on 2/2/2010. We implemented Tips for Successful Investigation sheet to be used by investigative team, consisting of Administrator, D.O.N. and SSD. Implemented 2/2/2010. Developed an Abuse / Theft reporting flow sheet that includes Date State was notified with the reminder that it must be done within 24 hours. Implemented 2/2/10. Abuse investigative team will meet monthly for six (6) months then quarterly for two (2) years. The Administrator, D.O.N. and / or	

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F 225	Continued From page 6 POLICY occurred on January 4, 2010. The policy, revised September 2001, stated, ". . . INVESTIGATION: PROCEDURE . . . NOTIFY STATE HEALTH DEPARTMENT: The Administrator, DON [Director of Nurses], Social Worker or Designee will notify the State Health Department alerting them of the alleged incident and of the initiation of the investigation. . . . TIME FRAME OF INVESTIGATION: Investigations must be documented and all findings reported in writing to the Administrator as soon as possible following the alleged incident. The Administrator or Designee will, by the fifth working day notify the State Department of Health of the investigative results and/or the professional licensing board. 5. OUTCOME: If the investigation team finds that abuse did occur the incident will be reported to the state CNA [Certified Nursing Assistant] registry . . . Said employee will be terminated from this facility. . . ." - On the afternoon of 01/04/10, a request for written evidence of how the facility handled alleged violations of abuse and neglect occurred. An administrative staff member (#7) provided documentation regarding an injury of unknown origin which occurred on 08/26/09 and a possible correlation with a catastrophic reaction with a resident involving a CNA. The documentation lacked evidence of reporting to the State survey agency. The staff member identified a message was left at the State survey agency department answering machine. The staff member stated the facility did not send in the results of the investigation to the department. Two administrative staff members (#6 and #7) then identified plans to implement a policy revision to ensure reporting occurred to the State Health Department.	F 225	**SSD are responsible for reporting to QA team at the quarterly QA meetings.**	2/10/10 per Lynette Burlagi DON

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F 225	Continued From page 7 Review of documentation at the State survey agency identified a voice mail message left by the facility on 09/01/09 at 11:39 a.m. regarding an injury of unknown origin. The state survey agency's records identified the department received this voice mail message six days after the allegation occurred. - On the morning of 01/06/10, an interview occurred with a direct care staff member (#2) who identified making a report of an allegation of verbal abuse to two administrative staff members within the last six or seven months. The staff member described hearing a CNA holler at a resident to "shut up." Interviews with two administrative staff members (#4 and #6) occurred on the morning of 01/06/10. Both staff members verified the allegation which occurred on 08/18/09. Review of the allegation of verbal abuse occurred on the morning of 01/06/10. The review identified the facility failed to report the alleged violation immediately to the State survey agency, as well as the results of the investigation. The facility investigation identified the resident as oriented to person, place and time, and able to report what occurred, consistent with the witnesses report. The investigation identified corrective action as a three day suspension without pay, and probation for six weeks for the alleged. Observation during two of three days of survey (January 5 and 6, 2010) showed the alleged continued to work as a CNA within the facility.	F 225		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 8 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to complete assessments which accurately reflected the residents' status on their Minimum Data Set (MDS) for 2 of 9 sampled residents (Resident #4 and #8). Findings include: The Centers for Medicare and Medicaid Services	F 278	**F 278 Resident Assessment** **Resident's #8 care plan did not reflect his ability to remove lap buddy. Per staff observation on 01-07-2010 resident was able to remove lap buddy. Care plan was updated reflecting this ability. A pre-restraining assessment tool has been reviewed and updated for use on any current or future resident requiring a restraint. On 2/2/2010 an in-services was held with all licensed staff (R.N, LPN) to review the pre-restraining assessment tool. Reviewed and up-dated ADL sheet to reflect the use of restraint and to allow charting on times resident removes per self. In-service held for all C.N.A.'s to review the revised ADL sheets. This in-service was held 01-26-2010. All residents residing in the skilled facility have the potential to be affected therefore during the MDS reference period MDS coordinator will use observation, documentation and interviews for any resident unable to remove device and code appropriately. Resident's #4 had undated changes made to care plan that indicated area had cleared. However on treatment sheet nurses were to check reddened areas on feet TID. MDS coordinator looked at treatment documentation and coded according to that. The MDS for resident #4 dated 6/14/09 and 9/14/09 have been corrected**	- as well as use of " per Lynette Burig Don

