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 ______	12/06/2018

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 The standard Medicare/Medicaid recertification survey started on 12/03/18 and concluded 12/06/18.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		1/10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/19/2018

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F 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: 1. Based on review of facility provided Medicare Part A letters/notices, and staff interview, the facility failed to provide the correct uniform denial letter "Skilled Nursing Facility Advanced Beneficiary Notice Form CMS-10055", and to include the Quality Improvement Organization (QIO) name on the "Notice of Medicare Non-Coverage Form CMS 10123-NOMNC" provided to 3 of 3 residents (Resident #7, #17, and #29) discharged in the last 6 months from a Medicare covered Part A stay, with benefit days remaining. Failure of the facility to provide the correct letters/notices (Resident #7, #17, and #29) that contained correct/accurate information limited the residents' ability to exercise their rights regarding Medicare Part A services.	F 582	The new CMS letter 10055 will be sent to resident #7, #17 and #29. The corrected CMS letter 10123 will be sent to resident #7, #17 and #29 with the corrected QIO information highlighted. All current residents on a part A stay have the potential to be affected by the deficient practice. Therefore all CMS 10123 letters have been updated to include the QIO Kepro and the new CMS 10055 letter will be used moving forward. Resident #7 was issued a refund in the amount of $420.12 on 12/19/2018. A demand bill was filed on 12/19/2018 for the dates 9/21/2018 to 10/26/2018 (which would be days covered by demand bill). It was explained to resident #7 that if the	

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F 582	Continued From page 2 Finding include: - On 12/05/18 at 9:58 a.m. review of the Medicare Part A notices/letter provided to Resident #7, #17, and #29, showed the facility issued expired notices to the residents. The Centers for Medicare and Medicaid Services (CMS) revised the CMS-10055 as of January 2018 and by May 7, 2018 all long-term care facilities had to initiate the new form. The denial letters reviewed included the following: *Resident #7 - denial letter signed and dated 09/18/18. *Resident #17 - denial letter signed and dated 11/06/18. *Resident #29 - denial letter signed and dated 07/16/18. - On 12/05/18 at 9:58 a.m. review of the CMS 10123 forms for Resident #7, #17, and #27 showed the facility failed to include the name of the QIO in the information provided to the residents. During an interview on 12/05/18 at 9:58 a.m., an administrative staff member (#3) confirmed the CMS Form 10055 was not updated in May, and the CMS Form 10123 used by the facility failed to include the name of the QIO. 2. Based on facility billing statements, and staff interview, the facility failed to respect a resident's choice of a Demand Bill for 1 of 1 resident (Resident #7) who requested a Demand Bill. Failure of the facility to honor the request of a Demand Bill by continuing to bill the resident for Medicare Part A expenses disregards the resident's right to challenge the facility	F 582	demand bill is denied she will be responsible to repay the $420.12 that was refunded to her. Administrator and Business Manager reviewed the educational material Demand Bill at https://www.novitas-solutions.com and also reviewed the CMS Form instructions Advance Beneficiary Notice of Noncoverage (ABN). Once a month the business manager will check the CMS website for any new Medicare letters and will replace the existing letters as needed. Once a week for twelve (12) weeks; then once a month for twelve (12) months and then quarterly thereafter for two (2) years an internal audit will be conducted to check to see if there were any demand bills; and to insure that the proper letter(s) were sent. The business manager will report her findings to the QAPI team on a quarterly basis for two (2)years.	

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F 582	Continued From page 3 determination for termination of Medicare Part A benefits. Findings include: During an interview on 12/05/18 at 9:58 a.m., an administrative staff member (#3) reported the facility billed and received payment from Resident #7 after she completed the request for a Demand Bill. This staff member (#3) reported the facility informed Resident #7 the resident would be reimbursed for any payment sent from Medicare, after the determination by Medicare on the Demand Bill. - Review of the CMS-10055 completed by Resident #7 showed the resident indicated the desire for a Demand Bill. Review of the billing statements, on 12/05/18 at 10:49 a.m., showed the facility billed and received payment from, Resident #7.	F 582		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		1/10/19

