| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/30/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Four Seasons Health Care Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>39211<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment in multiple areas of the facility (supply room, laundry room, oxygen storage room, and resident rooms) observed during survey. Failure to maintain a safe, clean, comfortable, and sanitary environment and keep resident care equipment clean and properly stored does not provide a homelike area for residents or promote quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled Oxygen Concentrator occurred on 10/30/24. This policy, dated 10/23/24, stated, . An 'oxygen concentrator' is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen from the oxygen. Keep concentrators covered when not in use. Care of the Concentrator . Nurse responsibilities . The main body cabinet should be dusted when needed .<br><br>Observations during survey showed the following:<br><br>- Clean Supply Room:<br><br>* An oxygen concentrator with a layer of dust on the outside and filter.<br><br>* Oxygen tubing and a mask attached to the concentrator laid on the floor beside the machine. A portable liquid oxygen tank and a nebulizer machine sat on the floor next to the concentrator.<br><br>- Laundry room:<br><br>* Visible dust/debris on a fan grate and blades blowing into the clean laundry area.<br><br>- Oxygen storage room:<br><br>* Two ceiling vents had a thick layer of dust accumulation.<br><br>* Floor tiles cracked/broken and a visible layer of fine dirt along the perimeter of the floor.<br><br>* Ceiling tiles with water leak marks.<br><br>(continued on next page) |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355103 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Resident rooms:<br><br>* Rooms on Unit A with scuff marks, chipped paint, and gouges/paint scratched off walls.<br><br>* An overbed table in room B8 with an approximate two-inch strip of missing laminate along the entire front length of the table with wood exposed, and a large area of loose laminate on the right top side of the table.<br><br>* The top of the oxygen concentrator in room B8 covered in dust.<br><br>During an interview the afternoon of 10/29/24, a maintenance staff member (#10) confirmed the facility failed to have a process for identifying areas within the facility and/or resident rooms in need of cleaning or repairs. He/she reported being unaware of any resident room concerns.<br><br>During an interview on 10/30/24 at 11:29 a.m., an administrative staff member (#1) stated he/she expected staff to clean/sanitize oxygen and nebulizer equipment removed from a resident's room prior to storage and dispose of items such as oxygen tubing and oxygen masks in the resident's room.<br><br>40488 |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave.<br><br>46963<br><br>Based on record review, review of facility policy, and staff interview, the facility failed to provide the resident or the resident's representative a written bed hold notice at the time of the transfer or if an emergency, within 24 hours for 1 of 2 sampled residents (Resident #23) reviewed for hospital transfers. Failure to provide a written copy of the bed hold notice in a timely manner does not allow the resident and/or their representative to make an informed decision regarding their rights.<br><br>Findings include:<br><br>Review of the facility policy titled Bed Hold Notice Upon Transfer occurred on 10/30/24. This policy, dated 12/12/23, stated, . Before a resident is transferred to the hospital . the facility will provide to the resident and/or the resident representative written information that specifies . The duration of the state bed-hold policy . The reserved bed payment policy . The facility policies regarding bed-hold periods . Conditions upon which the resident would return to the facility . In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies .<br><br>Review of Resident #23's medical record occurred on all days of survey and identified a hospital transfer occurred on 06/30/24. The medical record identified the facility provided the resident and/or representative with a written bed hold notice on 07/08/24, eight days after the transfer.<br><br>During an interview on 10/29/24 at 10:15 a.m., an administrative staff member (#3) confirmed staff provided the required bed hold notice to the resident and/or their representative eight days after the resident was transferred to the hospital. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39211<br><br>Based on observation, 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) for 8 of 12 sampled residents (Resident #3, #4, #6, #11, #15, #20, #23, and #24). Failure 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.<br><br>Findings include:<br><br>SECTION H - BLADDER AND BOWEL<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2024, page H-2, stated, . Check next to each appliance that was used at any time in the past 7 days. H0100A, indwelling catheter .<br><br>- Review of Resident #4's medical record occurred on all days of survey. A nursing home recertification of care, dated 07/10/24, stated, Resident does not currently have a foley catheter in place. Observation on 10/28/24 at 3:30 p.m. showed no indwelling catheter present. Review of the MDS, dated [DATE], Section H0100A, indicated the presence of an indwelling catheter.