DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/06/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	10/31/2013

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

(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 For the standard Medicare/Medicaid recertification survey started on 10/29/13 and completed on 10/31/13, the sample included two residents for complete review, seven residents for focused review, and one closed record for review.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 5	F 279	F279 1. Add diagnosis of depression to resident #4 care plan. Ensure all residents have all dianosis on care plan. For all other residents - per telephone DON 11/27/13 dl 2, all triggered areas on CAA; s has been reviewed and is on care plans. 3.Revise Care Conference notes to include section on Depression with reminder to care plan. Responsible Party: DON, MDS Coordinator. to complete QA. per telephone c DON 11/27/13 dl QA done monthly for 3 month and quarterly for 1 year. Completed 11-18-13	11-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Cochran, LTHA	Administrator	11-20-13

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 279	Continued From page 1 sampled residents (Resident #4) identified with moderate to moderately severe depression on the Minimum Data Set (MDS). Failure to develop a care plan that includes goals and interventions to address mood issues does not allow the resident to reach the highest practicable physical, mental, and psychosocial well-being. Findings include: The Long-Term Care Facility RAI User's Manual, Version 3.0, dated October 2013, page D-1 states, ". . . record the presence or absence of specific clinical mood indicators. . . . consider them when developing the resident's individualized care plan. . . ." Page D-3 defines the 9-item Patient Health Questionnaire (PHQ-9) as, "A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder." Page D-9 interprets the PHQ-9 Total Severity Score as, ". . . 10-14: moderate depression; 15-19: moderately severe depression . . ." Review of Resident #4's medical record occurred on all days of survey. Resident #4's Total Severity Score on the admission MDS, dated 11/27/12 and the annual MDS, dated 10/15/13, indicated "moderate depression," and the score on the quarterly MDS, dated 07/22/13, indicated "moderately severe depression." Resident #4's Care Area Assessment (CAA) - Mood State, dated 10/22/13, noted the resident answered yes to feeling down, depressed, or hopeless nearly every day. The CAA stated, "[Resident's name] is at risk for increased depression r/t [related to] communication difficulty, and being in the nursing home" and "Revise current plan."	F 279		

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F 279	Continued From page 2 Review of Resident #4's medications included sertraline 50 milligrams daily, ordered 07/23/13, for "depression." Review of Resident #4's current care plan failed to identify a problem area related to depression. During an interview on 10/31/13 at 12:15 p.m., a supervisory nurse (#1) when asked about care areas, such as mood state identified on the MDS, stated "We typically would do a care plan."	F 279		