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	355103	A. BUILDING _____ B. WING _____	11/03/2016

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 October 31, 2016 and completed on November 3, 2016, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to promptly investigate 1 of 1 abuse allegation. Failure to implement written abuse prevention policies and procedures and ensure a prompt investigation placed residents at risk for abuse and mistreatment. Findings include: Review of the facility's policy titled "Abuse and Neglect Policy" occurred on 11/02/16. This policy, revised 10/20/16, stated, ". . . IDENTIFICATION: 1. Any staff witnessing or possessing knowledge of any act or suspected act, patterns, or trends involving mistreatment, neglect, or abuse . . . must IMMEDIATELY notify the charge nurse, who in turn will notify the D.O.N. [director of nursing], the ADMINISTRATOR, or the SOCIAL SERVICE DESIGNEE. . . . INVESTIGATION: . . . The	F 226	We are unable to take corrective action as this event already occurred. All residents have the potential to be affected by staff not reporting abuse/neglect allegations in a timely manner. The current policy/procedure for reporting abuse is being reviewed and revised. All Department Heads and Nursing Staff will be reeducated on the correct procedure for reporting abuse allegations and the proper way to complete the 1st Abuse Report. The SSD, Administrator or D.O.N. will check daily for any abuse/neglect allegations for one (1) month and then will monitor weekly for three (3) months and then monthly for 6 months and then quarterly thereafter for two (2) years. Results of monitoring will be immediately	12/6/16

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

Electronically Signed | 11/22/2016

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F 226	Continued From page 1 charge nurse on duty and/or the D.O.N and the Social Worker/Designee will conduct a physical examination of any alleged victim as soon as possible but no later than two hours following the allegation report. . . ." Review of the facility's abuse investigation identified an allegation of verbal abuse/neglect on 05/19/16. The investigation identified the direct care staff member who witnessed the incident reported it to the charge nurse; however, the charge nurse failed to inform administrative staff of the incident and/or perform an assessment of the involved resident. On 05/24/16, the direct care staff member also informed administrative staff of the incident, and an investigation began (five days after the alleged incident).	F 226	reported to D.O.N or Administrator. The SSD will submit a report of the monitoring results to the QA Committee at each scheduled meeting. Monitoring will begin December 1, 2016	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. 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	F 278		12/6/16

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F 278	Continued From page 2 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 record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.13), and staff interview, the facility failed to use the entire required days of observation when completing Minimum Data Set (MDS) sections, B, C, and E on 4 of 9 sampled residents (Residents #2, #5, #8, and #9) and 1 closed record (Resident #10). Failure to collect assessment information for the entire required observation period may result in an incomplete and/or inaccurate assessment of the resident's hearing, speech, vision, cognitive patterns, and behaviors. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, October 2016, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, for a MDS item with a 7-day	F 278	We are unable to take corrective action as we are past the timeframe for completion of those assessments. All residents are at risk for being affected by staff completing assessments prior to the end of the reference date. The staff member that completes sections B,C, E and Z will review the RAI manual pertaining to sections B,C,E and Z to insure that he/she knows the rules pertaining to the completion of those sections and the appropriate time frame in which to do so. Prior to completion date the MDS coordinator will review signatures on MDS to insure that entire look-back time is utilized. Once a month, for six months and then quarterly for two years the MDS coordinator, D.O.N., and/or administrator will complete a review of 3-5 randomly chosen resident MDS. Whoever completes the review of the MDS will be responsible for reporting findings to the Q.A. committee at each scheduled meeting.	

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look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations and events through the end of the day (midnight) of the ARD . . ."

Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed. . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.

- Record review for Resident #2, #5, #8, #9, and #10, occurred between 10/31/16 and 11/02/16. Review of these records revealed a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three sections (B, C, and E), as the staff member signed and dated each assessment as completed prior to the the ARD.

