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 _____	11/18/2015

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 11/16/15 and completed on 11/18/15 the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and review of manufacturer's instructions, the facility failed to follow professional standards of practice for 2 of 2 residents (Resident #11 and #12) observed receiving insulin. Failure to follow manufacturer's instructions for priming an insulin pen has the potential for residents to receive an incorrect dose of insulin. Findings include: Review of the Novolog FlexPen manufacturer's instructions, dated 2014, stated, ". . . To avoid injecting air and ensure proper dosing: Turn the dose selector to 2 units. Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. . . . "	F 281	At this time we are unable to take corrective action for those residents affected. All insulin dependent residents are at risk for licensed nurses to fail to follow manufacturer's instructions for priming an insulin pen. All licensed nurses have been shown the proper procedure for priming insulin pens. The D.O.N. will revise/update the Insulin Administration Policy and Procedure sheet. A Q.A. will be completed by D.O.N. once a week for three (3) months and then quarterly thereafter for a year to insure that the licensed nurses are correctly priming the insulin pens.	12/31/15

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

Electronically Signed | 12/04/2015

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F 281	Continued From page 1 - On 11/16/15 at 5:22 p.m., observation showed a licensed nurse (#5) prepared Resident #11's insulin injection. The nurse primed the Novolog FlexPen with two units of insulin while pointing the pen horizontally. - On 11/16/15 at 5:32 p.m., observation showed a licensed nurse (#5) prepared Resident #12's insulin injection. The nurse primed the Novolog FlexPen with two units of insulin while pointing the pen horizontally. Staff failed to hold, tap, and prime the pens in an upright position, therefore possibly giving an inaccurate dose of insulin.	F 281		
F 323	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, review of facility policy, resident interview, and staff interview, the facility failed to ensure appropriate use of assistive devices to prevent accidents for 1 of 5 sampled residents (Resident #2) observed transferred with a mechanical sit-to-stand lift. Failure to assess and evaluate Resident #2's capability, including providing interventions to	F 323	PT/OT will evaluate resident #2 to insure that the PAL lift is appropriate for her. All residents who need mechanical lifts are at risk for inappropriate use of assistive devices. D.O.N. will re-educate staff on coming to D.O.N. if they feel that lifts are not working properly and if they witness that a	12/31/15

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F 323	Continued From page 2 help strengthen the resident's lower extremities resulted in an unsafe transfer utilizing a sit-to-stand mechanical lift. This placed Resident #2 at risk for falls, pain, and injury. Findings include: Review of facility policy and procedure on the use of the Pal (sit-to-stand) lift occurred on 11/18/15. This policy and procedure, dated 07/15/15, stated: "POLICY: It is the policy . . . to ensure that each resident is safely transferred using the Pal Lift. PROCEDURE: The Pal lift is used on residents who are able to use their hands to hang onto the handles and who are able to stand on their legs. . . . PT/OT [physical therapy/occupational therapy] to evaluate for any concerns on PAL lift transfers. PAL lifts should never be used on residents who cannot hang onto the Pal lift handles or who can not or can no longer stand up using their legs. If a resident can no longer stand using their legs, or they are not able to hang onto the handles for whatever reason, the Hoyer lift may need to be used. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included paraplegia. Review of a quarterly Minimum Data Set (MDS), dated 11/14/15, and an annual MDS, dated 05/14/15, identified the resident required extensive assistance with transfers by one person and "Functional limitation in Range of Motion" of both lower extremities. The MDS identified the resident as cognitively intact. The current care plan identified a problem of needing	F 323	resident has any problems gripping the handles of the lift or with standing. D.O.N. will develop a lift assessment form to be used in determining whether mechanical lift is appropriate or not. Q.A. will be performed monthly for (3) three months and then quarterly thereafter to insure that lifts are appropriate for the residents they are being used on.	

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F 323	Continued From page 3	F 323		

help with Activities of Daily Living (ADLs) including, ". . . TOILETING: I need one assist with toileting during the day. Staff transfer me with the PAL lift in the big bathroom by the nurse's station and provide cares for me after toileting. . . . TRANSFERRING: I use the PAL lift and one assist with transfers. . . ."

