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	12/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Health Care Inc	483 4th St SW Forman, ND 58032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, review of facility policy, record review, and staff interviews, the facility failed to utilize appropriate assistive devices necessary to prevent accidents and/or injury for 2 of 2 sampled residents (Resident #1 and #2) observed during mechanical lift transfers. Failure to assess for and utilize the correct sling sizes for residents during full body mechanical lift transfers placed the residents at risk for falls and/or injuries. Findings include:Review of the policy titled Policy and Procedure on Using the Hoyer Lift occurred on 12/29/25. This policy, dated December 2023, stated, . It is the policy of Four Seasons Healthcare Center to ensure that each resident is safely transferred using the Hoyer Lift. 1. Identify correct lift and sling for the resident .- Review of Resident #1's medical record occurred on 12/29/25. The current care plan stated, . I need the two person hoyer (full body mechanical) lift and two assist with transfer.Observation on 12/29/25 at 4:15 p.m. showed two certified nurse aides (CNAs) (#1 and #2) assisted Resident #1 from the recliner to the bed using a full body mechanical lift. The tag on the sling stated, Proactive with no size noted.- Review of Resident #2's medical record occurred on 12/29/25. The current care plan stated, . I use the hoyer lift and two assist with transfer.Observation on 12/29/25 at 3:45 p.m. showed two CNAs (#1 and #2) assisted Resident #2 from the bed to the wheelchair using a full body mechanical lift. Prior to the transfer, CNA (#2) stated he needed to go get a sling since there was not one in the resident's room. When the CNA returned, he stated, I could not find the one (sling) she normally uses. The tag on the sling brought into the room identified, Invacare and size large. During an interview on 12/29/25 at 4:48 p.m., when asked how staff know what size hoyer sling to use for each resident, the CNA (#1) stated, There is a list posted in the supply room. Review of the list posted in the supply room stated, Hoyer Sling Sizing Chart Medium: 99 to 210 pounds Large: 198 to 350 pounds X - Large: 270 to 600 pounds Weight capacity is between 450 to 600 poundsDuring an interview on 12/29/25 at 5:27 p.m., a CNA (#2) confirmed they did not use the correct sling when they transferred Resident #2 with the mechanical lift. During an interview on 12/29/25 at 5:15 p.m., an administrative nurse (#3) confirmed the facility had not assessed residents who require the full body mechanical lift for appropriate sling size. The facility failed to assess Residents #1 and #2 for the appropriate sling size and provide staff with information and education regarding appropriate sling size when utilizing the mechanical full body lift.

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.

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