STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS HEALTH CARE INC	**483 4TH ST SW , FORMAN, North Dakota, 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
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 02/17/26 and concluded on 02/19/26.	F0000		03/13/2026
F0640 SS = F	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F0640	All residents have the potential to be affected by the deficient practices identified. The facility conducted a comprehensive review of all residents to identify any additional concerns related to the cited deficiencies. Any identified issues were addressed and systemic changes including staff education and monitoring processes have been implemented to ensure ongoing compliance. All outstanding MDS assessments for residents identified during the survey (#3, #4, #8, #9, #15, #18, #19, and #22) were reviewed, completed as necessary, and transmitted to CMS via iQIES. Education regarding accurate transmission was resolved March 2. MDS coordinator working with customer service at Point Click Care. An audit of all current residents was completed by the MDS Coordinator March 2 to ensure all required assessments were completed and transmitted according to CMS timelines. The facility implemented a weekly MDS submission and validation report review process. The MDS Coordinator will run iQIES validation reports weekly commencing March 2 to ensure assessments are accepted by CMS. A tracking log for all scheduled MDS assessments has been implemented. Admission assessments will be completed within 7 days of admission as per facility policy The MDS coordinator will audit MDS transmission and validation reports weekly for 4 weeks from March 2 and monthly for 6 months to ensure continued compliance. Education to ensure all clinical staff commenced March 18 and is due for completion April 6.	04/06/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

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F0640 SS = F	Continued from page 1 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, review of the Minimum Data Set (MDS) validation reports in Centers for Medicare and Medicaid Services (CMS) Internet Quality Improvement and Evaluation System (iQies), and staff interview, the facility failed to ensure timely electronic data submission of required assessments for 8 of 13 sampled residents (Resident #3, #4, #8, #9, #15, #18, #19, and #22) with late assessments. Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.20.1), page 2-34, stated, ". . . The MDS must be transmitted (submitted and accepted . . .) electronically no later than 14 calendar days after the MDS completion date . . .” Page 5-1 stated, ". . . All Medicare and/or Medicaid-certified nursing homes . . . must transmit required MDS data records to CMS' Assessment Submission and Processing (ASAP) system. . . ." Review of the validation reports in iQies identified	F0640	Continued from page 1 The results of the audits and education program will be shared with the quality assurance committee at the April 15 meeting and quarterly thereafter	04/06/2026

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F0640 SS = F	Continued from page 2 no MDS assessments submitted to CMS by the facility since 11/21/25. Review of medical records occurred on all days of survey and identified the last MDS submitted to CMS for the following residents as: * Resident #3: Quarterly MDS, dated 08/27/25 * Resident #4: Significant Change MDS, dated 10/09/25 * Resident #8: Quarterly MDS, dated 09/13/25 * Resident #9: Annual MDS, dated 09/18/25 * Resident #15: Quarterly MDS, dated 10/12/25 * Resident #18: Quarterly MDS, dated 10/19/25 * Resident #19: Quarterly MDS, dated 09/12/25 * Resident #22: Quarterly MDS, dated 10/11/25 During an interview on the afternoon of 02/19/26, an administrative staff member (#1) confirmed the facility does not run validation reports.	F0640		04/06/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	All residents have the potential to be affected by the deficient practices identified. The facility conducted a comprehensive review of all residents to identify any additional concerns related to the cited deficiencies. Any identified issues were addressed, and systemic changes including staff education and monitoring processes have been implemented to ensure ongoing compliance. Resident #18's MDS was reviewed and corrected to accurately reflect PASRR Level II status. A review of all residents with PASRR Level II determinations will be completed to ensure accurate coding on the MDS. Education was provided to the MDS Coordinator and social services regarding PASRR coding requirements in the MDS March 19. Education for all remaining clinical staff commenced March 18 and will be finalised April 6.	04/06/2026

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F0641 SS = D	Continued from page 3 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 5 sampled resident (Resident #18) reviewed for Preadmission Screening and Resident Review (PASRR). 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. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30 through A-32, stated, ". . . A1500: Preadmission Screening and Resident Review (PASRR) . . . Coding Instructions: . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . ." - Review of Resident #18's medical record occurred all days of survey. Diagnoses included anxiety, depression, and psychotic disorder. A “Notice of PASRR Level II Outcome,” dated 09/29/22, stated, ". . . this evaluation has determined that you have a PASRR condition . . . The facility should mark yes for question A1500 on the Minimum Data Set . . .” The annual MDS, dated 07/19/25, showed the facility failed to code Resident #18's diagnoses of serious mental illness. During an interview on 02/19/26 at 12:30 p.m., an administrative staff member (#1) confirmed coding issues within the MDS.	F0641	Continued from page 3 PASRR documentation will be reviewed and completed by Social Services to enssure accurate coding in Section A1500 as per facility policy The MDS Coordinator will audit 5 MDS assessments weekly for 4 weeks and monthly for 6 months to ensure accurate coding. Audit results will be shared with the quality assurance Aprill m15 meeting in and quarterly thereafter	04/06/2026

