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	09/14/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 31725 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 2 of 2 sampled residents (Resident #17 and #22) and one supplemental resident (Resident #2) with medications left for the resident to self-administer later in the day. Failure to determine whether SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled Resident Self-Administration of Medication occurred on 09/13/22. This policy, dated July 2020, stated, . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. - Observation of medication pass on 09/12/22 at 5:15 p.m. showed a medication assistant (MA) (#5) administered medications to Resident #22. The MA obtained Resident #22's Ipratropium-Albuterol nebulizer medication (used for shortness of breath and chest congestion) and set it on the medication cart stating, I will set this up and she will do it herself. Resident #22's medical record lacked a SAM assessment. - Observation of medication pass on 09/12/22 at 5:20 p.m. showed a MA (#5) administered medications to Resident #17. The MA dished up Tums E-X, set the medication on the table and stated, Take an hour after you eat. Resident #17's medical record lacked a SAM assessment. - Observation of medication pass on 09/13/22 at 8:00 a.m. showed a MA (#4) administered medications to Resident #2. The MA placed Resident #2's Ipratropium-Albuterol nebulizer medication and Trelegy inhaler (Respiratory Combination Inhaler) into her walker bag with instructions to use in her room. Resident #2's medical record lacked a SAM assessment. During an interview on 09/13/22 at 10:32 a.m., a supervisory nurse (#3) confirmed staff failed to complete SAM assessments for the above residents.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, policy review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 14 sampled residents (Resident #28) reviewed for advanced directives. Failure to ensure all methods of communication and/or documentation of code status accurately reflected the resident/resident representative wishes has the potential to limit his/her access to life-sustaining services or result in unwanted treatment. Findings include: Review of the policy titled Advance Directives occurred on [DATE]. This policy, reviewed/revised [DATE], stated, . It is the policy of this facility to ensure that a resident's choice about advance directives be respected . Changes . must be submitted to the facility, in writing. Review of Resident #28's medical record occurred on [DATE]. A physician's order, dated [DATE], stated, DNR [Do Not Resuscitate]. The most recent Physician's Order For Life Sustaining Treatment (POLST) form, signed and dated by the resident on [DATE], identified Yes CPR [Cardiopulmonary Resuscitation]. The current care plan stated, I do not want CPR if my heart would stop. During an interview on [DATE] at 3:10 p.m., an administrative staff nurse (#3) stated, If there's a heart on the resident's name plate on their door it means to do CPR. Observation on [DATE] and [DATE] showed a large red heart and a small red heart on Resident #28's name plate outside of her room. During an interview on [DATE] at 4:25 p.m., a social service staff member (#11) stated Resident #28's code status changed from CPR to DNR [DATE] and confirmed there is still a heart on Resident #28's name plate indicating CPR. On [DATE] 3:54 p.m., a social service staff member (#11) presented a copy of an updated POLST document to the surveyor. The POLST form, signed by Resident #28 on [DATE] indicated, Comfort measures only. The facility failed to ensure all methods of communication and/or documentation accurately reflected Resident #28's code status wishes and may have resulted in unwanted treatment.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 13101 Based on review of Medicare Part A letters/notices, facility policy, and staff interview, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form and Notice of Medicare Non-coverage (NOMNC) form two days in advance of discharge for 2 of 3 residents (Resident #16 and #79) reviewed for discharge from Medicare Part A services. Failure to provide Medicare Part A letters/notices within the required time frame has the potential to limit the residents' right to an expedited review of service termination (NOMNC) and to exercise their rights to Medicare Part A services (SNFABN). Findings include: Review of the facility policy titled Advance Beneficiary Notices occurred on 09/14/22. This policy, dated 01/02/22, stated, . It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055. Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO). To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay . Review of the Medicare notices provided showed facility staff failed to provide the forms two days before Resident #16's services ended on 07/07/22 and before Resident #79's ended on 09/07/22. During an interview on 09/13/22 at 2:45 p.m., a managerial staff member (#1) agreed the facility failed to provide two days advance notice to Resident #16 and #79 regarding the end of their Medicare Part A benefits.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40489 Based on record review, facility policy, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled residents (Resident #19) reviewed for Preadmission Screening and Resident Review (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. Findings include: Review of the facility policy titled Resident Assessment - Coordination with PASARR Program occurred on 09/14/22. This policy, revised July 2021, stated, . 