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F 278	Continued From page 9 Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2008, pg. 3-198, stated c. Trunk Restraint - Includes any device or equipment or material that the resident cannot easily remove (e.g. . . . belts used in wheelchairs) d. Limb Restraints - Includes any device or equipment or material that the resident cannot easily remove that restricts movement of any part of . . . lower extremity (i.e. . . . leg) . . .e. Chair Prevents Rising - Any type of chair with locked lap board . . . Include in this category . . . lap cushions that a resident cannot easily remove. . . ." - Review of Resident #8's medical record occurred on 01/06/10. The medical record identified the diagnoses of acute confused state and multifarct dementia. The medical record lacked evidence of Resident #8's ability to remove a physical restraint. Review of Resident #8's care conference note, dated 12/30/08, identified facility staff implemented the use of a lap buddy. The note stated, ". . . Care plan team and [resident's family member name] discussed fall interventions including the use of a lap buddy. Care plan team and [resident's family member name] decided a lap buddy would be used when [resident's name] has increased agitation and confusion and is putting himself at great risk for falling at that time. . . ." Review of Resident #8's current care plan identified the problem, dated 11/21/09, of "I have a history of falls . . ." and an approach of, ". . . May put a lap buddy in my wheelchair prn [as needed] as it helps me to stay sitting up straight in my wheelchair. . . . Take off if I am sitting	F 278	and will be submitted by 02-12-2010. Regarding resident # 8, the MDS dated 2/7/09, 5/7/09, 8/7/09, and 11/7/09 were not corrected, as there is no supporting documentation indicating that the restraint was used during those MDS look back period. Education has been given to all persons completing MDS and Care Plan that during MDS reference period observation, documentation and interviews are to be used for accurate coding and must be reflected on care plan. This was done via in-service on 2/2/2010. Interdisciplinary Care Plan Team was educated on 1-27-2010 that any changes / updates to care plan must be dated. Developed a flow sheet to track sections M and P on the MDS to be implemented 2/2/2010. D.O.N. and / or MDS coordinator will review the flow sheet on a monthly basis for six (6) months and then quarterly for two (2) years. D.O.N. and / or MDS coordinator will report to Q.A. at the quarterly Q.A. meeting.	2/12/10 (12) pm Lynette Buddy Don

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F 278	Continued From page 10 quietly. . . ." Observation on the evening of 01/04/10, showed Resident #8 seated in his wheelchair with a lap buddy. The MDSs completed on 02/07/09, 05/07/09, 08/07/09, and 11/07/09 failed to identify Resident #8's use of a "chair prevents rising" restraint. During an interview on the afternoon of 01/06/10, an administrative nursing staff member (#3) confirmed use of a "chair prevents rising" restraint during the assessment periods of the identified MDS assessments. - The Centers for Medicare and Medicaid Services (CMS) defined a stage I pressure ulcer as a persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Review of Resident #4's medical record occurred on January 4-5, 2010. Current diagnoses included arthritis, obesity, and senile dementia with behaviors. Resident #4's care plan, dated 05/14/09, indicated red areas to the resident's left outer foot and left big toe nail, a bunion on the left foot, and too small of shoes. Undated changes followed, including: deletion of the reddened areas, and no difficulty wearing new shoes. Resident #4's treatment record during this time, and continuing through January 2010, identified an intervention to check the resident's feet twice daily until redness goes away to left toenail and left outer foot. The quarterly MDSs, dated 06/14/09 and 09/14/09, indicated the resident had two stage I pressure ulcers.	F 278		

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F 278	Continued From page 11 During an interview on 01/06/10 at 7:55 a.m. a licensed nursing staff member (#5) stated, "I coded the June and September MDSs with stage I pressure ulcers because of the entry in the treatment book." This staff member then pointed to the entry on the January 2010 treatment book written, "Check feet bid until redness goes away to left toenail and left outer foot." The licensed nursing staff member (#5) failed to provide any documentation supporting a pressure ulcer and stated, "I may have to correct those [June and September, 2009] MDSs."	F 278	F 309 Quality of Care Resident #7 was started on scheduled Tylenol on 01-10-2010 TID. All residents have the potential to be at risk for pain therefore Licensed Nurses (RN's and / or LPN's) will complete a Pain Evaluation flow sheet on all residents on a weekly basis. This policy was implemented on 2/2/2010. We also educated all staff via in-service on what to do if a resident complains of pain and also educate nurses on revised Pain Re-evaluation Form. In-service was held on 2/2/2010. Q.I. Team reviewed and revised Pain Management Policy. Revision completed and implemented on 02-02-2010. D.O.N. will monitor pain evaluation flow sheet by completing pain management checklist on 3 – 5 randomly selected residents on a monthly basis for six months and then quarterly thereafter for two years. The D.O.N. will be responsible for reporting to the Q.A. team at the quarterly Q.A. meeting for two years then will re-evaluate procedure.	2/10/10
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of policy and procedure, review of professional literature, resident interview, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #7) observed having pain on 3 of 3 days of survey. Failure to provide an ongoing assessment, recognition, and management of Resident #7's pain limited the resident's ability to attain the highest practicable physical, mental, and psychosocial well-being. Findings include:	F 309		

