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	355103	A. BUILDING _____ B. WING _____	09/22/2021

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 The standard Medicare/Medicaid recertification survey started on 09/20/21 and concluded 09/22/21.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		10/15/21

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

Electronically Signed | 10/15/2021

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F 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident and/or resident's representative of a transfer outside of the facility for 1 of 1 sampled resident with a recent hospital transfer (Resident #15). Failure to provide a notice of transfer does not allow the resident and/or representative to make an informed choice regarding the resident's rights. Findings include: Review of Resident #15's medical record occurred on all days of survey. The record identified a transfer to the emergency room and	F 623	483.15 Notice Requirements Before Transfer/Discharge- The facility failed to notify resident #15 and /or family representative of a transfer to the ER with admission to the hospital on 8/28/21. 1. Resident #15 was provided the reason for transfer in writing by the SSD on 9/23/2021 and understanding was verified and documented. The resident's representative was also notified and given a copy of the notice. The State Long-Term care Ombudsman was notified on next business day after transfer	

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F 623	Continued From page 3 admission to the hospital on 08/28/21. The record failed to include evidence of a transfer notice given to the resident and their representative. During an interview on 09/22/21 at 9:05 a.m., a social services staff member (#2) stated she could not find documentation that the facility gave a notice of transfer to Resident #15 and their representative.	F 623	8/30/2021. 2. The facility has determined that all residents who have been transferred or discharged have the potential to be affected. 3. Education to the charge nurses and SSD on charting verbal notice of transfer/discharge to another facility from resident or representative on day it occurs. Education on completing the Bed Hold and having the resident or representative sign if able at time of transfer/discharge. This education will be completed immediately and reviewed at the next nurses meeting. 4. A QA was developed to audit records of all residents who have been transferred or discharged from the facility to ensure the record includes a copy of the transfer/discharge notice. This audit will be completed for a period of twelve weeks by the SSD. This plan of correction will be monitored at the quarterly QA meeting until such time consistent substantial compliance has been met.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the	F 637		10/15/21

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F 637	Continued From page 4 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 3 sampled residents (Resident #17 and #27) admitted to hospice. Failure to determine the need for and complete a SCSA limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.17), revised October 2019, page 2-23 stated, ". . . A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD (assessment reference date) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. . . ."	F 637	483.20 Comprehensive Assessment after Significant Change (Long term care facilities) was not met on resident's #17 and #27 when admitted under the care of Hospice. A significant change MDS was not completed. 1. A significant change for resident's #17 and #27 will be completed in accordance to date of Hospice admission. 2. All residents in the facility have the potential to be affected as they all have the potential to be admitted under Hospice care. 3. Nursing staff and Hospice will be educated regarding giving notice to the MDS Coordinator to alert her to a new Hospice admission. 4. The MDS Coordinator will be responsible to monitor/audit that a significant change is started per criteria when going on Hospice. These new QA audits will be reviewed at the quarterly QA meetings by the MDS Coordinator for a year effective start date of 10/15/2021.	

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F 637	Continued From page 5 - Review of Resident #17's medical record occurred on all days of survey. A physician's order, dated 04/06/21, stated, "referral to (name of hospice agency)."The resident's current care plan stated, ". . .I am receiving hospice services . . ." Minimun Data Set (MDS) completed on 04/15/21 and 07/15/21 weref quarterly assessments. The record lacked evidence a significant change assessment was completed. -Review of Resident #27's medical record occurred on all days of survey. A physician's order stated, "referral to (name of hospice agency) 04/06/21."The hospice admitted Resident #27 on 04/08/21. The record lacked evidence a significant change assessment was completed. During an interview on 09/22/21 at 11:34 a.m., a MDS coordinator (#1) confirmed after admission to hospice the facility failed to complete a significant change MDS assessment for Resident #17 and #27.	F 637		
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: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version	F 641	483.20 Accuracy of Assessments (Long term care facilities) not met for coding on Section A1500/A1510: Preadmission	11/2/21