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health intellectual disability authority for a level II resident review. Examples include: . a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental health disorder . Review of Resident #19's medical record occurred on all days of survey and identified an original PASARR completed on 07/18/22. A physician's order, dated 07/25/22, included Seroquel (antipsychotic medication) 25 milligrams related to a new diagnosis of unspecified psychosis. Another physician's order, dated 07/28/22, included Mitrazapine {antidepressant medication) 15 milligrams related to a new diagnosis of suicidal ideations. The record lacked evidence of an updated PASARR which included the diagnosis of schizophrenia with psychotic disorder. During an interview on 09/14/22 at 8:50 a.m., an administrative staff member (#3) agreed the facility failed to complete a new level 1 screen when Resident #19 received a new mental health diagnosis.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 1. Based on observation, policy review, review of the Volaro Operator's Manual, record review, and staff interview, the facility failed to provide adequate assistance for 3 of 5 sampled residents (Resident #1, #4, and #6) observed during a sit-to-stand mechanical lift transfer. Failure to ensure proper use of the stand lift, and use the leg strap caused the residents unnecessary pain/discomfort and placed them at risk of possible injury. Findings include: Review of the facility policy titled POLICY AND PROCEDURE ON USING PAL [mechanical] LIFT occurred on 09/14/22. This policy, reviewed October 2021, stated, . POLICY . 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 the Volaro Operator's Manual occurred on 09/14/2022. These operator's instructions, stated, . ATTACHING SLING TO LIFT . have him hold onto the handle grips. attach the colored loops to the positive-locking J hooks. NOTE: Make sure you use the same colored loops on each J hook. - Review of Resident #1's medical record occurred on all days of survey and included the diagnoses of bursitis (inflammation) to right and left shoulders. The current care plan stated, I have . shoulder pain at all times. I am alert and able to report pain . I need assistance with my activities of daily living . I need the stand-up lift and one assist for transfer . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 09/11/22 at 4:31 p.m. showed a certified nursing assistant (CNA) (#8) assisted Resident #1 out of the recliner using the sit to stand lift. The CNA applied the sling around the resident's abdomen, secured the buckle, attached the gray colored loops to the handle bars and not the J hooks, and told the resident to put her hands on the handle bars. Utilizing the lift, the CNA transferred the resident onto the toilet. During the transfer, the harness sling slid up the resident's back to the axilla area, and the resident leaned forward, causing the resident's elbows to bow outward above the shoulders. While lowering the resident onto the toilet and pulling the resident's pants down the resident stated, Oh I'm going down, I'm slipping and both of the resident's hands fell off the handle bars. The resident fell approximately 3 inches onto the toilet. The CNA left the sling loops connected to the handle bars while the resident used the toilet. When the resident finished, the CNA instructed the resident to place her hands on the square handle bar and attempted to lift the resident off the toilet. The resident stated, I'm slipping again, my arms, oh mercy. The CNA then lowered the resident to the toilet again. The CNA stated, Let's try using the blue loops, and changed the gray loops to the blue loops, attaching them again to the handle bar. The CNA attempted to lift the resident with the sit to stand. The resident stated, My arms and shoulders hurt, oh my arms, ouch (expletive) it hurts ouch ouch. The CNA lowered the resident to the toilet again and stated, Let's try a different lift that's not so hard on your arms and shoulders. The CNA called for assistance with the transfer and requested staff bring a different lift. At 4:45 p.m., a nurse (#16) entered the resident's room with a different sit to stand lift. Using the new lift, observation showed the nurse attached the loops to the correct hooks, secured the feet strap and proceeded to transfer the resident to her wheelchair. Once seated in the wheelchair the resident stated, Oh does that feel good. - Review of Resident #4's medical record occurred on all days of survey and included the diagnoses of osteoporosis and dementia. The current care plan stated, I have . shoulder pain at all times. I am alert and able to report pain . I need assistance with my activities of daily living . I need the Pal [sit to stand] lift and one assist with transfers. Observation on 09/11/22 at 4:16 p.m. showed a CNA (#8) used the sit to stand lift and transferred Resident #4 from her recliner to the toilet. The CNA applied the sling around the resident's abdomen, secured the buckle, attached the gray colored loops and not the J hooks, and told the resident to put her hands on the square handle bar. During the transfer, the harness sling slid up the resident's back to the axilla