For Resident #2, #5, #8, #9, and #10, listed below is the ARD of the current OBRA (Omnibus Budget Reconciliation Act) MDS, and the completion date identified at Z0400 for Sections B, C, and, E:

* Resident #2 - ARD 08/14/16. Sections B, C, and E completed 08/12/16

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F 278	Continued From page 4 * Resident #5 - ARD 08/07/16. Sections B, C, and E completed 08/05/16 * Resident #8 - ARD 10/01/16. Sections B, C, and E completed 09/30/16 * Resident #9 - ARD 05/08/16. Sections B, C, and E completed 05/06/16 * Resident #10 - ARD 09/20/16. Sections B, C, and E completed 09/19/16 During an interview on 11/02/16 at 2:00 p.m., an administrative nurse (#1) verified staff should wait until after the ARD to complete the MDS sections or parts of sections not requiring a resident interview.	F 278		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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		12/6/16

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F 329	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure each resident's drug regimen was free from unnecessary medications for 2 of 9 sampled residents (Resident #4 and #7) receiving psychotropic medications. Failure to attempt a gradual dose reduction (GDR) or provide an explanation as to the benefit versus risk for continued use placed residents at risk of receiving medications in either excessive dose, excessive duration, or without adequate indications for use. Findings include: Review of the policy titled "Antipsychotic Medications" occurred on 11/02/16. This policy, dated 03/30/16, stated, "Policy: Four Seasons HealthCare Center supports the cooperative efforts of the Physician, Pharmacist, Nursing staff, and mental health professionals to establish specific goals and objectives for review of the use of antipsychotic medications. . . . If medication therapy is indicated, the agent selected should be the most effective with the fewest side effects. Consistent monitoring should be done to assess the risk/benefit relationship of psychotropic drug therapy, included the . . . continued need for the medication. . . . The doctor or psychiatrist will make the determination as to whether attempts will be made to decrease	F 329	Resident #4, and #7 will have a review of antipsychotic medication performed by their primary MD and a dose reduction will be attempted or there will be clear documentation from MD as to why the dose reduction was not attempted. All residents on antipsychotic medications have the potential to be affected. A new policy/procedure for dose reductions will be developed. The RN that assists with MD rounds will inform the MD of the revised policy. The RN that assists with doctor rounds will monitor to assure that dose reductions are attempted at least once a year. A member of the Q.A. team will monitor quarterly for one year that the doctor has reviewed psychotropic medications. The SSD, D.O.N, MDS coordinator or administrator will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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the antipsychotic medication to the lowest possible dose needed to manage the behavioral difficulty, while minimizing adverse effects and side effects. They will also assess the need for continual drug therapy. . . ."

Review of the policy titled "Policy and Procedure on Gradual Dose Reductions" occurred on 11/03/16. This undated policy stated, "Policy: To ensure the appropriate treatment and medication are given to . . . residents, it is the policy . . . that any resident on an antidepressant, antipsychotic, or antianxiety medication have trial dose reductions at least yearly unless clear documentation from resident Physician or Psychiatrist as to why dose reduction should not be done. Procedure: Any resident on an antidepressant, antipsychotic, or antianxiety the following will be done: 1.) Have a current diagnosis to support medication use. 2.) Resident to be seen and medication evaluation at least quarterly. 3.) Dose reduction to be done at least yearly. 4.) Put on To Do List to do follow-up behavior charting for at least 2 weeks. 5.) Update MD [Medical Doctor]/Psychiatrist for any increase in behaviors and/or concerns. 6.) Careplan."

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included several types of dementia. Medications included Seroquel, an antipsychotic, 25 milligrams (mg) daily, ordered on 12/26/14 for "hallucination." The QA (quality assurance) Psychotropic Medication Reduction Flowsheet, dated September 2016, identified a start date of 07/20/12 for Resident #4's Seroquel.

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Resident #4's current care plan stated, "Problem (Psychotropic Med [medication] Use): I am at risk for Adverse side effects . . . I have a diagnosis of dementia and have a history of hallucinations . . . Dose reduction last done 11/12/13. . . ."

A Pharmacy Review Report, dated March 2016, stated, "Alternative treatment or medication should be considered (explain): Seroquel 25 mg . . . has been used since 12/26/14 to treat visual hallucinations. A dosage decrease is suggested to assess the continued need for the medication." A physician assistant (PA) responded, "No dose reduction due to hx [history] of [increased] hallucinations. Daughter does not want dose decrease." The resident's physician, per federal regulation and facility policy, failed to address the Pharmacy Review Report recommendation.