An entry in the nurse's progress notes, dated 11/23/14, stated regarding the resident: "MUSC [muscular]/SKELETAL FINDINGS: paralysis lower extremities. LOWER EXTREMITY ROM [range of motion]: loss noted, ADL interference and/or risk of injury present." The medical record identified currently Resident #2 received passive range of motion to both legs three times a week.

During interview on 11/16/15 at 2:40 p.m., Resident #2 stated at times the stand lift would not lift her up, but let her down.

During observation on the afternoon of 11/16/15, a certified nursing assistant (CNA) (#8) transferred Resident #2 from a wheelchair to the toilet utilizing a sit-to-stand lift. After the CNA connected the harness to the lifting arms and pushed the 'up' button on the hand controls, Resident #2 stated, "See how it don't lift." Observation showed the resident's trunk raised slightly and the resident's legs maintained little greater than a 90 degree angle to get the resident onto the toilet. This required the lift to provide the support for the transfer. This occurred also the transfer off the toilet as well.

During observation on the afternoon of 11/17/15, a CNA (#4) transferred Resident #2 from a wheelchair to toilet utilizing the sit-to- stand lift.

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F 323	Continued From page 4 Observation showed Resident #2's trunk raised slightly and the resident's legs maintained little greater than a 90 degree angle to get the resident onto the toilet. This required the lift to provide the support for the transfer as noted above. After toileting, the CNA notified two nurses to come do a dressing change. The CNA raised the resident up to get her off the toilet, and with the resident suspended from the harness, knees at a 90 degree angle, and not bearing weight the two nurses (#5 and #9) performed a treatment to the resident's upper buttock which included a dressing removal, cleansing, and placement of a new dressing. During interview on 11/17/15 at 5:30 p.m., an administrative staff nurse (#2) stated she expected staff to inform her when they think a resident needs more or less assistance with transferring. She stated an evaluation would be completed to determine if a change to the transfer should be made for that resident. When asked if an evaluation had occurred, either by nursing or physical/occupational therapy for Resident #2, the nurse stated an evaluation had not been done. Failure to assess, provide appropriate interventions specific to Resident #2's needs/current health status, and evaluate the resident's capabilities to utilize the lift safety placed the resident at risk for falls, pain, and injury.	F 323		
F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		12/31/15

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F 371	Continued From page 5 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 and staff interview, the facility failed to store food under sanitary conditions for 1 of 1 kitchen. Failure to maintain the cleanliness of the kitchen does not ensure food is prepared and served under sanitary conditions. Findings include: The dietary tour occurred on 11/16/15 at 2:43 p.m. with a dietary manager (#7). Observation during the tour showed the following: * Dust/debris on and around the fan in the walk-in cooler. * A large amount of ice build up around the base of the walk-in freezer. * A pair of shoes under the three compartment sink. * A coat on a side table in the kitchen. During an interview on 11/17/15 at 1:10 p.m., the dietary manager (#7) stated the fan needed cleaning in the walk-in cooler and agreed the ice build up was an issue.	F 371	At this time we are unable to take corrective action for those residents affected by this deficient practice. All residents that use the dietary services are at risk; therefore all dietary staff will be in-serviced on kitchen sanitation, cleaning schedule and placement of personal items. The weekly cleaning schedule will be updated to include cleaning of fan in walk-in refrigerator and clearing of condensation in the freezer. The Dietary Manager will conduct Q.A.'s to monitor for kitchen sanitation for the dietary department. Q.A.'s will be completed once a week for one (1) month and then quarterly thereafter.	
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		12/31/15

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F 441	Continued From page 6 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 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	F 441		