area, and the resident leaned forward, causing the resident's elbows to bow outward above the shoulders. When the resident finished using the toilet, the CNA attempted to lift the resident off the toilet. The resident stated, Oh boy, that hurts. The CNA then lowered the resident to the toilet again. The CNA changed from the gray loops to the blue loops, attaching them again to the handle bar. The CNA transferred the resident from the toilet to the wheelchair. Again during the transfer, the harness sling slid up the resident's back to the axilla area, and the resident leaned forward, causing the resident's elbows to bow outward above the shoulders. When the CNA was placing the resident in the wheelchair, the resident's buttocks were lower than the wheelchair and the CNA had to tip the wheelchair forward to get the resident seated. - Observation of care on 09/12/22 at 9:26 a.m. showed a CNA (#2) transferred Resident #6 from the toilet to his wheelchair using a sit to stand lift. As the CNA (#2) transferred the resident, observation showed the sling around Resident #6's torso loose, and the velcro strap not closed, the CNA (#2) failed to tighten the loose belt. As Resident #6 semi- squatted in the lift, his elbows rose almost level with his shoulders. The CNA (#2) failed to ensure the torso strap was fitted properly before transferring the resident, which may put him at risk for injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/12/22 at 2:30 p.m., an administrative nurse (#3) stated she expected staff to use the sit to stand lift correctly by securing the sling loops to the positive-locking J hooks (and not the handle bar) and using the leg straps at all times when transferring a resident. 2. Based on observation, record review, facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopements from the facility for 1 of 1 sampled resident (Resident #19) coded for elopement. Failure to provide adequate supervision and monitoring may result in avoidable accidents and/or injury. Findings include: Review of the facility policy titled ELOPEMENT ASSESSMENT FOR NEW ADMITS occurred on 09/14/22. This policy, dated May 2020, stated, . POLICY . To ensure the safety of new residents on admission. 2. If resident is at high risk for elopement a Wanderguard will be placed. Review of Resident #19's medical record occurred on all days of the survey and identified an admitted [DATE]. The record included the diagnoses of cognitive communication deficits, delirium, suicidal ideations, and unspecified psychosis. The current care plan stated, . I have behaviors. I try to leave the building, I hit out at staff, am very paranoid. Staff needs to monitor me closely . I have tried to go out the window multiple times. Staff has a wanderguard on me to alert staff if I am trying to leave out the door. Staff monitors often to make sure I do not go out the window. I have removed the wanderguard so staff needs to try to reapply and check often to make sure that I still has this on. Review of Resident #19's electronic treatment record showed on 08/30/22 the facility discontinued monitoring the resident's wanderguard twice a day. Observations on all days of survey showed Resident #19 without a wanderguard. The admission Minimum Data set (MDS), dated [DATE] identified the resident wandered 1-3 times a week. Review of Resident #19's Risk Assessment, dated 07/19/22, indicated the resident scored a 9 out of 10 potential risk factors and was at risk for elopement. Nursing progress notes included the following: * 07/30/22 at 9:07 p.m., . Resident becomes more restless after family leaves. Resident is trying to exit out door 8 x 2 [attempted to exit out of door 8 twice]. * 07/31/22 at 6:31 a.m., . Resident is up in the hall early this am looking for her husband. Resident has her clothes packed up in boxes and folded on her bed. Other personal items also packed up. She is looking for [husband's name] to take her home. * 07/31/22 at 9:15 a.m., . Resident declined to allow staff to assist her with am cares until now. She has a couple staff only today that she is trusting. Increased delusions noted this morning . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	* 8/10/22 at 5:40 a.m., . Attempted Elopement. CNA was walking on the B wing hall way when she saw someone standing in front of the exit door in A wing. She notified writer through the walkie and writer ran after the resident. resident [sic] was pushing the door to go out and had also tried to push the automatic door button for the door to open. * 8/30/22 at 11:34 a.m., . Resident has shown no signs of elopement behaviors since initial admit, Resident has exhibited no behaviors. Current medication schedule has been working effectively for resident. During an interview on 09/14/22 at 10:00 a.m., an administrative staff member (#3) confirmed the facility failed to adequately assess the resident's current elopement risk and did not complete another risk assessment prior to removing her wanderguard. 13101