<br><br>SECTION N: MEDICATIONS<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2024, page N-3, stated, . N0350: Insulin . Coding Instructions . Enter in Item N0350A, the number of days during the 7-day look-back period . that insulin injections were received.<br><br>- Review of Resident #11's medical record occurred on all days of survey. The physician's orders included Insulin Glargine (used to control high blood sugar) in the evening for diabetes mellitus 2. The facility failed to code insulin use on the significant change in status MDS, dated [DATE].<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2024, pages N-6 to N-8, stated, . 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.<br><br>- Review of Resident #3'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 [DATE].<br><br>- Review of Resident #6'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 [DATE].<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - 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 [DATE].<br><br>- 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 [DATE].<br><br>- 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 [DATE].<br><br>- 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 [DATE].<br><br>During interviews the morning of 10/30/24, an administrative nurse (#2) confirmed staff failed to code the MDSs correctly for Residents #3, #4, #6, #11, #15, #20, #23 and #24.<br><br>46963 |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>39211<br><br>Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #8) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with the resident's needs.<br><br>Findings include:<br><br>The North Dakota PASARR Provider Manual, revised December 2020, page 13, stated, . Change in Status Process . Whenever the following events occur, nursing facility staff must contact [the contracted agency] 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 discovered.<br><br>Review of Resident #8's medical record occurred on all days of survey and identified the following;<br><br>* PASARR completed on 08/13/21.<br><br>* Progress note, dated 09/22/24, . communication with physician . updated on resident's delusion's [sic] and hallucinations that he has been having over the last month or more.<br><br>* Progress note, dated 09/24/24, . communication with physician . Recommendations: New orders received and observed by fax from [name of physician] . increase Quetiapine [antipsychotic medication] to 37.5 mg [milligram] in PM [evening].<br><br>The record lacked evidence facility staff completed a PASARR related to the new diagnoses of delusions and hallucinations.<br><br>During an interview on 10/29/24 at 1:32 p.m., a social services staff member (#3) confirmed the facility failed to complete a change in status Level 1 screen for Resident #8. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>39211<br><br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 3 of 12 sampled residents (Resident #4, #10, and #23). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled Comprehensive Care Plans occurred on 10/30/24. This policy, dated 10/29/24, stated, . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment.<br><br>- Review of Resident #4's medical record occurred on all days of survey. A nursing home recertification of care, dated 07/10/24, stated, Resident does not currently have a foley catheter in place. Observation on 10/28/24 at 3:30 p.m. failed to identify the presence of an indwelling catheter. The current care plan stated, . I have an indwelling catheter .<br><br>During an interview on 10/30/24 at 11:56 a.m., an administrative nurse (#2) confirmed staff failed to revise Resident #4's care plan following the removal of the foley catheter.<br><br>- Review of Resident #10's medical record occurred on all days of survey. A physician order, dated 07/29/24, included Eliquis (an anticoagulant medication) five milligrams (mg) two times a day. The current care plan stated, . Staff will monitor me for any bleeding problems that may be due to Plavix (an antiplatelet medication) use.<br><br>- Review of Resident #23's medical record occurred on all days of survey and identified warfarin [an anticoagulant medication] discontinued on 05/01/24. The care plan stated, . Staff will do PT/INR (a blood test done for people on warfarin) checks as ordered, and change Coumadin [warfarin] dose as directed.<br><br>The facility staff failed to review and revise Resident #10 and #23's care plans following medication changes.<br><br>46963 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>40488<br><br>Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 resident (Resident #14) observed receiving a topical medication. Failure to administer topical medications according to physician orders may result in adverse outcomes for the resident.<br><br>Findings include:<br><br>Review of the facility policy titled Medication Administration occurred on 10/30/24. This policy, dated 05/15/24, stated . Medications are administered . as ordered by the physician and in accordance with professional standards of practice . administer medication as ordered in accordance with manufacturer specifications .