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F 309	Continued From page 12 Review of a facility policy, "PAIN MANAGEMENT" occurred on 01/06/10. The policy, dated 08/09, stated: "POLICY: It is the policy of [the facility] that residents of [the facility] are free of pain or pain is controlled. PROCEDURE: 1. Upon admission, quarterly and significant change residents will be assessed for pain. 2. Pain will be assessed using the Pain Assessment form. 3. Upon completion of assessment care plan will be updated with needed interventions. 4. Resident [sic] Dr. [doctor] will be notified if deemed necessary." The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding pain recognition and management which states effective pain recognition and management requires an ongoing facility-wide commitment to resident comfort, to identifying and addressing barriers to managing pain, and to addressing any misconceptions that residents, families, and staff may have about managing pain. Nursing home residents are at high risk for having pain that may affect function, impair mobility, impair mood, or disturb sleep, and diminish quality of life. It is important, therefore, that a resident's reports of pain, or nonverbal signs suggesting pain, be evaluated. The resident's needs and goals as well as the etiology, type, and severity of pain are relevant to developing a plan for pain management. Challenges to successfully evaluating and managing pain may include stoicism. Processes for the prevention and management of pain include recognizing the presence of pain and assessing the pain; addressing/treating the	F 309		

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F 309	Continued From page 13 underlying causes of the pain, to the extent possible; developing and implementing interventions/approaches to pain management depending on factors such as whether the pain is episodic, continuous, or both; identifying and using specific strategies for different levels or sources of pain; monitoring appropriately for effectiveness and/or adverse consequences; and modifying the approaches, as necessary. - Observation of Resident #7 on all days of survey included the following: * On the afternoon of 01/04/10 between 1:45 p.m. and 2:00 p.m., while resting in bed, Resident #7 complained of right knee and leg pain. Resident #7 stated she takes Aleve (a non-prescription non-steroidal anti-inflammatory drug - NSAID) and Tylenol (an over the counter pain reliever) for pain and they "help some." Resident #7 stated it "hurts so bad to get up I don't want to get up." A nursing staff member (#5) stated Resident #7 was independent with cares and required set up assistance. * On 01/05/10 at 8:30 a.m., Resident #7 ambulated from the dining room to her room after breakfast. Resident #7 stopped at the nurse's station and asked regarding the time of a meeting. Resident #7 complained of generalized arthritic discomfort. A staff member (#8) passing by stopped and humored the resident about moving to a warmer climate. Resident #7 asked for staff assistance to get to the meeting in one hour. * On 01/05/10 between 10:00 a.m. and 10:15 a.m., during an interview of several residents within the facility, Resident #7 stated her "knees hurt so bad and I don't have enough to help." Resident #7 sat in a wheeled walker with a seat during the 45 minute interview. A staff member	F 309		

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F 309	Continued From page 14 assisted Resident #7 from her room to the meeting room in her seated walker. * On 01/06/10 at 10:00 a.m., a certified nursing assistant (CNA) (#9) entered Resident #7's room to ask her if she wanted to go to church. The resident requested to go to the bathroom and told the CNA she may have to push her down to the service. The CNA (#9) told this surveyor the most assistance Resident #7 usually needs is with morning cares; and this morning the resident had complained of pain in her ankle. The CNA stated the resident did not say anything regarding the need for a pain medication and the CNA (#9) said she did not know if the resident asked the nurse. At 10:10 a.m., after assisting the resident with toileting, the CNA (#9) asked the resident if it was her left leg that was bothering her. Resident #7 stated, "It is the same leg that bothered me yesterday." The resident requested the CNA (#9) to push her while she sat on her walker seat to the church service, and then said her knee (didn't specify) was hurting, and said this morning it was her ankle. The resident said her ankle was better now. The resident stated she told the nurse about her pain this morning and the nurse decided to wait to give her anything because the resident had 15 pills already, which included her Aleve. Resident #7 stated the Aleve didn't seem to help and added "I think you get immune to it." Resident #7 stated she had Tylenol last evening and that helps for a little while. Review of Resident #7's record occurred on 01/06/2010. Resident #7's medical diagnoses included depression, osteoarthritis, chronic pain and osteoporosis. Resident #7's current medication regimen included Aleve 220 milligrams (mg) two tablets two times a day, and Tylenol 325 mg two tablets every six hours as	F 309		

