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 _____	11/08/2012

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 11/05/12 and completed on 11/08/12, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents 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, RULES, SERVICES, CHARGES 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nellie Cowsson, VCHA | TITLE: Administrator | (X6) DATE: 11-26-12

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.

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

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 _____	11/08/2012

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 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.	F 156	F156 Families of Residents #12, #13, and #14, were notified and none of the three wanted a demand bill. All other Residents were identified that could possibly want a demand bill. After we notified them, all declined that a demand bill be sent. A form was reviewed and put into use that was very clear about a demand bill. Adopted on November 20, 2012	11-20-12

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 _____	11/08/2012

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 156	Continued From page 2 The facility must comply with the requirements 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: Based on review of Medicare billing records and staff interview, the facility failed to correctly explain denial notices to 3 supplemental residents (Resident #12, #13, and #14) whose Medicare coverage ended. Failure to ensure residents and/or their responsible parties understand their options regarding Medicare Part A benefits, including the option to request a demand bill, is an infringement of the residents' rights.	F 156		

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 _____	11/08/2012

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 156	Continued From page 3 Findings include: Review of the facility's Medicare billing records occurred on 11/07/12. The records identified Resident #12, #13, and #14's Medicare coverage ended on the following dates: *Resident #12: 09/23/12 *Resident #13: 09/14/12 *Resident #14: 09/22/12 Although the above residents received a "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)" (a denial notice - including the option to request a demand bill), the facility failed to provide the residents with a correct explanation regarding their options as their Medicare benefits ended. The form included the following two options: *"Option 1. YES I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision." (This option should be selected to request a demand bill). *"Option 2. NO. I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any	F 156		

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 _____	11/08/2012

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 156	Continued From page 4 physician-ordered items or services, I should notify my doctor who ordered them that I did not receive them." Resident #12, #13, and #14's denial notices all identified the residents (or their responsible parties) selected "Option 1" (requesting a demand bill); however, the facility failed to submit the requests for demand bills. During an interview on 11/07/12 at 1:15 p.m., an office manager (#6) stated she misunderstood the options and incorrectly explained to residents and/or their responsible parties to select "Option 2" to request a demand bill.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess the safety of self-administration of medications (SAM) for 1 of 1 supplemental resident (Resident #11) observed with medications left at the dining room table. Failure to determine if SAM is a safe practice has the potential to result in a medication error. Findings include: Review of the facility policy titled	F 176		

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 _____	11/08/2012

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 176	Continued From page 5 "SELF-ADMINISTERED MEDICATIONS AND TREATMENTS" occurred on 11/06/12. This policy, updated 11/10/11, stated, "PROCEDURE: If a resident request [sic] to self-administer a medication, the following must be done: 1. Doctor's order must be received. 2. Assessment for Self-Administration of Medications will be filled out by the charge nurse on duty. 3. Completed assessment for self-administration of medications will be given to D.O.N. [director of nursing] and Administrator to review and sign. . . ." A random observation during the breakfast meal on 11/06/12 showed an unidentified certified nurse aide (CNA) pick up a medication (pill) from the floor under a dining room table and gave it to the nurse to dispose. Observation on 11/06/12 at 5:35 p.m. showed a licensed nurse (#2) placed a medication cup, which contained four medications: Lipitor, Zetia (both for high cholesterol), Senna (laxative), and Metformin (for diabetes), on the dining room table for Resident #11 to self administer. The nurse returned to the medication cart and stated Resident #11 will take the medications when she's ready. Review of Resident #11's medical record occurred on 11/06/12. The record failed to identify a doctor's order or an assessment for SAM. During an interview on 11/06/12 at 5:55 p.m., an administrative nurse (#1) stated some residents do not like to be "watched" when they take their	F 176	No harm to Resident #11. All nurses were immediately notified via word of mouth and communication book to NOT leave medications unattended to resident #11. 2. Because all residents receive medications in dining room, all Nurses were instructed to not leave medications unattended with any resident, until Assessments were completed and care plans reflect any self medication. DON conducted observations daily for 1 week to ensure all nurses were complying. 3.. New Policy and Procedure devised for giving medications to residents who can self medicate. Care Plans updated. All staff will be in-serviced to New Policy and Procedure on 11-28-12. QA form devised. Will be done monthly X 6 months and quarterly thereafter X 2 years. Responsibility: DON.	11-28-12