<br><br>Skidmore-Roth's Mosby's 2023 NURSING DRUG REFERENCE, 36th Edition eTEXT, 2023, Elsevier Inc., pages 365-367, stated, . diclofenac sodium [Voltaren] . Topical gel route . Use only for osteoarthritis, mild to moderate pain . use dosing card to measure .<br><br>Observations during medication pass on 10/28/24 at 10:00 a.m. showed a staff nurse (#4) removed a box of Voltaren gel from the medication cart and carried the box into Resident #14's room. The nurse (#4) dispensed an undetermined amount of the gel from the tube into his/her gloved hand and applied the gel up and down the resident's left arm and partial left shoulder. The nurse (#4) dispensed another undetermined amount of the gel into the same gloved hand and applied the gel starting at the resident's right upper arm, down to the right wrist, and then onto the right back shoulder area.<br><br>Review of Resident #14's medical record occurred on all days of survey. Physician's orders, dated 03/24/22, identified . Voltaren Gel . Apply to shoulder and knees topically two times a day for OA [osteoarthritis] 2 grams for shoulders and 4 grams for knees . and . Voltaren Gel . Apply to affected areas topically every 24 hours as needed for pain 2 grams for shoulders and 4 grams for knees .<br><br>The nurse (#4) failed to measure the correct dose of Voltaren gel and apply as ordered.<br><br>During an interview on 10/30/24 at 11:29 a.m., an administrative staff member (#1) agreed the nurse (#4) failed to follow the provider orders for accurately measuring and applying the medication. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39211<br><br>Based on record review, review of facility policy, and staff interview, the facility failed to provide necessary care and services for 1 of 1 closed record resident (Resident #28) reviewed. Failure to assess, monitor and implement interventions in response to Resident #28's decline in condition may have contributed to the resident's death.<br><br>Findings include:<br><br>Review of the facility policy titled Vital Signs occurred on 10/30/24. This policy, dated 12/12/23, stated, . 'Vital signs' are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. Vital signs shall be obtained at least in the following circumstances: . When the resident's general condition changes. When a resident reports nonspecific symptoms of physical distress (e. g., [example] feeling 'funny' or 'different'). Acceptable ranges for adults: . Oxygen saturation: > [greater than] 90% [percent].<br><br>Review of Resident #28's medical record occurred on 10/30/24. Diagnoses included chronic obstructive pulmonary disease (COPD), pulmonary fibrosis (damaged lung tissue), and congestive heart failure (CHF). The baseline care plan identified the resident as independent with bed mobility, transfers, walking, toileting and eating, assistance of one with locomotion grooming/hygiene and bathing and oxygen use at two liters per minute. The care plan also stated the resident, Wants to do as much as possible for himself but feels weak so at least offer assist and supervise.<br><br>The medical record identified Resident #28 admitted [DATE]. The record lacked documentation in the nurse progress notes for August 30, 31, and September 1, 2024. The nurse progress notes dated 09/02/24 stated the following:<br><br>* At 4:06 p.m. Note Text: Vitals completed. O2 [oxygen] sat [saturation] 81% at 3 liters. Resident has normal respirations at 20 per minute and non labored. and denies shortness of breath.<br><br>* At 6:22 p.m. Note Text: Resident states he is not feeling well. Vitals are stable and has no fever. O2 sat 89%. It is warm in his room so fan is moved to blow on him per his request.<br><br>The nurse progress notes dated 09/03/24 stated the following:<br><br>* At 3:20 a.m. Note Text: Resident told this nurse he is dying and can't eat because it's too hard to breathe. This nurse mentioned Hospice and resident stated, 'That is a great idea because I am definitely dying.' This nurse will pass message on to the day nurse.<br><br>* At 6:50 a.m. Note Text: Called [family member's name], the president's [sic] son and informed him of his dad's condition. Resident is having SOB [short of breath]. Poor appetite. He said he did not eat or drink for four days. [Resident #28] asked for the nurse's opinion. Informed will consult with the provider and get back to him. Called [Resident #28's son] again but went to his voice. Left message that his dad is on his way to the emergency. Left phone number to call back.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | * At 7:30 a.m. Note Text: Called the [name of clinic] and spoke with [name of physician] nurse, [name of nurse] Informed her that the resident is having SOB and had not been eating or drinking. [name of nurse] said she will check with [name of physician] and call back. [Name of physician] called and ordered ER [emergency room ] transfer for evaluation. Resident sent to the ER via ambulance 0820 [8:20 a.m.].<br><br>* At 8:00 a.m. COMMUNICATION - with Physician* Situation: SOB. Accessory muscle for breathing. Background: Poor appetite. SOB. Oxygen 2L [liters] NC [nasal cannula]. Assessment (RN) [registered nurse]/Appearance (LPN) [licensed practical nurse]: BP [blood pressure] 98/62, P [pulse]-96, r[respirations]-28, Oxygen 82, T[temperature]-97.3. Recommendations [sic]: Send to ER via Ambulance to [name of town].