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F 309	Continued From page 15 needed. A "Pain Evaluation," dated 11/02/09, identified the resident's diagnosis of "osteoporosis, arthritis," for "many years," described as "Aching, Tender, Hot/Burning, Tingling wrists/hands." A diagram identified the location as across the resident's shoulders, wrists and hands, and knees. The evaluation identified "Body Actions/Observed behaviors" included "Rubbing body parts, Fidgeting/irritability, Wringing of hands." The evaluation identified relief obtained by medication, and heat; comments included "Res. [resident] has refused prior meds [medications] ordered R/T [related to] side effects." The conclusion stated, "Res has arthritic pain - Have tried several different medications/interventions - res refuses at [times]. See POC [plan of care]." Review of Resident #7's quarterly Minimum Data Sets (MDSs), dated 11/11/09 and 08/11/09 identified the resident with moderate joint and "other" pain less than daily in the seven day assessment period. Preceding MDSs, dated 05/11/09 and 02/22/09 (admission) identified the resident with mild joint and "other" pain less than daily in the seven day assessment period. The 11/11/09 and 08/11/09 MDS identified the resident as independent in walking in her room and in the corridor. Resident #7's Activities of Daily Living (ADL) Resident Assessment Protocol Summary, dated 02/13/09, stated, ". . . Resident requires limited to extensive assist with most ADL's. The amount of help she requires varies from day to day/shift to shift. Why is it a problem? The cause of the problem is: Resident was in our basic care unit and was recently admitted to our skilled care due to requiring more assist. She has diagnoses of osteoarthritis and osteoporosis. She	F 309		

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F 309	Continued From page 16 has a history of limited ROM [range of motion] to shoulders and this has been getting progressively worse. She was evaluated by PT [physical therapy] and did receive therapy for shoulder. She is now on a restorative program. No other referrals at this time. Encourage ADL participation as she is able. Continue with restorative program. Develop Care Plan with further interventions." Resident #7's current care plan identified the following problems: * "I occasionally have increased anxiety and have many health concerns but refuse to do tests that Dr.'s [physicians] recommend" with an approach of "I walk by myself using a walker . . . I need reassurance every day that it is okay to ask for help as I need help with all my ADL's . . ." * "I have occasional pain to my knees, shoulders and numbness and tingling in my hands r/t dx [diagnosis] of osteoarthritis, osteoporosis and chronic pain" with approaches of ". . . I will ask for pain meds if I need them . . . I have icy hot in my room that aids [CNAs] apply to knees at bedtime . . ." Care plan goals included "My pain will be well controlled through with [sic] current pain management through next review." Review of "Weekly Nursing Summary" reports, completed every Wednesday from 10/21/09 through 12/30/09 identified Resident #7 experienced pain. The summary sheet stated, "If yes, see flow sheets." On the afternoon of 01/06/10, a nursing staff member (#10) stated the "flow sheet" refers to the prn (as necessary) medication sheet. The prn medication sheet identified the order for Acetaminophen (Tylenol) 325 mg two tablets every six hours as needed. Review of the prn medication sheets identified nursing staff medicated Resident #7 for	F 309		

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F 309	Continued From page 17 discomfort (described as "achiness, Hurt all over, achy legs, shoulder pain") with the Tylenol once daily on four of the 11 Weekly Nursing Summary reports, and not at all on seven of the 11 Weekly Nursing Summary reports. On each occasion from October through December 2009, when nursing staff administered the Tylenol, Resident #7 obtained improvement in her pain. Review of Resident #7's nurse's notes, between 07/29/09 to current, included the following entries: * 07/29/09: "Requested to go back to using the Aleve - Educated on pain medication that she tried in the past. Voices Aleve worked best." * 09/18/09: "Pain under fairly good control per resident." * 11/01/09: Resident complained of left shoulder and leg pain over the weekend, "given Tylenol, family asked re: [regarding] Prednisone therapy for resident." * 11/19/09: Resident seen by [physician], "options given for pain. Res [Resident] agreed to try injections to [right] knee, then decided she wanted to wait until after Christmas." * 11/20/09: Resident decided she didn't want injections or X-rays. * 11/24/09: Resident started on Prednisone, "refused Naproxen [Aleve] during course." * 11/27/09 at 10:30 p.m.: Resident experienced no discomfort throughout shift. Physician progress notes included the following: * 07/09/09: ". . . The patient's main complaint at this time is that of arthritis in both knees. She was started on Mobic 7.5 mg daily, but this does not appear to be helping her. The patient is reluctant to have any cortisone injection into her knee; however, the arthritis appears to be a significant limiting factor. . . . The patient's Mobic . . . will	F 309		