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F 441	Continued From page 7 by: Based on observation, record review, review of facility policy and procedures, and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 3 of 4 sampled residents (Resident #1, #2, and #5) observed transferred with a sit-to-stand lift, 1 of 2 sampled residents (Resident #4) with a Foley catheter, and 2 of 2 sampled residents (Resident #1) with a history of Methicillin Resistant Staphylococcus Aureas (MRSA). Failure to follow established infection control practices may result in the spread of infection within the facility. Findings include: Review of the facility policy and procedure on contact precautions occurred on 11/18/15. The policy and procedure, dated 11/14/13, stated: "POLICY: To help prevent/stop the spread of infection from resident to another resident. PROCEDURE: When a resident is placed on contact precautions, the following will be done: . . . Put in treatment book to wipe down w/c [wheelchair], walker, blood pressure cuff, stethoscope etc. . . ." - LIFT TRANSFERS/CONTACT PRECAUTIONS Review of the facility "POLICY AND PROCEDURE ON USING PAL LIFT [sit-to-stand]" occurred on 11/18/15. The procedure, dated 07/15/15, stated: "PROCEDURE: . . . When using the Pal lift the following will be done . . . Pal lift to be wipe [sic] off after each use using one-minute Tb [tuberculocidal sanitizing] wipes. . . ."	F 441	At this time we are unable to take corrective action for resident #1,#2 and #5. All residents are at risk for the spread of infection within the facility, therefore D.O.N. will do re-education for all nursing staff on the Policy / Procedure of sanitizing the mechanical lifts. D.O.N. will update Policy and Procedure on proper storage of medications for residents on contact precautions. D.O.N. will re-educate all licensed nursing staff of the proper storage of medications for residents on contact precautions. D.O.N. will do a Q.A. monitoring the proper storage of medications for residents on contact precautions once a week for three (3) months and then quarterly thereafter for (1) one year. D.O.N. will do a Q.A. monitoring for proper procedure of sanitizing the mechanical lifts weekly for three (3) months then quarterly thereafter for one (1) year. Any resident with catheters are at risk for improper care of their catheters. All nursing staff will be given the policy and procedure sheet on proper catheter care. All nursing staff will demonstrate proper catheter care to D.O.N., infection control nurse or charge nurse. D.O.N will do a Q.A. monitoring for proper catheter care once a weekly for three months and then quarterly thereafter for one year.	

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During observation on the afternoon of 11/16/15, a certified nursing assistant (CNA) (#8) transferred Resident #2 onto and off the toilet utilizing a sit-to-stand lift. The CNA failed to wipe off the lift following use and moved it to a storage area for reuse. Resident #2's care plan identified the resident on contact precautions due to a history of MRSA.

During observation on the afternoon of 11/16/15, two CNA (#8 and #10) utilized a Hoyer lift to transfer Resident #1 from the bed to a wheelchair. The CNA's failed to wipe off the lift following use and returned the lift to a storage area for reuse. Resident #1's care plan identified the resident on contact precautions due to a history of MRSA.

Observation on 11/17/15 at 8:45 a.m. showed two CNAs (#3 and #4) used a sit-to-stand lift for Resident #5. The CNAs failed to clean the lift before returning it to the storage area.

Observation of the lifts in the storage area identified each had a container of sanitizing wipes attached to the lift.

- On 11/16/15 at 3:45 p.m., a nurse (#5) performed a dressing change to Resident #1's gastric tube insertion site. The dressing change included a light application of Desenex powder around the site. The nurse completed this task and then removed the Desenex powder from the room and took it to the medication room for storage in the resident's medication drawer. On 11/17/15 at 2:45 p.m., a nurse (#5) completed the same task and again brought the container of Desenex into the room and carried it out of the

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room after use. In addition, the nurse brought in a container of Gentac silicon tape and removed it from the room and carried it to the medication room. Resident #1's care plan identified the resident on contact precautions due to a history of MRSA.

During interview on the morning of 11/18/15, a supervisory nurse (#2) stated she expected staff to not remove the Desenex powder from Resident #1's room after use.

- CATHETER CARES

Review of the facility policy and procedure on emptying a urinary collection bag occurred on 11/18/15. The policy and procedure, dated 05/15/15, stated, ". . . PROCEDURE . . . 3. Wipe outlet tube with an alcohol wipe. . . . allow urine to drain from bag. . . . Clamp the outlet tube. Wipe the outlet tube with an alcohol wipe and replace in holder. . . ."

During observation on 11/16/15 at 5:10 p.m., a CNA (#11) emptied Resident #4's Foley catheter drainage bag. The CNA failed to wipe the outlet tube with an alcohol wipe before draining the urine into a graduate and before returning the outlet tube into the holder.

During interview of 11/18/15 at 11:20 a.m., a supervisory nurse (#2) stated staff are required to clean the outlet of catheter tubing with alcohol after emptying.