<br><br>* At 8:20 a.m. Transfer to Hospital Summary* Note Text: Resident had been experiencing SOB and poor appetite. Complained of pain as well but said 'pain is a lesser evil. I can't breathe' [name of physician] ordered ER transfer for evaluation.<br><br>* At 8:21 a.m. Note Text: Report given to the ER nurse. Resident on his way in Ambulance to the ER.<br><br>* At 9:25 a.m. Note Text: [name of person], Nurse from the [name of town] Hospital called and reported that the patient passed away today at 0908 [9:08 a.m.]. Family notified per the nurse.<br><br>During an interview the morning of 10/30/24, an administrative nurse (#2) confirmed the medical record lacked nurse progress notes for August 30, 31, and September 1, 2024.<br><br>The medical record lacked documentation or evidence of the following;<br><br>* An assessment, treatment interventions, and/or symptom management interventions, and/or physician notification on 09/02/24 at 4:06 p.m., when the resident was on three liters of oxygen with an oxygen saturation of 81% and again at 6:22 p.m. (almost two and a half hours later), when the resident's oxygen saturation was 89%.<br><br>* Vital signs or assessment of resident condition from 09/02/24 at 6:22 p.m. until 09/03/24 at 3:20 a.m. (almost nine hours later) when the resident reported to nurse he is dying and can't eat because it's too hard to breathe.<br><br>* Physician notification of a change in resident condition when Resident #28 first reported difficulty breathing and statements of dying on 09/03/24 at 3:20 a.m. until four hours later at 7:30 a.m. when the facility first contacted the physician's clinic.<br><br>The facility failed to promptly identify and intervene for an acute change in a resident's condition resulting in an actual decline in health status, delayed treatment, and a negative outcome. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>46963<br><br>1. Based on observation, record review, and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 3 sampled residents (Resident #11) observed during a gait belt transfer. Failure to utilize a gait belt during transfers placed the resident at risk for falls and/or injury.<br><br>Findings include:<br><br>Review of the policy titled Use of Gait Belt occurred on 10/30/24. This policy, dated 04/04/24, stated, . It is the policy . to use gait belts with residents that cannot independently ambulate or transfer for the purpose of resident and staff safety.<br><br>Observation on 10/28/24 at 10:44 a.m. showed a licensed nurse (#4) assisted Resident #11 to stand up from a sitting position by placing her arm under the resident's arm. The nurse failed to utilize a gait belt during the transfer.<br><br>Review of Resident #11's medical record occurred on all days of survey and identified repeated falls. The care plan, dated 07/20/23, stated, . Staff will assist me with transfer and locomotion .<br><br>2. Based on observation, record review, review of a facility incident report, and staff interview, the facility failed to ensure the safety of 1 of 1 resident (Resident #20) who ingested non-toxic craft paint. Failure to ensure craft paint is secured in a locked cabinet placed Resident #20's safety and health at risk.<br><br>Findings include:<br><br>Review of the policy titled Supplies & Equipment occurred on 10/30/24. This policy, dated 07/10/19, stated . When not in use, supplies and equipment are stored in designated activity storage.<br><br>Review of Resident #20's medical record occurred on all days of survey and included diagnoses of dementia, restlessness, agitation, and wandering. A progress note dated 08/03/24, stated, . Resident was found with a battle [sic] of craft paint on his arms, mouth, and pant [sic]. The nurse was not sure of how much the resident might have consumed. resident [sic] tongue and teeth were all blue from the paint. Nurse called the on-call provider who gave an order to send resident to the ER for evaluation.<br><br>Review of the facility's incident report, dated 08/03/24, stated, . Storage of Paint: . The cabinet door does have a key to unlock it hanging beside it and staff are aware that it needs to be always locked. Keeping any liquids that could potentially be drank by a resident with altered mental status out of reach and in a locked cabinet, cupboard, or room.<br><br>Observation on 10/29/24 at 1:11 p.m., with an administrative nurse (#1) showed the activities supply cabinet unlocked. The administrative nurse (#1) confirmed the cabinet should be locked. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355103 | A. Building<br>B. Wing | 10/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Four Seasons Health Care Inc | 483 4th St SW<br>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) |