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 _____	11/08/2012

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 176	Continued From page 6 medications.	F 176		
F 272 SS=C	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F-0272 1. CAA;s completed since 11-9-12 have identified the location of the information. 2. All department heads that do CAA's have been educated on applying the location of the information to the CAA. 3. Re-education will be given at the in-service on 11-28-12. 4. QA to be done monthly x 3 months and quarterly thereafter for 1 year. \ 5. Completed by 12-05-12. Responsibility; DON and staff doing CAA's.	11-28-12

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 _____	11/08/2012

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 272	Continued From page 7	F 272		

This REQUIREMENT is not met as evidenced by:
Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, facility staff failed to identify information used in support of the clinical decision making or the location of the information for 9 of 9 sampled resident records (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9) and 1 of 1 closed record (Resident #10) reviewed. Failure to identify the location of the information in each resident's medial record does not allow staff the opportunity to thoroughly review individual resident areas triggered, to assess the nature of the problem, and determine the specific causes for each individual triggered area.

Findings include:

The Long-Term Care Facility RAI User's Manual, Version 3.0, dated April 2012, page 4-7, stated ". . . Use the 'Location and Date of CAA [Care Area Assessment] Documentation' column on the CAA Summary (Section V of the MDS [Minimum Data Set] to note where the CAA information and decision making documentation can be found in the resident's record. . . ."

Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10's medical records occurred on November 05-08, 2012. The CAA Summary failed to identify the specific location on the

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 _____	11/08/2012

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 272	Continued From page 8 "Location and Date of CAA Information" column where the CAA information could be located in the medical record. The following CAA Summaries lacked the specific location: Resident #1 - significant change MDS, dated 10/21/12 Resident #2 - annual MDS, dated 10/13/12 Resident #3 - annual MDS, dated 08/10/12 Resident #4 - significant change MDS, dated 08/16/12 Resident #5 - significant change MDS, dated 10/04/12 Resident #6 - annual MDS, dated 10/01/12 Resident #7 - significant change MDS, dated 09/30/12 Resident #8 - significant change MDS, dated 04/01/12 Resident #9 - significant change MDS, dated 06/23/12 Resident #10 - significant change MDS, dated 09/19/12 During an interview on 11/07/12 at 4:05 p.m., a licensed nurse (#5) agreed the CAA summaries failed to identify where the information related to the CAA can be located in each resident's medical record.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		

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 _____	11/08/2012

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 309	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, facility staff failed to provide the necessary care and services to prevent the development of pressures ulcers for 1 of 3 sampled residents (Resident #3) care planned for heel protector boots. Failure to utilize the heel boots as care planned may result in Resident #3 developing skin breakdown and/or heel pressure ulcers. Findings include: Review of the facility policy titled "POLICY AND PROCEDURE FOR PREVENTION OF PRESSURE ULCERS" occurred on 11/08/12. This undated policy stated, "POLICY: It is the policy of FSHCC [Four Seasons Health Care, Inc.] that every possible measure to prevent pressure ulcers will be taken. PROCEDURE: On admit, the following will be done by a licensed nurse: a.) Prevention Of Pressure Ulcer Checklist will be read over and put on treatment sheet to monitor what best meets the needs of the new admit . . . Heel protectors . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia. The annual Minimum Data Set (MDS), dated 08/10/12, identified the resident required extensive assistance for bed mobility, transfers, and dressing, and at risk for pressure ulcers. Resident #3's current care plan stated, "Problem: I am at risk for pressure ulcers . . . Approach: Heel protectors on when in bed and in recliner . . .	F 309	F-309 1. Heel protectors immediately placed on Resident #3. Immediate talking to the staff via word of mouth and communication book was done by D O N. 2. Residents who are care planned to have heel protectors on were observed by DON and a licensed nurse X one week to be sure heel protectors were applied while in chair/bed. 3. Assignment sheet for nursing were updated to include heel protectors for those at risk. In-service will be given on 11-28-12 to re=educate on the importance of applying heel protectors on residents who need them to prevent heel breakdown. 4. QA done monthly x 5 months and quarterly thereafter x 2 years. 5. Responsibility: DON and Nursing Department. 6. Completed by 12-05-12	11-28-12

