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 _____	R-C 12/30/2024

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 An on-site revisit survey was concluded on 12/30/24 to determine compliance with deficiencies identified during the recertification and complaint survey completed on 10/30/24.	{F 000}		
{F 641} SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 12/30/24 EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 10/30/24 CMS-2567. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) identified in the prior survey 4 of 6 sampled residents (#15, #20, #23, and #24). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTIONS N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page N-6 to N-8, stated, ".	{F 641}	F641 Accuracy of Assessment 1. The MDS Coordinator modified #15, #20, #23, and #24 ‘s Section N of the MDS assessments to reflect that they take aspirin, coding it as an Antiplatelet medication. This was completed on 1/3/2025 by the MDS Coordinator and verified by the Director of Nursing on 1/4/2025. 2. All residents are determined to be affected by staff failing to accurately complete the MDS does not allow each resident’s assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. 3. Education was received on the importance of notifying the MDS Coordinator about new physician orders and how to use the new communication forms for medication changes at the	1/14/25

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

Electronically Signed | 01/15/2025

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{F 641}	Continued From page 1 . . Code all high-risk drug class medications according to their pharmacological classification . . . N0415: High-Risk Drug Classes . . . Coding Instructions: . . . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g. [example] aspirin/extended release . . . was taken by the resident at any time during the 7-day observation period. . . ." - Review of Resident #15's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the annual MDS, dated 07/20/24. - Review of Resident #20's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the annual MDS, dated 09/18/24. - Review of Resident #23's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated 10/05/24. - Review of Resident #24's medical record occurred on all days of survey. The physician's orders included aspirin. The facility failed to code the antiplatelet medication on the quarterly MDS, dated 08/30/24 During an interview on 12/30/24 at 5:45 p.m., administrative staff member (#1) confirmed the modifications for MDSs had not been completed.	{F 641}	All-Staff meeting on 1/14/2025. A Communication form was compiled for nursing staff to let the MDS Coordinator know of new physician's orders or changes for residents. This form will allow the MDS Coordinator to know immediately about changes to be made to the care plan and to any areas that would be coded differently to the MDS. 4. A QA audit for MDS Section N: High-Risk Medications ~ Medication Record 7-day look back compiled for the Director of Nursing to complete on all residents. This form tracks all high-risk medications in Section N and can be compared to the MDS prior to submission date. This QA audit will be reviewed at the quarterly QA meetings by the Director of Nursing. 5. Date of Compliance: 1/14/2025	
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	{F 880}		1/14/25

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{F 880}	Continued From page 2 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	{F 880}		

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{F 880}	Continued From page 3 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: DURING THE ON-SITE REVISIT COMPLETED ON 12/30/24 EVIDENCE SHOWED THE FACILITY FAILED TO ACHIEVE COMPLIANCE WITH THIS REQUIREMENT. Refer to 10/30/24 CMS-2567. Based on observation, record review, and review of facility policy, the facility failed to follow	{F 880}	F880 Infection Prevention & Control 1. (System Failure)Nursing staff were educated on PPE use entering and exiting resident rooms during the COVID-19 outbreak to comply with the CDC standards and Facility Policy. This was completed on 12/31/2025.	

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{F 880}	Continued From page 4 standards of infection control and prevention for 2 of 7 sampled residents (Resident #6 and #8) who tested positive for COVID-19. Failure to practice infection control standards related to COVID-19 precautions, has the potential to spread infection throughout the facility. Findings include: Review of the facility's policy titled "COVID-19 Prevention, Response and Reporting" occurred on 12/30/24. This policy, dated 06/07/24, stated, ". . . It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections . . . HCP [health care professionals] who enter the room of a resident with suspected or confirmed . . . COVID infection should adhere to standard precautions and use a NIOSH [National Institute for Occupational Safety and Health] approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection . . . - Review of Resident #6 and #8's medical record occurred on 12/30/24. Physician's orders, dated 12/29/24, identified contact and droplet precautions related to COVID-19 for both residents. Observation on 12/30/24 at 12:30 p.m. showed a staff nurse (#2) applied a gown, gloves and a standard mask, entered a Resident #6's room, delivered a meal tray, and provided set-up assistance. The nurse (#2) removed the gown and gloves, exited the room, walked down the hall wearing the same mask, applied a new gown	{F 880}	2. All residents, staff, volunteers, visitors, and individuals providing services under a contractual arrangement area at risk of being affected by this deficient act. 3. The facility policy titled “COVID-19 Prevention, response and Reporting was reviewed and revised on 1/2/2025. All staff were educated on said policy on 1/14/2025. Infection Control Education and Skills Checks will be done on hire and annually for all staff, including travel staff effective 1/14/2025. Records will be kept in their training files by their department heads. 4. A QA audit was implemented on 12/31/2024 to audit proper use of Masks and N95s by all staff daily during the COVID-19 outbreak with the goal of 100% compliance. The findings will be compiled and brought to the Weekly QA Committee Meetings and Quarterly QA Meetings by the DON. The Weekly QA Committee has started the process to review and revise the current Infection Prevention and Control Program to the most current national standards on 1/9/2025. Updates will be reported at the QA Meeting quarterly by the DON, to allow for the Medical Director and Pharmacist Consultant to review. 5. Date of Compliance: 1/14/2025	

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{F 880}	Continued From page 5 and gloves, and entered Resident #8's room, delivered a meal tray, and provided set-up assistance. The staff nurse (#2) failed to properly utilize a NIOSH N95 mask or eye protection when entering COVID-19 positive resident rooms. During an interview on 12/30/24 at 12:45 p.m., an administrative nurse (#1) stated staff are expected to wear appropriate personal protective equipment per facility policy during cares for COVID-19 positive residents.	{F 880}		