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F 309	Continued From page 18	F 309		

discontinue. I will give it a trial of Tylenol No. 3 [Tylenol with codeine] to be taken one [by mouth twice a day] for a month. If this helps the pain, we will continue her on the same and the patient feels that if it does not help, then she would consider proceeding with the cortisone injection." Mobic is a prescription NSAID.
* 09/21/09: ". . . Patient has been doing fairly well. She did try Tylenol No. 3 in July; however, after two to three weeks, she developed constipation and refused to take this medication. The arthritis has been under fairly good control and only occasionally needs Tylenol p.r.n., which relieves the symptom. She is comfortable at this time. . . ."
* 11/19/09: ". . . Nursing staff indicates that the patient has been complaining of increasing problems with arthritic discomfort. She complains of the discomfort in the knees and has also been complaining of tingling in her hands. She has been evaluated by [provider], who has ordered x-rays of the knee and nerve conduction studies to rule out the possibility of carpal tunnel syndrome. However, nurses indicate that she does not proceed with the testing. She also has been tried on various anti-inflammatory medications and has actually felt that the Aleve helps her the most. . . . I suspect the patient has bilateral carpal tunnel syndrome. She has significant osteoarthritis. I will proceed with an x-ray of the right knee and we will set her up for Synvisc [an injectable treatment used for osteoarthritic knee pain] injections and see if this helps. . . ."

A MDS review, dated 08/11/09, stated the resident refused the scheduled Tylenol No. 3 twice during the assessment period and that "Due to this refusal her mood has deteriorated since last assessment. Discussed ADL's with CNAs,

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F 309	Continued From page 19 CNA's voiced they do still assist resident to get legs into and out of bed. . . ." The 08/11/09 MDS identified the resident resisted cares 1-3 days in the last 7 days of the assessment period and this behavior was not easily altered. An interview with an administrative staff nurse (#4) occurred on 01/06/10 at 3:30 p.m. The staff nurse stated Resident #7 is not accepting of additional pain medications. On 01/06/10 at 3:35 p.m., Resident #7 laid in bed. Resident #7 stated she had Tylenol at noon and her pain was better. Resident #7 stated she can have the Tylenol four times a day and wished staff would just give it to her that often.	F 309	F 329 Unnecessary Drugs Resident #4 seen by physicians assistant (documented - see 4 28) On 1-20-2010 the physician's assistant was seen by resident #4. Resident #4's medication was reviewed. Physician's Assistant advised to continue with Seroquel at current dose of 25mg ½ tab in the morning and 1 tab in the evening r/t at times resident will still barricade her door. Any resident on a psychotropic medication has the potential to be affected. Therefore SSD and D.O.N. created a form that will be reviewed by physician for dose reduction attempts on a monthly basis when she / he is doing re-certifications. The MDS coordinator and / or LPN and / or RN assisting with rounds will complete this form and present it to the physician for review. The SSD and / or D.O.N. will do a chart review on 3 – 5 randomly selected residents on a monthly basis for six months and then quarterly thereafter for two years. This monitoring will be implemented by 2/10/2010. The D.O.N. and / or SSD will be responsible for reporting to the Q.A. team at the quarterly Q.A. meeting for two years then we will re-evaluate the need for a procedure.	2/10/10
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview, the facility staff failed to ensure that 1 of 3 sampled residents (Resident #4) taking an antipsychotic drug received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. Failure to taper a resident's antipsychotic medication has the potential for a resident to receive unnecessary medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction (GDR) which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.	F 329		

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F 329	Continued From page 21 Review of Resident #4's medical record occurred on January 4-5, 2010. The facility admitted the resident in December 2008. Current diagnoses included senile dementia with behaviors and depression. The physician orders listed an admission order of Seroquel 25 milligrams - 1/2 tab (tablet) po (orally) Q (every) AM (morning) and 1 tab Q evening. Review of the medical record failed to show a GDR of the Seroquel or documentation that a GDR is clinically contraindicated. During an interview on 01/06/10 at 3:45 p.m., an administrative staff member (#4) stated, "We haven't done a gradual dose reduction on this resident since admission, and feel this resident needs the current dose of Seroquel." The administrative staff member (#4) failed to provide evidence of attempted GDR or documentation by the physician that a GDR was contraindicated, since Resident #4's admission.	F 329	**F 428 Drug Regime Reviewed** **On 2/5/2010 the pharmacist reviewed #4's chart and noted that the PA had reviewed the use of psychotropic medication on 1-20-2010 and documented that a reduction would be contraindicated at this time. Any resident on a psychotropic medication has the potential to be affected. Therefore we created a form that will be reviewed by physician for dose reduction attempts on a monthly basis when she / he is doing re-certifications. The MDS coordinator and / or LPN and / or RN assisting with rounds will complete this form and present it to the physician for review. The pharmacist will generate a pharmacy report based on pharmacy records to indicate anyone on a psychotropic drug. The pharmacist will run this report on a monthly basis prior to pharmacist's consult visit. The pharmacist will then check his report against FSHCC Flow-sheet. The pharmacist will turn his report into D.O.N. These changes will be implemented by 02-01-2010. D.O.N. and / or SSD and / or MDS coordinator will be responsible to review these reports on a monthly basis for six (6) months and then quarterly for two (2) years. D.O.N., SSD and / or MDS coordinator will report on Drug Regimen review to the Q.A. team during Q.A. quarterly meetings.**	2/10/10
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional	F 428		