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 _____	11/08/2012

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 309	Continued From page 10 " Observation of Resident #3 seated in her recliner in her room occurred on 11/05/12 at 4:05 p.m., 11/06/12 at 9:20 a.m., 11:03 a.m., 1:30 p.m., and 4:55 p.m., and 11/08/12 at 9:45 a.m. All observations showed Resident #3's heels rested directly on the footrest of her recliner and no heel protector boots utilized. During an interview on the morning of 11/08/12, an administrative nurse (#1) stated facility staff are expected to follow Resident #3's care plan and apply her heel protector boots when she is seated in her recliner.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff appropriately utilized a PAL lift (a sit to stand mechanical lift) for 1 of 3 sampled residents (Resident #3) who required a PAL lift for transfers; and failed to provide the necessary interventions to prevent falls for 1 of 1 sampled resident (Resident #3) care planned not to be left alone in a wheelchair in her room or lounge area.	F 323		

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 _____	11/08/2012

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 323	Continued From page 11 Failure to assess the continued use and safety of a PAL lift placed Resident #3 at risk for pain and/or injury. Failure to supervise Resident #3 in her room and in the lounge area while seated in her wheelchair placed her at risk for continued falls and/or injury. Findings include: Review of Resident #3's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia, anxiety, osteoarthritis, and osteoporosis. Daily pain medications included Tramadol and acetaminophen. Review of the annual Minimum Data Set (MDS), dated 08/10/12, identified Resident #3 required extensive assistance for transfers and experienced one fall without injury in the past three months. The resident's current care plan stated, "Problem: I am at risk for falls . . . Approach: . . . Do not leave me sitting in my w/c [wheelchair] alone in my room or in the lounge . . . Problem: I am at risk for pressure ulcers . . . Approach: . . . Ask me to reach forward and grab PAL lift on my own - do not pull on me . . ." Review of Resident #3's nurse's notes identified the following: * 10/05/12 at 6:45 p.m. - "Observed [Resident #3] rocking self slightly in w/c. Seconds later noted resident on carpeted floor R [right] side by fire door. . . ." * 10/11/12 at 6:40 p.m. - "Resident found sitting on carpeted floor front lounge on buttock. Confused as normal. Chair alarm sounding. . . ." - Observation on 11/05/12 at approximately 4:30	F 323	F-323 1. Staff reminded by word of mouth or communication book, that Resident #3 needs to be in a recliner or up to a table when in wheelchair as per care plan. Resident #3 will be a two person transfer and the pal lift cannot be used. 2. Residents using Pal lift were re-evaluated by DON on 11-09-12. Residents who are at risk for falls when wheelchair are care planned to leave alone only in a safe chair of positioned at a table, etc. 3. In-service on 11-28-12 to include education on when, and when not to use pal lift. New Policy and Procedure on Pal lift and Hoyer; lift. The importance on reading and following careplans, communication book to ensure safety of residents and prevention of falls. 4. QA monthly x 6 months and quarterly thereafter x 2 years. Responsibility: DON and Nursing Department.	12-05-12

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 _____	11/08/2012

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 323	Continued From page 12	F 323		

p.m., showed a certified nursing assistant (CNA) (#7) transported Resident #3 via wheelchair from her room to the lounge area and positioned her in front of the television and adjacent to a table. At 5:20 p.m., the CNA (#7) transported the resident via wheelchair from the lounge area to the dining room. Resident #3 sat in the lounge area, unattended by facility staff, for approximately 50 minutes.

- Observation on 11/06/12 at 9:20 a.m. showed the CNA (#8) applied the harness and belt of the PAL lift around Resident #3's waist. As the CNA raised the resident to an upright position, the harness slipped upward under her armpits and the belt became loose. The CNA failed to lower Resident #3 and reposition the harness and failed to tighten the belt.