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F 644	Continued From page 4 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) & Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to refer 2 of 2 sampled residents (Resident #26 and #31) reviewed for PASRR screening for evaluation following a significant change in status. Failure to refer residents with newly evident mental disorders to the appropriate state-designated authority (Ascend) for a level II PASRR evaluation may result in the residents not receiving the appropriate care and services for their mental health disorders. Findings include: The North Dakota PASRR Provider Manual, page 13, states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was	F 644	Corrective Action was taken on 12/6/2018 for both residents #26 and #31. A new PASRR Level I was completed and sent to DDM for review. Approval for nursing home stay was granted on 12/10/2018 for resident #26 and Resident #31. All residents currently residing at FSHCC have the potential to be affected by this deficient practice, therefore the Administrator and / or the SSD will do on internal audit on all resident records for residents currently residing at FSHCC to determine if a new PASRR Level I is required due to a significant change in status or a new mental illness diagnosis. SSD attended a Ascend (Maximus Company) ND PASRR Provider Training on 10/9/2018. Administrator and SSD reviewed the educational material provided at the course on 12/21/2018. Administrator and SSD also viewed PASRR Info with Dan Timmel video on 12/21/2018. An internal audit will be completed on a quarterly basis for one year and the results of the audit will be reported to the QAPI team on a quarterly basis for one year by the SSD. A morning huddle Q.A. form has been developed that specifically asks if there	

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F 644	Continued From page 5 discovered. . . ." - Review of Resident #31's medical record occurred on all days of survey. The record showed a PASRR Level I, dated 06/02/11, identified mild or situational depression, ". . . No Level II Evaluation needed. . . . No further Level I screening is required unless a significant change occurs which suggests the presence of mental retardation condition, a developmental disability, or a major mental illness which is not dementia." Resident #31's record included diagnoses of bipolar II disorder and personality disorder on 10/01/15, and major depressive disorder on 01/24/18. The record lacked evidence staff submitted an updated PASRR I screening to Ascend following the change in Resident #31's status. During an interview on 12/05/18 at 2:28 p.m., a social service's staff member (#1) confirmed the facility failed to submit an updated PASRR I to Ascend after Resident #31's change in status. - Review of Resident #26's medical record occurred on all days of survey. The record identified, on 10/02/12, staff completed a Level I screening for Resident #26. The record showed a new diagnosis of personality disorder (10/01/15), bipolar II disorder (01/24/18), major depressive disorder (01/24/18), and generalized anxiety disorder (09/12/18). The record lacked evidence staff performed a new Level I assessment following these new diagnosis. During an interview on 12/05/18 at 2:52 p.m., a social service's staff member (#1) confirmed staff	F 644	have been any significant change in status for any residents and / or any new psychotropic medications started or new mental health diagnosis. These morning huddle forms are completed daily Monday thru Friday and SSD will complete a PASRR level I on any resident that needs one. SSD and / or administrator will review daily huddle forms on a weekly basis for three (3) months, then review monthly for a year. The findings will be reported to QAPI team on a quarterly basis for one (1) year.	

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F 644	Continued From page 6 failed to submit a new Level I PASRR when Resident #26 received the new diagnosis.	F 644		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, resident group interview, and staff interview, the facility failed to ensure sufficient staff for meal service for 2 of 2 observations (evening meal 12/03/18 and noon meal 12/04/18). Failure to serve resident meals in a timely manner did not enhance the dining experience for the facility's residents. Findings include: - During an interview on 12/03/18 at 3:20 p.m., a	F 802	No corrective action can be taken for the slow meal service on 12/3/18 or 12/4/18 as those dates have passed. All residents of FSHCC have the potential to be affected by slow meal service; therefore moving forward a policy and procedure will be developed regarding meal service and substitutions. This policy and procedure will be explained to each resident by dietary manager and a reminder will hang on the menu board. A letter will be sent out	1/10/19