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 31725 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 1 of 7 residents (Resident #14) observed during medication administration. Two medication errors occurred during staff administration of 29 medications, resulting in a 6% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse consequences. Findings include: Review of the facility policy titled Medication Administration occurred on 09/13/22. This policy, revised 09/13/22, stated, . Medications are administered . as ordered by the physician . Compare medication . with MAR [medication administration record] to verify resident name, medication name, form, dose, route and time. Review of Resident #14's medical record occurred on 09/12/22. A physician's order stated, GenTeal Tears solution . (Artificial Tear Solution) instill 2 drop [sic] in both eyes every 4 hours as needed for dry eyes Observation on 09/12/22 at 11:45 a.m. showed a medication assistant (MA) (#5) administered Genteal eye drops to Resident #14. The MA administered one drop in each eye. Observation on 09/13/22 at 8:20 a.m. showed a MA (#5) administered Genteal eye drops to Resident #14. The MA administered one drop in each eye. The MA failed to compare the medication to the MAR or read the directions on the eye drop box which stated, . Instill two drops in both eyes . During an interview on 09/13/22 at 8:22 a.m., the MA (#5) stated, Oh he is supposed to get two drops.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 31725 Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner in 1 of 1 medication cart. Failure to store all medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled Medication Storage occurred on 09/14/22. This policy, dated 07/28/21, stated, . All drugs and biologicals will be stored in locked compartments . During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage/cart. Observation on 09/12/22 at 11:45 a.m. showed a medication assistant (MA) (#5) passing medications in the dining room, the medication cart remained unlocked in a nearby room out of view of the MA. Observation on 09/13/22 at 4:56 p.m. showed a MA (#15) passing medications in the dining room, the medication cart remained unlocked in a nearby hallway out of view of the MA. The MA (#15) left a medication cup containing several medications on top of the cart as the MA walked away to assist visitors at the front door. During an interview on the morning of 09/14/22, an administrative staff member (#3) stated she expected staff to lock the medication cart when it is not within view and not leave medications unattended on the medication cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 13101 Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 8 sampled residents (Residents #7 and #12) and 2 supplemental residents (Resident #2 and #5) observed during cares and/or treatments. Failure to follow infection control standards has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy/procedure titled Hand Hygiene occurred on 09/14/22. This policy, dated August 2019, stated, . Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. TABLE: After handling items potentially contaminated with blood, body fluids, secretions, or excretions . After assistance with personal body functions (e.g., elimination, hair grooming, smoking,) . Additional considerations: . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. HAND HYGIENE - Observation on 09/11/22 at 3:19 p.m. showed a certified nurse aide (CNA) (#6) donned gloves and provided perineal care for Resident #12. The CNA (#6) cleansed the frontal perineal area then reached up with a soiled glove and moved Resident #12's neck pillow. The CNA (#6) cleaned the resident of stool, placed a new brief, redressed the resident, and removed her gloves. Without performing hand hygiene, the CNA (#6) pulled up the resident's covers, gave her the call light, lowered the bed, and assisted with placement of the neck pillow. The CNA (#6) then gathered the garbage and left the room without performing hand hygiene. The CNA (#6) failed to perform hand hygiene after perineal care and before moving to other tasks. - Observation on 09/11/22 at 4:57 p.m. showed Resident #5 lying in bed as a CNA (#6) donned gloves, completed perineal care, and without removing her gloves, assisted the resident to turn in bed by holding the resident's hand. The CNA (#6) removed her gloves, pulled up the resident's pants, placed the hoyer sling under the resident, and left the room without performing hand hygiene. - Observation on 09/11/22 at 05:19 p.m. showed two CNAs (#7 and #8) donned gloves and provided perineal care for Resident #12. The CNA (#7) provided cleansing and without removing her gloves, assisted Resident #12 to a sitting position so the other CNA (#8) could place a sling for a stand lift transfer. The CNA (#7) used the controls on the lift while the other CNA (#8) positioned the resident into the wheelchair. The CNAs (#7) failed to remove her gloves and perform hand hygiene after perineal care and before moving to other tasks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observation on 09/12/22 at 9:36 a.m. showed a CNA (#9) assisted Resident #7 with toileting in a communal bathroom. The CNA (#9) used a dry towel type product sprayed with a cleanser for perineal care. The CNA (#9) sprayed cleanser on each towel as she used them, holding the spray bottle with the hand she used to complete perineal care. At one point, the CNA (#9) wiped stool off her gloved hand then picked up the spray bottle and sprayed the cleanser onto a towel. The CNA (#9) performed hand hygiene, took the resident to her room, and returned to the bathroom to clean up. The CNA (#9) repeatedly used a communal bottle of cleansing spray with soiled gloves and failed to sanitize the bottle at the end of care. During an interview on 09/14/22 at 09:45 a.m a supervisory staff member (#3) stated she expected staff to remove gloves and perform hand hygiene after cares and before leaving the room. 31725 MEDICATION PASS Observation during medication pass on 09/13/22 at 4:42 p.m. showed a medication aide (MA) (#4) obtained Resident #2's medications and dropped two of the pills on top of the medication cart. The MA (#4) picked up the pills, using her bare hand, placed them into the medication cup, and administered the medications to Resident #2. 