

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/26/2019
NAME OF PROVIDER OR SUPPLIER FOUR SEASONS HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039			12/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/12/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 039	Continued From page 1 emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039			

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E 039	Continued From page 2 emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at	E 039			

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E 039	Continued From page 3 §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):]	E 039			

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E 039	Continued From page 4 (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]:	E 039			

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E 039	Continued From page 5 (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:	E 039			

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E 039	Continued From page 6 (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: The facility failed to conduct exercises to test the emergency plan annually. Review of documentation and interview with staff determined the facility did not conduct a full-scale exercise in the past year. Failure to conduct annual exercises to test the emergency preparedness plan increases the risk of injury or death due to fire. This deficiency affected the entire facility.	E 039	Corrective action: The facility did experience an actual emergency on 9/18/2019 when it was reported to us by the county sheriff that there was a fugitive within a two block radius from our facility that they were attempting to take into custody and suggested we go into lockdown. This fugitive had previously worked in our facility and did have a relative that worked here at that time. The emergency plan was put into place and the facility was placed on lockdown for about 1 hour. Facility response was evaluated by staff and adjustments made to emergency preparedness plan. This affects the whole building and all residents. Moving forward, staff will discuss during quarterly QA meetings regarding scheduling of annual		

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E 039	Continued From page 7	E 039	emergency preparedness drills to ensure these drills are done at least annually. This will involve determining timeframe of when annual drill needs to be completed by, what emergency drill will be done, who will be involved in regard to local agencies, and who is responsible to coordinate the drill with local agencies. Policy for annual emergency drills developed and will be implemented by 12/27/2019 and all department heads/QA staff will be educated on the policy and procedure as well as forms to be filled out by that date.		
K 000	INITIAL COMMENTS This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 18-New Health Care Occupancies, Chapter 19-Existing Health Care Occupancies, and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction with a crawl space beneath. An addition of Type V (111) construction was attached to the south end of the existing building in 2019. The addition was surveyed using Chapter 18. The building was protected by a wet and dry automatic fire sprinkler system designed to comply with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. A two-hour fire resistance rated barrier provided separation to a building attached to the northwest	K 000			

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K 000	Continued From page 8	K 000			
K 291 SS=F	side of the nursing facility housing assisted living apartments. Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Testing of required emergency lighting systems shall be permitted to be conducted as follows: 1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. 2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. 3) Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered. 4) The emergency lighting equipment shall be fully operational for the duration of the tests. 5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.1 The facility failed to ensure the emergency lighting was in proper operating condition to provide 1½ hours of emergency illumination in the event of failure of normal lighting. Review of records indicated the facility failed to conduct a 90-minute test of the emergency	K 291	Corrective action was taken on 12/10/19 when 90-minute testing of the emergency battery back-up lights was performed by the maintenance man on all emergency lights and was successful. Documentation is attached. Policy developed for testing of emergency lighting. Maintenance staff will be educated on policy and it will be put in place by 12/27/19. Moving forward, QA will be performed on monthly and annual checks starting January 1, 2020 every month for 6 months and then quarterly for one year to assure testing is done per regulations.	12/27/19	

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K 291	Continued From page 9 battery back-up lights in the past year.	K 291			
K 345 SS=F	Failure to provide emergency lighting as required increases the risk of death or injury due to fire. The deficiency affected all emergency battery back-up lights throughout the building. Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 19.3.4.1 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. 9.6.1.3. 2010 NFPA 72, 14.1.1 The facility failed to test the fire alarm system as required. No record was available indicating an annual inspection and testing of the fire alarm system had been completed in the past year.	K 345	Corrective action: Inspection and testing of the fire alarm system was done by Protection Systems on 6/24/2019, but documentation was not available the day of the survey. Documentation is provided proving testing was done on time.	12/11/19	

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K 345	Continued From page 10	K 345			
K 347 SS=F	Failure to install, test and maintain the fire alarm system in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected numerous tests of the fire alarm system. The fire alarm system serves the entire facility. Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: The facility failed to ensure smoke detectors were installed, maintained, inspected and tested in accordance with NFPA 72, National Fire Alarm and Signaling Code. Sensitivity testing of smoke detectors is to be completed for all smoke detectors during the first year in service, and the alternate year following. After the second required calibration test, if the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests may be extended, not to exceed five years. 19.3.4.5, 9.6.2.10.1.1, NFPA 72 14.4.5.3 Review of the fire alarm test results indicated the smoke detection system did not have sensitivity testing at frequencies in compliance with the minimum requirements of NFPA 72.	K 347	Corrective action: Testing of the smoke detection system was done on 6/24/19 by Protection Systems when the fire alarm system was done. Documentation provided proving testing was done.	12/11/19	