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F 641	Continued From page 6 1.17), and staff interview, the facility failed to complete Minimum Data Sets (MDSs) that accurately reflected the residents' status for 12 of 13 sampled residents (Resident #1, #2, #5, #11, #12, #13, #15, #16, #17, #27, #28, and #29). Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include: Section A: Identification Information The Long-Term Care Facility RAI Manual revised October 2019, page A-21 to A-23, stated, ". . . Section A1500: Preadmission Screening and Resident Review (PASRR) . . . Coding instructions: Code 0, no, and skip to A1550 . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . and continue to A1510 . . . " -Review of Resident #13's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder, bipolar, and personality disorder. The record showed a new PASRR Level I completed on 12/18/19, Level II referred and completed. Review of the annual MDS, dated 01/13/21, showed section A1500 coded 0, as No, instead of 1, as Yes, which resulted in a skipped coding pattern. Staff failed to code section A1510. Section P: Restraints and Alarms The Long-Term Care Facility RAI Manual, revised	F 641	screening and Resident review (PASRR)coding was not correct on the MDS for Resident #13. 1. For Resident # 13 PASRR coding will be corrected by the MDS Coordinator for all new MDS assessments. 2. All residents who enter or re-enter the nursing home have the potential to be affected. 3. All residents with a new PASRR will be assessed for accurate coding on the MDS. MDS Coordinator will review PASRR when they are completed and refer back to them when coding on the MDS. 4. A QA audit has been developed to check the PASRR screening and MDS section A1500 are coded correctly. The QA will be completed for monthly for one year, with quarterly review at the QAPI meetings with finding reported by the MDS Coordinator. This will be went into effect 10/15/2021. -Coding of Physical Restraints for Resident's #1,2,5,11,12,13,15,16,17,27,28,and #29 on the current MDS identified bed rails coded as restraints under Section P, is incorrectly coded. Upon review of medical records and care conference notes the bed rails were identified as being used for repositioning, turning, or assistance	

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F 641	Continued From page 7 October 2019, page P-1, stated, ". . . PHYSICAL RESTRAINTS . . . Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body . . ." and page P-8 to P-10, ". . . An alarm is any physical or electronic device that monitors resident movement and alerts staff, by either audible or inaudible means, when movement is detected, and may include bed, chair, and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarm, or elopement/wandering devices . . . Bracelets or devices worn by or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E. . . ." Review of Resident #1, #2, #5, #11, #12, #13, #15, #16, #17, #27, #28, and #29's current MDS identified bed rails coded as restraints under Section P. - Review of Resident #1's medical record occurred on all days of survey. The record included a care conference note, dated 09/15/21, which identified bed rails used for repositioning. - Review of Resident #2's medical record occurred on all days of survey. The record included a care conference note, dated 06/16/21, which identified a right-side bed rail used for repositioning and assistance with transfers. Resident #2's care plan stated, ". . . I like to have my 1/2 rails on my bed so I can grab them and turn independently from side to side and assists me to sit up. . . ."	F 641	during a transfer. -Coding of Section P: Alarms was not coded correctly to reflect that the resident #27 wore a wander/elopement alarm during the look-back period under section P0200E Wander/Elopement. 1. Resident's #1,2,5,11,12,13,15,16,17,27,28,and 29 MDS coding will be coded correctly on their next assessments as not using a side rail as a restraint. Resident #27 MDS coding on use of wander/elopement alarm will be coded correctly on the next assessment. 2. All resident's who use a bed rail for repositioning or use who have a wander/elopement alarm have the potential to be affected. 3. The MDS Coordinator, DON, and Nursing Staff were educated by the ND State Survey Team on exit that our resident use of bed rails was not considered a restraint. They are considered a repositioning aid as documented at care conferences. Education on the definition of Restraints and Alarms will be reviewed with all nursing staff at the next all staff meeting on 10/26/2021. 4. A QA audit was developed to ensure that MDS coding of Restraints and Alarms correctly will be completed by the MDS Coordinator. The Bed rail use consent form will continue to be used at care	