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F 802	Continued From page 7 dietary manager (#2) stated breakfast is "open" scheduled from 7:00 a.m. to 9:30 a.m., lunch is served at 11:30 a.m., and dinner is served at 5:00 p.m. - Observation of the dinner meal service on 12/03/18 showed residents in the dining room at approximately 4:45 p.m. and staff beginning to serve residents at approximately 5:00 p.m. Observation showed the last resident meal tray served in the dining room at 6:25 p.m., one hour and twenty-five minutes after the scheduled start of meal time. - Observation of lunch meal service on 12/04/18 showed residents in the dining room at approximately 11:15 a.m. and staff beginning to serve residents at 11:33 a.m. Observation showed the last resident meal tray served in the dining room at approximately 12:30 p.m., one hour after the scheduled start of meal service. - During the resident group interview on 12/04/18 at 1:14 p.m., six of nine residents in attendance identified service for supper the night before and the noon meal earlier today "took forever". At the noon meal today, one of the residents attending group, described the meal service to the serving staff as, "[expletive]". - During an interview on the afternoon of 12/05/18, a dietary manager(#2) and an administrative staff member (#4) agreed staff failed to serve the meals in a timely manner.	F 802	explaining this policy / procedure to the resident's representative as needed. Policy / Procedure for Timely Meal Service: POLICY: Food will be delivered promptly to assure proper temperatures and high-quality food. PROCEDURE: 1) Nursing staff will notify the food service department in writing of those who wish to eat in their rooms. 2) Room trays will be prepared after all residents in main dining room have been served. The plate and any juice receptacles will be covered. 3) Dietary staff will notify charge nurse that room trays are ready to be delivered. Charge nurse will appoint staff member to supervise / assist resident if needed. 4) At least one person will be stationed in the dining room during meal service to assist individuals with eating and to handle any emergency situation that might arise. 5) To ensure timely meal service residents are encouraged to make special/alternate menu request at meal previous to meal where substitution is requested (if substitution requested for evening meal request preferred at noon meal.) 6) When special / alternate is requested at mealtime, resident will be served their request after all residents are served the meal. (This includes residents choosing to eat in their rooms or at any other location besides main dining room.) 7) See attached sign on menu board. The dietary department will review the	

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F 802	Continued From page 8	F 802	new policy / procedure regarding meal service and substitutions at a dietary in-service. Dietary manager will observe and times meals three (3) times a week for one (1) month, once a week for three (3) months and then monthly thereafter for a year. Dietary manager will report his findings to the Q.A.P.I. team at their quarterly meetings.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of the Food and Drug Administration (FDA) Food Code 2013, and staff interview, the facility failed to store, prepare,	F 812	Corrective action was taken on 12/6/2018 the dishwasher booster was activated and the water temperature in	1/10/19

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F 812	Continued From page 9 and serve food under sanitary conditions in 1 of 1 kitchen (Main kitchen). Failure to ensure proper sanitation of dishes and utensils may result in foodborne illness to residents, staff, and visitors. Findings include: The FDA Food Code 2013, pages 145-146, stated, ". . . Sanitization of equipment and utensils . . . Hot water mechanical operations . . . achieving utensil surface temperature of 71 degrees Celsius [C] (160 degrees Fahrenheit [F]) as measured by an irreversible registering temperature indicator. . . ." Observation on 10/12/18 at 9:45 a.m. showed a dishwasher currently in use in the main kitchen. A hotplate thermometer, placed in the dishwasher, showed a maximum temperature of 140 degrees F on two consecutive cycles. This surveyor indicated all dishes would need to be rewashed. The "Dishwasher Temperature Record" indicated, ". . . Rinse must be 180 degree F. . . " Review of the November 2018 dishwasher temperature record showed the kitchen staff failed to record temperatures 17 out of the 30 days and 4 of the 13 temperatures recorded were below 180 degrees F. An unidentified cook approached the dish washing area and identified the booster on the dishwasher was off. The cook turned on the booster and ran water through. A hotplate thermometer, placed in the dishwasher, showed a maximum temperature of 141.2 degrees F on two consecutive cycles. The kitchen staff members continued to run water through the	F 812	the water tank that supplies the water for the dishwasher was increased until the dishwasher reached the correct temperature. All residents of FSHCC have the potential to be affected by the deficient practice; therefore moving forward dietary staff will record dishwasher temperatures daily. A dietary in-service will be held to educate dietary staff on the policy / procedure for monitoring dishwasher temperatures. The dietary manager will monitor the recording of dishwasher temperatures on a weekly basis and take disciplinary action as needed. Dietary manager will report the results of dishwasher temperatures to the Q.A.P.I. team at their quarterly meetings for one year.	

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F 812	Continued From page 10 dishwasher to increase water temperature. A hotplate thermometer, placed in the dishwasher on 12/06/18 10:15 a.m., showed a maximum temperature of 156.2 degrees F. The kitchen staff members continue to run water through the dishwasher to increase water temperature. A hotplate thermometer, placed in the dishwasher on 12/06/18 10:30 a.m., showed a maximum temperature of 163.2 degrees F. During an interview on the morning of 12/05/18, a dietary staff member (#2) stated he expected dietary staff to check the dishwasher temperatures daily. The facility is responsible to ensure staff monitor/record dishwasher temperatures in the main kitchen. Failure to use a dishwasher thermometer and maintain utensil surface temperatures at 160 F may result in inadequate sanitization and/or foodborne illness.	F 812		