- Observation on 11/06/12 at 11:03 a.m. showed the CNA (#8) entered Resident #3's room with a PAL lift. The CNA applied the harness and belt around the resident's waist and encouraged her to grasp the handle bars on the lift. Resident #3 did not cooperate and the CNA pulled on the resident's hands and arms to get her to grasp the bars. The resident stated, "Ow." The CNA (#8) placed her hands over Resident #3's hands on the handle bars and transferred her to the commode. After the resident had voided, the CNA (#8) utilized the PAL lift and raised her off the toilet to a 90 degree angle. Observation showed the harness positioned under the resident's armpits, her elbows bowed upward, and only the tips of her toes were on the lift platform. The CNA (#8) failed to position Resident #3 correctly on the PAL lift, failed to lift her to an upright position, and failed to correctly

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 _____	11/08/2012

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 323	Continued From page 13 position the harness around the resident's waist. - Observation on 11/06/12 from 1:00 to 1:30 p.m. showed Resident #3 unattended in her room and seated in her wheelchair. At 1:30 p.m., a CNA (#8) transferred the resident from her wheelchair to her recliner. During an interview on the morning of 11/08/12, an administrative nurse (#1) agreed Resident #3 should not be left unattended in her room or the lounge area.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, review of manufacturer's recommendations, and staff interview, the facility failed to use the correct concentration of chlorine sanitizer to wipe kitchen counters and dining room tables in 1 of 1 kitchen/dining room. Failure to follow manufacturer's guidelines for mixing sanitizing solution placed residents at risk for adverse health effects related to the high chemical concentrations.	F 371		

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 _____	11/08/2012

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 371	Continued From page 14 Findings include: Review of the facility policy titled "Cleaning Instructions: Cleaning Counter Space" occurred on 11/08/12. This policy, dated 2008, stated, "Policy: Counter space will be wiped and sanitized prior to and following food preparation and meal service, and as needed. Procedure: 1. Spills will be wiped up as needed using a clean cloth and warm water. 2. To sanitize: * Remove small appliances and other items from the counter * Wipe off debris * Spray the counter with sanitizing solution . . . * Wipe the outer surfaces of small appliances * Allow countertops and small appliances to air dry." The manufacturer's recommendations on the back of the package of sanitizing solution stated, ". . . HAZARDS TO HUMANS AND DOMESTIC ANIMALS . . . Corrosive to eyes. Causes eye and skin damage. Do not get in eyes, on skin or on clothing . . . Harmful if swallowed . . . Wash hands thoroughly with soap and water after handling . . . DIRECTIONS FOR USE: It is a violation of Federal Law to use this product in a manner inconsistent with its labeling . . . 3.) In sanitizing tank (last tank) mix contents of this package in 3 gallons of water. This provides 100 ppm [parts per million] available chlorine for an 8 hour shift. Use supplied test strips to assure required chlorine levels. Immerse glassware for at least two minutes or for contact time specified by governing sanitary code. 4.) . . . air dry . . ."	F 371	F-371 Sanitizer will be made in the A>M> and tested with the appropriate strips to ensure it is at the 100ppm. Sanitizer will be tested with a test strip and documented every 4 hours. Sanitizer will be disposed of after 8 hours according to the directions of the manufacturers. All dietary staff was re-in serviced to the importance of the proper solution. QA forms were adapted and QA will be done by Dietary Supervisor weekly for 1 month and then monthly for 1 year. Responsibility: Dietary Supervisor.	11-11-12

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 _____	11/08/2012

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 371	Continued From page 15 Observation on 11/05/12 at 1:20 p.m. showed a dietary staff member (#3) sprayed chlorine sanitizer on dining room tables after the noon meal. The dietary manager (#4) tested the solution with a strip which identified a concentration of greater than 200 ppm. The dietary manager (#4) stated the chlorine sanitizing solution should be 100 ppm and disposed of the solution in the spray bottle. During an interview on 11/05/12 at 1:25 p.m., a dietary staff member (#3) stated she uses the chlorine sanitizing solution in the spray bottle until it runs out, usually after two or three days. On 11/06/12 at 1:30 p.m., a dietary manager (#4) tested a spray bottle of sanitizing solution with a strip which identified a concentration of greater than 200 ppm. On 11/06/12 at 1:45 p.m., the dietary manager (#4) confirmed the dietary staff failed to mix a new batch of solution every eight hours and maintain a concentration of 100 ppm as identified by the manufacturer's recommendations.	F 371		