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F 641	Continued From page 8 - Review of Resident #5's medical record occurred on all days of survey. The record included a care conference note, dated 09/30/20, which identified bed rails used for repositioning and assistance with transfers. The current care plan stated, ". . .I can reposition myself in bed by grabbing on to the half bed rails. I have been informed of the risk of having these but like them so I can use them for repositioning. . . ." - Review of Resident #11's medical record occurred on all days of survey. The record included a care conference note, dated 10/14/20, which identified bed rails used for repositioning and assistance with transfers. -Review of Resident #12's medical record occurred on all days of survey. The record included a signed consent form identified bedrails used for repositioning and transfers. -Review of Resident #13's medical record occurred on all days of survey. The record included a signed consent form identified bedrails used for repositioning, transfers, and call light placement. - Review of Resident #15's medical record occurred on all days of survey. The record included a care conference note, dated 07/21/21, which identified bed rails used for repositioning and assistance with transfers. - Review of Resident #16's medical record occurred on all days of survey. The record included a care conference note, dated 06/02/21, which identified bed rails used for repositioning	F 641	conferences to educate resident/family representatives on risks even when just used for repositioning. These forms can then be utilized in coding on the MDS in Section P: Physical Restraints. The QA audits will be completed monthly for one year, with quarterly review at the QA meetings submitted by the MDS Coordinator. Effective 10/15/2021	

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F 641	Continued From page 9	F 641		

and assistance with transfers.

- Review of Resident #17's medical record occurred on all days of survey. The record included a care conference note, dated 10/21/20, which identified bed rails used for repositioning and assistance with transfers.

-Review of Resident #27's medical record occurred on all days of survey. The record included a signed consent form identified bedrails used for repositioning and transfers.

- Review of Resident #28's medical record occurred on all days of survey. The record included a care conference note, dated 09/08/21, which identified bed rails used for repositioning and assistance with transfers.

-Review of Resident #29's medical record occurred on all days of survey. The record included a signed consent form identified bedrails used for repositioning and transfers.

During an interview on 09/22/21 at 11:34 a.m., an administrative nurse (#1) confirmed staff incorrectly coded assist rails as restraints.

Section P: Alarms

Observation on all days of survey identified Resident #27 with a wander guard on her left leg.

-Review of Resident #27's medical record occurred on all days of survey. Current physician orders stated, "Check wander guard on left leg every shift related to Alzheimer's Disease with late onset."

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F 641	Continued From page 10 Review of Resident #27's care plan stated, ". . . Staff needs to make sure that I have my wander guard on. . . ." Review of Resident #27's quarterly MDS, dated 08/30/21, section P0200E Wander/Elopement, failed to show the resident wore a wander/elopement alarm during the look-back period.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of the facility policy, the facility failed to ensure residents received the necessary services to maintain oral hygiene for 1 of 2 sampled residents (Resident #11) observed during morning cares. Failure to provide assistance with oral care may result in poor hygiene and a decreased quality of life. Findings include: Review of the facility policy titled "Routine Daily Cares" occurred on 09/22/21. This policy, reviewed May 2021, stated, ". . . It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases. . . ." Review of Resident #11's medical record	F 677	483.24 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene was not met. Resident #11 was not assisted by CNA to complete oral cares. Care plan and facility policy were not followed for resident #11. 1. Resident #11 will be assisted by staff with oral cares as stated in the care plan. 2. All residents who require assistance with oral cares by staff have the potential to be affected. 3. The current policy/procedure for oral cares of a resident who are unable to complete oral cares is being reviewed	10/28/21

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F 677	Continued From page 11 occurred on all days of survey. The current care plan stated, ". . . I need assistance with my activities of daily living due to body control problems, some cognitive loss, . . . Staff needs to assist me with brushing my teeth. I prefer to have my teeth brushed one-two times per day with a soft tooth brush (sic). Staff will monitor me for any problems and make dental appointments for me if needed. . . ." Observation on 09/21/21 at 8:45 a.m., showed Resident #11 in bed wearing pajamas. A certified nursing assistant (CNA) (#3) transferred Resident #11 to the bathroom, assisted with a partial bath, and assisted the resident to dress. The CNA (#3) transferred the resident to the wheelchair, combed her hair, put her glasses on and took the resident to the dining room. The CNA (#3) failed to provide oral cares. During an interview on 09/22/21 at 11:34 a.m., an administrative nurse (#4) stated she expected the staff to perform oral cares with morning cares for dependent residents.	F 677	and revised. A in-service on Oral Cares in the Elderly will be set up for CNA's in November 2021. Education on Facility policy "Routine Daily Cares" will be given to CNA's at this meeting. Review of resident care plans in regards to oral cares for those who need assistance with ADL's will be completed with all CNA's at the in-service. 4. A QA audit was developed to check to ensure oral cares for those needing staff assistance will be done on 5 residents every month for 1 year by the DON and/or Charge Nurse. These finding will be reviewed at the quarterly QA meeting, reported on by the DON. 5. Effective 10/15/2021	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record	F 689	483.25(d)(1)(2) Free of Accident	10/28/21