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F 428	Continued From page 22 literature, and staff interview, the facility's consultant pharmacist failed to report irregularities to the attending physician and the director of nursing for 1 of 3 sampled residents (Resident #4) currently on an antipsychotic medication. Failure to suggest gradual dose reduction (GDR) of an antipsychotic medication to the physician has the potential for the resident to receive unnecessary medications, develop adverse consequences, and fail to maintain the highest level of functioning. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/GDR which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. Review of Resident #4's medical record occurred on January 4-5, 2010. The facility admitted the resident in December 2008. Current diagnoses included senile dementia with behaviors and depression. The physician orders listed an	F 428		

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FOUR SEASONS HEALTH CARE INC	483 4TH ST SW FORMAN, ND 58032

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F 428	Continued From page 23 admission order for Seroquel 25 milligrams - 1/2 tab (tablet) po (orally) Q (every) AM (morning) and 1 tab Q evening. Review of the medical record failed to show a GDR of the Seroquel or documentation that a GDR is clinically contraindicated. Review of the consultant pharmacy reports occurred on January 6, 2010. The reports, dated monthly from January to November 2009, indicated the pharmacist conducted a review of medications each month. The reports failed to show any recommendation by the pharmacist for a GDR on Resident #4's dose of Seroquel. In an interview on 01/06/10 at 3:45 p.m., an administrative staff member (#4) stated, "We haven't done a GDR on this resident since admission, and feel this resident needs the current dose of Seroquel." The staff member stated no awareness of a recommendation for a GDR by the consulting pharmacist for Resident #4's Seroquel.	F 428		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		

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F 431	Continued From page 24 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional literature, and staff interview, the facility failed to ensure only authorized personnel have access to 1 of 1 medication room. Failure to limit access to the medication room has the potential to endanger the security of the drugs stored there. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined the standards of practice regarding access to medications which states a facility is required to limit access to authorized personnel consistent with state or federal requirements. The facility must have a system to limit who has security access and when access is used.	F 431	F 431 Pharmacy Services **Policy and procedure for Authorized Personnel for Locked Medication Room has been reviewed and revised and implemented as of 01-26-2010. A new Policy on Master Key developed and implemented on 01-26-2010. The administrator will monitor who has access to the master key once a month for the 1st quarter, quarterly for two (2) quarters and annually thereafter.**	2/10/10

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F 431	Continued From page 25 On the morning of 01/06/10, observation of the medication room showed both locked and unlocked cabinets and carts. In an interview on the morning of 01/06/10, a licensed nursing staff member (#10) stated, "The nurse on duty, the director of nursing [DON], and [name of facility administrator] have keys to the medication room." In an interview on 01/06/10 at 4:15 p.m., an administrative nursing staff member (#4) stated, "[Name of administrator] has access to the med [medication] room because she has a master key, which opens all the doors in the facility. The staff member indicated the administrator uses her key to open the med room if the nurse accidentally locks the keys inside, and the other nurse with keys, who lives over 30 miles away, has gone home for the day. The staff member indicated the facility lacked a policy identifying which personnel the facility considered to be authorized to have access to the medication room.	F 431		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 26 This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policy, professional literature, and staff interview, facility staff failed to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice on 1 of 2 days (January 4, 2010) of medication pass observed. Failure to wash hands after removing gloves and before applying clean gloves has the potential to contaminate the clean gloves and failure to wash hands before and after invasive procedures, such as injections and fingersticks, has the potential to spread infection to residents, visitors, and staff. Findings include: Review of the facility policy titled "HANDWASHING-EMPLOYEE" occurred on January 6, 2010. This policy, revised 10/28/09, stated, "Procedure: . . . 7. Hands are always washed/sanitized after removal of gloves. . . . Miscellaneous: 1. Appropriate 10-15 second handwashing/sanitizing must be performed under the following conditions: c. Before and after performing invasive procedures. . . . 2. The use of gloves does not replace hand washing. . . ." The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding infection control and states hand hygiene continues to be the primary means of preventing the transmission of infection. Situations that require hand hygiene include, but are not limited to, before and after performing any invasive procedure (e.g. fingerstick blood sampling).	F 441	F 441 Infection Control D.O.N. reviewed with nursing staff the Hand-washing Policy and the Finger Stick for Glucose Policy. This was completed by 2/1/2010. D.O.N. and Infection Control Nurse watched Licensed Nursing Staff (LPNs / RNs) demonstrate proper hand washing between Finger Sticks for Glucose. This observation was on going between 01-08-2010. Developed and implemented a Q.A. Form for Blood Sugar Monitoring / Hand washing to be implemented by 2/1/2010. The D.O.N. and / or infection control nurse will monitor proper hand washing techniques monthly for six (6) months and than quarterly for two (2) years. D.O.N. will be responsible for reporting to Q.A. team once a quarter at Q.A quarterly meeting. B. Tub Sanitation Switched to a sixty (60) second disinfectant on 01-26-2010. All C.N.A.'s have been educated via in-service held 01-26-2010 on proper way to use new disinfectant. Revised Tub Cleaning / Disinfecting Policy and Procedure to reflect new product. This policy was implemented on 1/27/10. D.O.N. and / or infection control nurse will monitor tub sanitation on a	