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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>40488<br><br>Based on confidential resident interviews, the facility failed to ensure the availability of sufficient nursing staff to respond to residents' needs for 3 of 3 confidential residents (Residents A, B, and C). Failure to provide sufficient staffing for resident needs/assistance may negatively affect the residents' physical, mental, and psychosocial well-being.<br><br>Findings include:<br><br>During confidential interviews the morning of 10/30/24, Resident's A, B, and C (identified as interviewable by the resident's most recent Brief Interview for Mental Status (BIMS) score) stated the following:<br><br>* Resident A - Not enough staff at night. The resident reported a wait time of 20-30 minutes about every night for toileting clean up assistance ever since I've been here [several weeks].<br><br>* Resident B - The facility is shorthanded. I need two people and they can't help me. So, I have to wait [until a second person is available]. My pad will be wet. I have to sit in it. I get sore. The resident stated this occurs after he/she receives evening cares and throughout the night.<br><br>* Resident C - I wait 1-2 hours for my pain cream for my knees. The resident indicated the wait time for the pain cream occurs on all shifts<br><br>The facility failed to provide sufficient staffing to meet the needs and assistance required by residents during the overnight shift. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/30/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Four Seasons Health Care Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE: 483 4th St SW Forman, ND 58032 | |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>40488<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure posting of accurate and complete staffing information on 3 of 4 days of survey (October 27-29, 2024). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift.<br><br>Findings include:<br><br>Review of the facility policy titled Daily Nurse Staffing Form occurred on 10/30/24. This undated policy stated, . requires skilled nursing facilities and nursing facilities to post daily for each shift the number of licensed and unlicensed staff directly responsible for resident care in the facility.<br><br>Observations of a clipboard located by the nurse's station containing the facility daily staffing reports showed the facility failed to update the number of licensed and unlicensed staff working each shift from October 27 - 29, 2024.<br><br>During an interview on 10/30/24 at 11:29 a.m., an administrative staff member (#1) stated she expected the charge nurse to complete and post a daily census/staffing report. |

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

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>40488<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure medications were properly dated, expired medications are discarded, and medications were securely stored in 2 of 3 storage areas (treatment cart and medication room). Failure to store all medications securely may result in unauthorized access to medications (treatment cart) and failure to dispose of expired medications and date an opened multi-dose vial (medication room) may result in reduced efficacy of the medications.<br><br>Findings include:<br><br>Review of the facility policy titled Medication Storage occurred on 10/30/24. This policy, reviewed 05/15/24, stated, . All drugs and biologicals will be stored in locked compartments (i.e., medications carts, cabinets, drawers .) . During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.<br><br>Review of the facility policy titled Multi-Dose Vials occurred on 10/30/24. This policy, dated 11/10/23, stated, . Multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured .<br><br>- Observation on 10/28/24 at 9:10 a.m. showed a staff nurse (#4) obtained medication from a treatment cart and entered a Resident's room. Observation showed the treatment cart remained unlocked and unattended for approximately 20 minutes. During this time residents and staff walked past the unlocked cart and one resident stood next to the cart without the nurse present.<br><br>- Observation on 10/28/24 at 10:50 a.m. of the treatment cart contents with the nurse (#4) showed multiple topical medications and nebulizer medications.<br><br>- Observation on 10/29/24 at 3:14 p.m. of the medication room with a staff nurse (#5) present showed a locked refrigerator contained:<br><br>* Three acetaminophen suppositories expired 12/31/23.<br><br>* An opened, undated multi-dose vial of tubersol (tuberculosis testing solution).<br><br>During an interview on 10/30/24 at 7:44 a.m., an administrative staff member (#1) stated she expected staff to lock the treatment cart unattended or out of sight. |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488<br><br>Based on observation, review of facility policy, and staff interview, the facility failed to prepare and store food in a sanitary manner in 1 of 1 kitchen and 1 of 2 resident refrigerators (main lobby). Failure to ensure proper concentration of sanitizer solution, apply an identifying label and an open date on food items brought into the facility, and ensure cleanliness in a resident refrigerator has the potential to affect food quality/preparation and may result in the spread of foodborne illness to residents, staff, and visitors.<br><br>Findings include:<br><br>Review of the facility policy titled Food Storage occurred on [DATE]. This undated policy stated, . Food will be stored in an area that is clean . and free from contaminates. Scoops must be provided for bulk foods (such as sugar, flour, spices). Scoops are not to be stored in food . but are kept covered in a protected area near the containers.