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K 347	Continued From page 11 No records were available to indicate smoke detectors were sensitivity tested at the required two-year test interval.	K 347			
K 524 SS=E	Failure to install, maintain, inspect and test the smoke detection system in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected all smoke detectors in the facility. HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54 This REQUIREMENT is not met as evidenced by: Direct-vent gas fireplaces, as defined in NFPA 54, National Fuel Gas Code, shall be permitted inside smoke compartments containing patient sleeping areas, provided that all of the following criteria are met. 18.5.2.3(2) (a) All such devices shall be installed, maintained, and used in accordance with 9.2.2. (b) No such device shall be located inside of a patient sleeping room.	K 524	Corrective action: The controls for the direct-vent gas fireplace are now under a locked tamper-proof box. Keys are located with the maintenance supervisor. This was completed on 12/5/19. QA will be performed monthly for 6 months and then quarterly for one year to ensure the tamper-proof box is in place and locked. Electrician was called to place a carbon monoxide detector in the room with the fireplace but time has not been set up yet.		12/11/19

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(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	
K 524	Continued From page 12 (c) The smoke compartment in which the direct-vent gas fireplace is located shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 9.7.1.1(1) with listed quick-response or listed residential sprinklers. (d) The direct-vent fireplace shall include a sealed glass front with a wire mesh panel or screen. (e) The controls for the direct-vent gas fireplace shall be locked or located in a restricted location. (f) Electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is located. The facility failed to ensure the direct-vent gas fireplace located in the new addition sitting area was in compliance with these requirements. 1) Observation determined electrically supervised carbon monoxide detection in accordance with Section 9.8 was not provided in the room where the fireplace was located. 2) The controls for the direct-vent gas fireplace were not locked or in a restricted location. Failure to comply with all required criteria for a direct-vent gas fireplace increases the risk of injury and death. This deficiency affected one (1) of four (4) resident occupied smoke compartments in the facility.	K 524	Plan is for them to be here next week so problem will be fixed by 12/20/19. Once carbon monoxide detector is in place, policy will be developed and implemented by 12/27/19 to ensure detector is working and check batteries and these checks will be done monthly. QA will be done monthly starting in January 2020 for 6 months to ensure detector is in place and monitoring is being done per policy.		

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K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to conduct fire drills as required. Fire drill records review determined no fire drills were conducted on the Second Shift during the fourth quarter in the past year. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected one (1) of twelve (12) drills in the past year.	K 712	Corrective action cannot be done to fix the missed fire drill. Moving forward, it will be added to our morning daily huddle which is done Monday through Friday to discuss scheduling of monthly fire drills. This will be implemented starting 12/16/19. Policy developed and maintenance supervisor will be educated on in regards to timeliness of fire drills to be completed by 12/27/19. QA will be done monthly starting in January 2020 for one year to ensure fire drills are performed on timely basis.	12/11/19	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly	K 918		12/11/19	

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K 918	Continued From page 14 test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to test the emergency power generator in accordance with NFPA 110, Standard for Emergency Power and Standby Systems. Record review and interview with staff determined the diesel emergency power generator was not exercised under load for 4	K 918	Corrective action: Not able to fix missed load test. Moving forward, maintenance supervisor has been attempting to contact Cummins who services our generator. He did finally get in touch with them and a 4 hour load test is scheduled for 12/16/19 and will provide documentation upon completion. Email confirmation of		

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K 918	Continued From page 15 continuous hours in the past 36 months. Failure to test the emergency power generator in accordance with NFPA 110 increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) emergency power generator in the facility. The emergency power generator serves the entire facility.	K 918	scheduled date included. This will be scheduled once every 36 months per regulation thereafter. We are working with our software company to keep automatic scheduling of generator testing which maintenance supervisor will be required to check and sign off providing facility ability to monitor these tasks. This will be completed by 12/27/19.		