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F 441	Continued From page 27 On 01/04/10 at 5:15 p.m., observation showed a licensed nursing staff member (#1) applied hand sanitizer, donned clean gloves, administered an insulin injection during a random observation of a resident, and then removed the gloves. The licensed nursing staff member (#1) failed to perform hand hygiene after she removed the gloves and before she donned clean gloves prior to checking a resident's blood sugar. Through interview on the afternoon of 01/06/10, an administrative nursing staff member (#4) agreed she would expect staff to wash or sanitize their hands after removing gloves. 2. Based on observation, policy and procedure review, manufacturer's recommendations, and staff interview, the facility failed to properly sanitize 1 of 1 whirlpool tub. Findings include: Review of the "Tub Operation" procedure, posted in the bathing room, occurred on the afternoon of 01/06/10. The procedure stated, ". . . 7. Spray tub and chair with Lysol disinfectant after every bath! Very important! 8. When all done, clean tub with Awesome cleaner, and toothbrush, rinse. 9. Fill tub with warm water, add 3 ozs.[sic] Amphyl, turn jets on and whirl for 8 minutes. Drain and rinse, making sure water from jets comes out clear. 10. Stock towels, sweep and mop floor." - Observation of the bathing room and an interview of a certified nursing assistant (CNA) (#2), assisting with resident baths, occurred on 01/05/10 at 9:00 a.m. The interview identified this CNA sprayed the whirlpool tub with a disinfectant cleaner, "Quest," following each resident's bath	F 441	monthly basis for six (6) months and then quarterly thereafter. D.O.N. or Infection Control Nurse responsible to report to Q.A. team at the Quarterly Q.A. meetings.	

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F 441	Continued From page 28 and allowed the product to remain on the interior surface of the tub for "two minutes." This CNA stated she added "seven squirts" of another disinfectant cleaner, "Amphyl Hospital Bulk Disinfectant Cleaner," to a full tub of water following the bath of a resident with methicillin-resistant staphylococcus aureus (MRSA). The CNA stated she allowed the product to remain in contact with the interior surface of the tub about "five minutes." Observation of the process for disinfecting the whirlpool tub, utilizing the "Quest" disinfectant cleaner occurred on 01/05/10 at 9:40 a.m. The CNA (#2) sprayed the chemical on the interior surface of the tub, then sprayed the chemical on the exterior surface of the tub's lift chair. The CNA immediately began wiping the chemical from the surface of the chair and then the surface of the tub. This procedure provided no chemical contact time for the lift chair and two minutes of contact time for the tub. Review of the manufacturer's recommendations for the "Quest" disinfectant cleaner, identified, "To disinfect . . . wet all surfaces thoroughly for at least 10 minutes. Wipe or air dry. . . ." Observation of the process for disinfecting the whirlpool, utilizing the "Amphyl Hospital Bulk Disinfectant" cleaner and interview of CNA (#2) occurred on 01/05/10 at 10:20 a.m. The CNA stated she sprayed the tub with the "Quest" disinfectant cleaner immediately prior to this observation. The CNA poured approximately three ounces of "Amphyl Hospital Bulk Disinfectant Cleaner" from a three and a half ounce plastic cup, previously filled by the CNA, into the empty tub. She identified this amount	F 441		