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	355103	A. BUILDING _____ B. WING _____	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12 review, and staff interview, the facility failed to provide adequate assistance for 1 of 3 sampled residents (Resident #11) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift, including use of the leg strap, placed Resident #11 at risk of experiencing pain/discomfort and/or possible accidents with/without injury. Findings include: Review of the facility policy titled "POLICY AND PROCEDURE ON USING PAL [mechanical] LIFT" occurred on 09/22/21. This policy, updated February 2021, stated, ". . . ensure that each resident is safely transferred using the pal lift. . . . 1. All straps will be buckled unless resident specifically requests no straps. . . ." Review of Resident #11's medical record occurred on all days of survey. The current care plan stated, ". . . I need assistance with my activities of daily living due to body control problems, some cognitive loss . . . . I need staff to transfer me with the Pal lift from my bed to the wheelchair, wheelchair to bed, and from the wheelchair to the toilet and back. . . ." Observation on 09/21/21 at 8:45 a.m., showed a certified nursing assistant (CNA) (#3) assisted Resident #11 out of the bed using the sit to stand lift. The CNA applied the safety harness and chest strap to the resident and lifted the resident and trasferred the resident into the wheelchair. The CNA (#3) failed to secure the resident's legs by applying the leg strap. Observation on 09/21/21 at 10:40 a.m., showed a	F 689	Hazards/Supervision/Devices (Long term care facilities) was not met as observed by failure to ensure proper use of the stand lift, including use of the leg strap, placed Resident #11 at risk of experiencing pain/discomfort and/or possible accidents with/without injury. 1. Resident #11 will have all safety straps used for all transfers with the stand lift. 2. All residents who use the stand lift are at risk of experiencing pain/discomfort and/or possible accidents with/without injury. 3. The current policy and procedure is being reviewed and revised if warranted. Education and review of facility policy and procedure on Use of stand Lift will be completed with staff at the next mandatory in-service 10/26/2021. 4. A QA audit was developed to ensure transfers with the PAL lift on residents is completed according to policy and procedure, unless care planned. It will be completed on two residents monthly for one year. This will be reviewed at the QA meetings quarterly by the DON. 5. Effective 10/15/2021	

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F 689	Continued From page 13 CNA (#3) assist Resident #11 out of the wheelchair using the sit to stand lift. The CNA applied the safety harness and chest strap to the resident and lifted the resident into the bathroom. The CNA (#3) failed to secure the resident's legs by applying the leg strap. During an interview on 09/22/21 at 11:35 a.m., an administrative nurse (#4) stated she expected staff to use the leg straps at all times when transferring a resident with the sit to stand lift.	F 689		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to	F 838		10/15/21

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F 838	Continued From page 14 provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a facility-wide	F 838	483.70(e)(1)-(3) Facility Assessment (Long term care facilities)showed it lacked	

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F 838	Continued From page 15 assessment to evaluate the resident population and identify the resources needed to competently provide care and services to residents during both day-to-day operations and emergencies. This failure has the potential to affect all residents residing in the facility. Findings include: Review of the Facility Assessment on 09/22/21 showed it lacked all the required elements for a thorough and accurate facility assessment. During an interview on 09/22/21 at 2:27 p.m., an administrative nurse (#3) confirmed the facility did not have a completed facility assessment.	F 838	all the required elements for a thorough and accurate facility assessment. 1. No residents were affected by the deficient practice. 2. The prior Facility Assessment completed by previous Administrator and/or DON prior to survey time was not available. All residents who resident in the facility or may enter the facility have the potential to be affected. 3. A new Facility Assessment will be completed by the end of October 2021 by the Administrator and/or DON. The Facility Assessment will be updated with changes as they occur and with a full review of changes yearly by the Administrator and/or DON. 4. A QA audit was developed and will be reviewed quarterly at the QA meetings quarterly for 1 year. If additional information is identified by the QA team the information will be updated on the date of the meeting by the Administrator and/or DON. 5. Effective start date 10/15/2021 with completion date of Facility Assessment 10/31/2021	