Review of the Minimum Data Sets (MDS) for the past year, dated 10/05/16, 07/05/16, 04/05/16, 01/05/16, and 10/05/15, showed Resident #4 did not experience hallucinations or behaviors during the assessment periods.

Resident #4's record lacked evidence the physician attempted a gradual dose reduction for Seroquel in over a year, or documented an explanation as to the benefit versus risk for continued use or why a dose reduction should not be attempted.

- Review of Resident #7's medical record occurred on 11/02/16. Diagnoses included dementia with behavioral disturbance. Medication included Seroquel 50 mg twice daily and 125 mg daily at noon for "anxiety." The QA Psychotropic Medication Reduction Flowsheet, dated

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F 329	Continued From page 8 September 2016, identified a start date of 05/12/14 for Resident #7's Seroquel. Resident #7's current care plan stated, "Problem (Psychotropic Med Use): I am at high risk for adverse side effects . . . dose reduction of seroquel done 4/16/15 . . ." A Pharmacy Review Report, dated March 2016, stated, "Alternative treatment or medication should be considered (explain): Resident has been stable on quetiapine [Seroquel] therapy at a dose of 50 mg in the morning, 125 mg at noon, and 50 mg at 2000 [8 p.m.]. Trial of gradual dose decrease is suggested - possibly by decreasing his noon dose to 100 mg." The PA initialed the form and failed to address the Seroquel dose. The resident's physician failed to address the Pharmacy Review Report recommendation. Resident #7's record lacked evidence the physician attempted a gradual dose reduction for Seroquel in over a year, or documented an explanation as to the benefit versus risk for continued use or why dose reduction should not be attempted. During an interview on the afternoon of 11/02/16, when asked for evidence a physician reviewed the Pharmacy Review Reports recommendation for GDRs, an administrative nurse (#1) was unable to provide any evidence.	F 329		
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	F 371		12/6/16

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F 371	Continued From page 9 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, review of professional reference, and staff interview, the facility failed to store food under sanitary conditions in 1 of 1 facility kitchen. Failure to separate ready-to-eat food from raw food and discard ready-to-eat, potentially hazardous food within seven days may result in foodborne illness and affect all residents who consume food prepared in this kitchen. Findings include: The 2013 Food and Drug Administration (FDA) Food Code, page 92, states, ". . . (A) . . . refrigerated, Ready-to-Eat, Time/Temperature Control for Safety Food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of [41 degrees Fahrenheit] or less for a maximum of 7 days. . . . refrigerated, Ready-to-Eat, Time/Temperature Control for Safety Food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment . . . to indicate the date or day by which the food shall be consumed on the	F 371	Corrective action was taken by Dietary Manager as soon as the deficient practice was identified (i.e. the over-dated lunch meat was discarded and the cooked product was placed in a different pan on a shelf above the raw items.) All residents have the potential to be affected, therefore the following practices will be developed and implemented. 1) A Dietary In-service will be held to re-educate all dietary staff on the proper techniques for thawing food, the correct way to read a use by label and what to do when food is outdated. 2) Shelves in the walk-in refrigerator will be clearly labeled indicating where food should be placed to thaw. The Registered Dietician and/or the Dietary Supervisor will monitor weekly for 2 months and then bi-monthly for 6 months and then quarterly for two years. Results will be reported to the Administrator. If concerns are identified, corrective action will be implemented in a timely manner. The Dietary Manager will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 371	Continued From page 10 premises, sold, or discarded, based on the temperature and time combinations specified in [paragraph A] . . ." Review of the facility policy titled "Food Storage" occurred on 11/02/16. This policy, dated 2008, stated, ". . . Cooked foods must be stored above raw foods to prevent contamination. . . ." A tour of the facility's kitchen occurred on the afternoon of 10/31/16. Observation in the walk-in cooler showed a fully cooked, ready-to-eat ham stored in the same container as two raw turkeys. Observation showed the ham was frozen, and the turkeys were partially thawed. Observation in the reach-in cooler showed an opened package of lunch meat, dated 10/18/16 (13 days prior). The dietary manager (#2) thought the date indicated the day staff opened the package. The dietary manager threw away the lunch meat and moved the ham to a shelf above the turkey. During an interview on the afternoon of 10/31/16, the dietary manager (#2) stated staff should dispose of unused lunch meat within seven days of opening the package, and agreed staff should separate ready-to-eat ham from raw turkey.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		12/6/16