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F 441	Continued From page 29 equaled seven squirts of "Amphyl Hospital Bulk Disinfectant Cleaner." The CNA filled the whirlpool tub full of water, turned on the water jets, waited "5 minutes," emptied the water/disinfectant solution, and rinsed the tub. Review of the manufacturer's recommendations for "Amphyl Hospital Bulk Disinfectant Cleaner," identified, "For Broad Spectrum Disinfectant (use 1% solution) . . . wet all surfaces thoroughly. Let stand 10 minutes before wiping or allow to air dry. . . ." The manufacturer's recommendations identified a 1% solution as equaling four fluid ounces in three gallons of water. When interviewed on the afternoon of 01/06/10, a maintenance staff member (#3) identified the whirlpool tub, filled with water, contained 50 gallons of water. When the CNA added three ounces of chemical to 50 gallons of water, the resulting solution provided a lower concentration of chemical than recommended by the manufacturer for disinfecting surfaces. When interviewed on the afternoon of 01/06/10, the CNA (#2) identified the posted "Tub Operaton" procedure had been for the cleaners, "Lysol, Awsome, and Amphyl Disinfectant Cleaner," facility staff previously used. The CNA (#2) provided a bottle of the previously used "Amphyl Disinfectant Cleaner" and identified the new version of the chemical, "Amphyl Hospital Bulk Disinfectant Cleaner," had been received approximately two and a half months ago. Observation of the manufacturer's recommendations for the previously used chemical, "Amphyl Disinfectant Cleaner," identified, "For General Disinfection: . . . recommended solution (1:200) . . . Contact time:	F 441		

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F 441	Continued From page 30 Allow surface to remain wet for 10 minutes." The manufacturer's recommendations identified a (1:200) solution as a 0.5% solution equaling one and one-third ounces in two gallons of water or four fluid ounces in six gallons of water. When interviewed on the afternoon of 01/06/10, an administrative nursing staff member (#3) agreed chemical manufacturer's recommendations should be followed. Failure to follow the chemical manufacturer's recommendations regarding solution concentrations and contact time for disinfecting surfaces places residents at increased risk for developing infections from cross contamination of bathing equipment.	F 441	F492 Administration On 2-9-2010 a refund check has been issued to #13's wife. As of 2-10-2010 we have been unable to contact her to request reimbursement as Medicare has denied her demand billing due to resident not qualifying as he was receiving Hospice services and refusing therapy. All residents currently receiving Medicare Part A Benefits have the potential to be affected. Therefore SSD has created a flow sheet that identifies residents currently receiving Medicare Part A benefits, date benefits began, date benefits will end and the reason the benefits will stop. We will use this form in conjunction with QA Demand Billing Flow sheet pages 1 and 2. The Medicare Compliance Committee consisting of Office manager, administrator, D.O.N., MDS coordinator and SSD, will meet weekly to review the residents currently receiving Medicare part A benefits. We will review the QA Demand Billing Flow sheets to insure that all proper forms have been sent. To insure that correct forms are being used. SSD and Business Manager reviewed, updated and implemented the following on 2/1/2010. 4. CMS 100SS SNFABN 5. CMS 10123 (General denial)	
F 492 SS=B	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on review of Medicare records, review of professional literature, and staff interview, the facility failed to delay billing for services provided the resident until after review by the Fiscal Intermediary (FI) for 1 of 1 resident requesting a demand bill (Resident #13). Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined standards of practice regarding	F 492		includes checking % no. billed per Lynette Borlaug Dec 21

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F 492	Continued From page 31 informing Medicare beneficiaries of their rights related to billing. The facility must provide a liability notice using either the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a Denial Letter to the resident or his/her legal representative when the facility believes the skilled services will no longer be covered. This must be in writing. The facility must submit the bill to a fiscal intermediary (demand bill) when requested by the resident, and may not charge the resident for Medicare covered Part A services while waiting for results of a demand bill. Review of the "Determination of Benefits for Medicare Coverage" form (denial letter) for Resident #13 occurred on 01/06/10 at 11:30 a.m. The facility notified the resident's representative on 12/03/09 that the facility determined Resident #13 would no longer qualify for Medicare Part A benefits effective 12/06/09 and the resident's right to appeal this decision if desired. On 12/05/09, the resident's representative checked the line requesting a demand bill be submitted to the intermediary for a Medicare decision and signed the form. In an interview the morning of 01/06/10, an administrative staff member (#8) stated, "The demand bill had not been submitted yet, but the resident was billed for December 07-09, 2009 and his wife paid it."	F 492	• ~~CMS 10124 (Detailed~~ explanation of non-coverage) • Cover letter explaining CMS 100SS SNFABN • Beneficiary Notice Initiative Guide. Developed weekly CMS review flow sheet to insure that the CMS website is being checked weekly for any revised / updated Medicare forms and the instructions on how to complete them. Two (2) staff members from the Medicare Compliance Committee will be attending the Medicare University in Bismarck from March 16-18. Medicare Compliance Committee will meet weekly for one (1) month, than monthly for two (2) years to insure that we are in compliance. The SSD or Business manager will report to Q.A. team at the Q.A. quarterly meetings.	2/10/10