<br><br>Review of the facility policy titled Resource: Food Safety for Your Loved One occurred on [DATE]. This undated policy stated, If you plan to bring food into the facility . please be sure that the food is handled safely. Food or beverages should be labeled and dated to monitor for food safety . Foods in unmarked or unlabeled containers should be marked with the current date the food item was stored .<br><br>- Observations on [DATE] during the kitchen tour showed the following:<br><br>* A metal scoop in the flour bin.<br><br>* An unlabeled, undated shaker containing a liquid located inside a reach-in cooler in the kitchen. A dietary staff member (#6) identified the container contained milk and oatmeal and belonged to a staff person.<br><br>* An unidentified dietary staff member tested the sanitizer concentration in a bucket used to wipe down resident dining room tables. The results showed out-of-range (high). The test strips showed an expiration date of [DATE].<br><br>- Observation on the morning of [DATE] showed dried liquid substances on two shelves inside a refrigerator located in the main lobby used to store foods brought in by family.<br><br>During an interview on [DATE] at 10:38 a.m., the dietary manager (#8) stated she expected scoops for bulk foods be placed outside the storage bins in protective containers, all staff foods brought into the facility be labeled, dated, and stored away from resident foods, and verified the sanitizer test strips expired and may have altered the test results of the sanitizer bucket water. |

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

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>40488<br><br>Based on review of the State Agency (SA) facility files, review of the facility Quality Assurance and Performance Improvement (QAPI) program, review of facility policy, survey findings, and staff interview, the facility failed to develop a QAPI process to evaluate and identify problems and opportunities to improve services/outcomes, decrease or prevent likelihood of problems or occurrence of adverse events, and ensure compliance with federal requirements.<br><br>Findings include:<br><br>Review of the facility policy titled QAPI Change Process occurred on 10/30/24. This policy, dated 10/02/24, stated, . The QAA [Quality Assessment and Assurance] Committee utilizes a systematic approach to performance improvement, including analysis of data, corrective action, and performance tracking. As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. Performance on the measures are discussed in QAA Committee meetings. Data is analyzed, and the process continues as appropriate.<br><br>Review of the state agency files indicated the facility failed to maintain compliance at F625, F657, F684, F689, F812, and F880 as indicated by deficiencies cited during the last standard survey on 11/08/2023 and the comparative and extended Federal Monitoring Survey (FMS) on 12/04/23.<br><br>Refer to F625, F657, F684, F689, F812, and F880 for specific findings.<br><br>During an interview the morning of 10/30/24, administrative staff members (#1) and (#8) stated management staff monitor areas identified as needing improvement based on the previous survey results.<br><br>Failure of the facility to effectively utilize QA resulted in continued noncompliance in the following:<br><br>* F625 Notice Of Bed Hold Policy Before/upon Transfer<br><br>* F657 Care Plan Timing And Revision<br><br>* F684 Quality Of Care<br><br>* F689 Free Of Accident Hazards/supervision/devices<br><br>* F812 Food Procurement, store/prepare/serve-Sanitary<br><br>* F880 Infection Prevention and Control |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>40488<br><br>Based on observation, record review, and review of facility policy, the facility failed to follow standards of infection control and prevention for 1 of 1 sampled resident (Resident #11) observed during wound cares. Failure to practice infection control standards related to enhanced barrier precautions, has the potential to spread infection throughout the facility.<br><br>Findings include:<br><br>Review of the facility's policy titled Enhanced Barrier Precautions occurred on 10/30/24. This policy, dated 09/18/24, stated, . 'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . An order for enhanced barrier precautions will be obtained for residents with . Wounds . High-contact resident care activities include . Wound care: any skin opening requiring a dressing .<br><br>- Review of Resident #11's medical record occurred on all days of survey. A physician's order dated 10/14/24, stated, Daily dressing changes to abdominal wound and prn [as needed]. The care plan stated, . I have a wound on my right abdomen. Staff applies dressing as ordered by hospice.<br><br>Observation on 10/28/24 at 10:44 a.m. showed Resident #11's room lacked EBP signage. A staff nurse (#4) entered the room, applied gloves and changed ther resident's abdominal wound dressing. The nurse failed to apply a gown for the dressing change.<br><br>The facility staff failed to obtain an order and follow EBP according to the facility's policy.<br><br>46963 |