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F 441	Continued From page 11 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure staff followed infection control practices for 1 of 4 sampled residents (Resident #2) observed during cares. Failure to remove gloves and perform hand hygiene after removing soiled dressings and failure to perform hand hygiene	F 441	Unable to take corrective action as the incident has already occurred. All resident who need assistance with toileting have the potential to be affected. The hand-washing policy / procedure will be reviewed and revised as necessary. All staff will be re-educated on the	

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F 441	Continued From page 12 after performing personal cares for an incontinent bowel movement may contribute to the spread of infection within the facility. Finding include: Review of Resident #2's medical record occurred on October 31- November 2, 2016. Medical diagnoses included Stage III pressure ulcer in the sacral region and history of antibiotic resistant wound infection. - Observation on 10/31/16 at 5:15 p.m. showed a certified nursing assistant (CNA) (#3) provided personal cares to Resident #2, who had a large, soft, incontinent bowel movement (BM) while in bed. After cleaning the resident of the BM and removing the soiled brief, the CNA (#3) removed her gloves, applied a new brief, and then applied a leg strap to fasten the resident's urinary catheter tubing to the Velcro leg strap. The CNA (#3) placed pants and shoes on Resident #2 and transferred her from the bed to the wheelchair with a mechanical sit-to-stand lift. The CNA adjusted the resident's clothes, repositioned the resident in the chair, applied foot pedals to the chair, straightened the sheets and blankets on the bed, and cleaned the mechanical lift with disinfectant cloths. The CNA (#3) then entered the bathroom and washed her hands. The CNA (#3) failed to perform hand hygiene after providing perineal cares and before completing other tasks. - Review of the policy titled, "How To Change A Dressing" occurred on 11/02/16. This undated policy stated, "1. Put out all of your supplies that you need. (ex: gloves, tape, dressing, cleansing	F 441	importance of proper glove usage and hand-washing after toileting residents, once the resident is safe. The Infection Control Nurse, ward clerk and/or D.O.N. will monitor to assure that staff are properly washing hands and using gloves. These checks will be conducted weekly for one month, then monthly for 6 months then quarterly thereafter for a year. The Infection Control Nurse, ward clerk and/or D.O.N. will submit a report of the monitoring results to the QA Committee at each scheduled meeting. All residents with wounds requiring dressing changes have the potential to be affected. The Policy /Procedure on How to Change a Dressing will be reviewed / revised. All staff that do dressing changes (R.N., LPN's) will be educated on the new policy and procedure for changing a dressing. Once a week for 3 months the D.O.N. will observe a dressing change (if applicable), then once a month for 6 months dressing changes will be monitored by D.O.N. and then quarterly for one year. All findings will be reported to the Q.A. team at each scheduled meeting.	

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 _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13	F 441		

agent. 2. Wash hands with soap and water. 3. Remove the old dressing and discard. 4. Take of (sic) gloves. 5. Wash hands. 6. Put on gloves. 7. Cleans the wound with normal saline or as prescribed by physician. Inspect the wound . . . 8. Apply your dressing and secure with tape. 9. Remove gloves. 10. Hand wash . . ."

Observation on 11/01/16 at 4:20 p.m. showed the dressing covering Resident #2's coccyx wound came off when staff changed the resident's brief. A nurse (#4) entered Resident #2's room, wearing gloves and carrying dressing supplies. The nurse (#4) set the supplies on the table and removed the packing from Resident #2's stage III pressure ulcer. The nurse then used a gauze pad to clean the area around the wound. Without removing gloves or performing hand hygiene, the nurse removed the Iodoform (sterile gauze treated with an antiseptic and used to pack wounds to facilitate healing) packing from the bottle and lightly packed it into the resident's wound. The nurse then applied a dressing over the top of the packed wound and secured the dressing with tape. The nurse failed to remove her gloves, perform hand hygiene, and don new gloves after removing the soiled dressing/cleaning the wound and prior to packing the wound and applying a new dressing.

During an interview on 11/01/16 at 5:15 p.m., an administrative nurse (#1) confirmed staff should perform hand hygiene after perineal care and prior to completing other tasks and confirmed staff should remove gloves and perform hand hygiene after removing soiled dressings.