40489 MASKS - Observation on 09/12/22 at 12:10 p.m. showed an unidentified housekeeper going in and out of a resident's room wearing a surgical mask below their nose. - Observation on 09/12/22 at 5:00 p.m. showed an unidentified dietary aide in the dining room wearing a surgical mask below their nose. - Observation on 09/13/22 at 8:26 a.m. showed a MA (#4) going in and out of resident rooms passing medications with the surgical mask below their nose. - Observation on 09/13/22 at 1:53 p.m. showed the charge nurse (#12) at the nurses' station with the N95 mask on their chin, talking with two unidentified staff members. - Observation on 9/14/22 at 8:20 a.m. showed a staff nurse (#12) at the nurse's station with the N95 mask under their chin. - Observation on 09/14/22 at 8:33 a.m. showed a CNA (#9) in the hallway with a surgical mask below their nose. - Observation on 09/14/22 at 8:57 a.m. showed a CNA (#9) standing by the medication cart with a surgical mask below their nose. During an interview on 09/13/22 at 5:10 p.m., an administrative nurse (#3) identified she expects all staff to be wearing their masks appropriately.

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	09/14/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 40489 Based on record review, and staff interview, the facility failed to offer the COVID19 vaccine and provide education to unvaccinated residents (and/or their legal representatives) regarding the benefits and potential side effects of receiving the vaccination for 1 of 5 sampled residents (Resident #19) reviewd for immunizations. Failure to offer the COVID19 vaccine to all residents, provide education to residents (or their legal representatives), and document the refusal of the vaccine has the potential for non-immunized residents to contract COVID19 and spread the infection to other residents, visitors, and staff. Findings include: Review of Resident #19's medical record occurred on all days of survey. The record failed to show the facility assessed contraindications to the vaccine, provided the resident/resident representative with risks and benefits of receiving the vaccine, or a signed declination. During an interview on 09/14/22 at 10:15 a.m., an administrative nurse (#3) confirmed the facility lacked documentation for Resident #19 COVID19 vaccine refusal.

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	09/14/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 13101 Based on observation, review of the North Dakota Plumbing Code, and staff interview, the facility failed to provide an air gap for 2 of 2 food handling fixtures located in the kitchen area. Failure to provide the required air gap for the food preparation sink and the ice machine has the potential to allow contamination of these food preparation areas during a sewer back up. Findings include: Review of the 2018 North Dakota Plumbing Code, section 801.2 Air Gap or Air Break Required, stated, Indirect waste piping shall discharge into the building drainage system through an air gap or air break as set forth in this code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood-level rim of the receptor shall be not less than 1 inch (25.4 mm). Section 801.3.3 Food-Handling Fixtures, stated, Food-preparation sinks, steam kettles, potato peelers, ice cream dipper wells, and similar equipment shall be indirectly connected to the drainage system by means of an air gap. Bins, sinks, and other equipment having drainage connections and used for the storage of unpackaged ice used for human ingestion, or used in direct contact with ready-to-eat food, shall be indirectly connected to the drainage system by means of an air gap. Each indirect waste pipe from food-handling fixtures or equipment shall be separately piped to the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall be not less than the drain on the unit and in no case less than 1/2 of an inch (15 mm). Observations on 09/13/22 at 3:05 p.m. showed the following: * The food prep sink drainpipe lacked an air gap. * The drainpipe for the ice machine lacked an air gap. Observations on 09/14/22 at 10:30 a.m. showed the following: * A small drainpipe extended from the food preparation sink almost to the bottom of a receptor pipe (larger pipe a small pipe drains into). The facility failed to ensure a one-inch air gap between the food preparation sink drainpipe and the rim of the receptor pipe. * The ice machine drainpipe extended into the floor sink in the janitor closet off the kitchen. The pipe ended two inches past the lip of the floor drain sink. The facility failed to ensure a one-inch air gap between the ice machine drainpipe and the rim of the floor drain sink. During interviews on 09/13/22 at 3:05 p.m. and 09/14/22 at 10:30 a.m., the dietary manager (#14) and maintenance director (#13) confirmed the food preparation sink and the ice machine failed to have the required air gaps.