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F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 3 of 13 sampled residents (Resident #3, #5, and #22). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: - Review of Resident #3's medical record occurred on all days of survey and identified a diagnosis of Parkinson's Disease. A physician's order, dated 10/18/23 and discontinued on 11/15/24, stated, "Resting hand splint to L [left] hand daily. On in AM [morning] and off at HS [hour of sleep-bedtime] as	F0657	All residents have the potential to be affected by the deficient practices identified. The facility conducted a comprehensive review of all residents to identify any additional concerns related to the cited deficiencies. Any identified issues were addressed, and systemic changes including staff education and monitoring processes have been implemented to ensure ongoing compliance. Care plans for residents #3, #5, and #22 were reviewed and updated to reflect current physician orders, diagnoses, and interventions. A facility-wide audit of all resident care plans will be completed by April 6 to ensure care plans reflect current resident status, physician orders, and interventions. Education for all clinical staff commenced March 18 and will be completed April 6 on timely care plan updates following significant changes or physician orders within 30 days. A Care Plan Review Notification Form has been developed and will be implemented on a trial basis from March 30 for 2 weeks to improve communication between nursing staff, interdisciplinary team members, and the MDS Coordinator regarding significant changes in resident condition or physician orders that may require a care plan review. The Director of Nursing will audit 5 resident care plans weekly for 4 weeks commencing March 27 and then monthly for 6 months. Audit results will be shared with the quality assurance committee at the April 15 and quarterly thereafter.	04/06/2026

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F0657 SS = D	Continued from page 5 nursing measure for left hand contracture." The current care plan stated, "I need assistance with my ADL [activities of daily living] . . . Brace to my left hand and arm, On in am, off at hs." The facility failed to update Resident #3's care plan with discontinuation of the left hand and arm splint. During an interview on 02/19/26 at 12:30 p.m., an administrative nurse (#1) confirmed the facility failed to update Resident #3's care plan. - Review of Resident #5's medical record occurred on all days of survey. The current physician's orders identified Lasix (a diuretic medication) used for kidney disease. Resident #5's care plan failed to include problems, goals, and interventions for diuretic use. During an interview on 02/19/26 at 10:25 a.m., an administrative nurse (#4) confirmed Resident #5's care plan failed to address the use of diuretics. -Review of Resident #22's medical record occurred on all days of survey. Diagnoses included macular degeneration and bilateral cataracts. The current care plan stated, "I am at risk for decrease in ADL due to weakness and impaired vision. . . ." A physician's consult report, dated 08/21/25, stated, ". . . Eye screening and eye low vision testing; explained lamp use, ordered yellow fitover sunglasses, please encourage him to look just to the left of things, this gives him the best vision. Keep retina appointments as directed. RTC [return to clinic] to low vision clinic prn [as needed]." Observation on 02/17/26 at 4:47 p.m. showed Resident #22 in the activity room with a four-wheeled walker and two flashlights on the walker's seat. The resident voiced a concern regarding lack of vision in one eye and "95% [percent] gone" in the other eye.	F0657		04/06/2026

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F0657 SS = D	Continued from page 6 During an interview on 02/18/26 at 5:35 p.m., an administrative nurse (#1) confirmed Resident #22's care plan lacked specific interventions recommended by the physician and the use of a flashlight by the resident.	F0657		04/06/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, review of manufacturer's instructions for use, and staff interview, the facility failed to ensure staff followed standards of care for 1 of 1 resident (Resident #3) observed for insulin administration. Failure to administer rapid acting insulin within the time specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction. Findings include: Review of the facility policy titled "Timely Administration of Insulin" occurred on 02/19/26. This undated policy stated, ". . . Insulin administration will be coordinated with mealtimes . . . unless otherwise specified in the physician order . . . Administer insulin at appropriate times. . . ." Prescribing information for Insulin Aspart, found at https://www.novo-pi.com/insulinaspart, stated, ". . . This product is NovoLog® (insulin aspart) . . . Insulin Aspart is rapid acting human insulin analog indicated to improve glycemic control in adults . . . Preparation and Administration Instructions . . . Inject Insulin Aspart subcutaneously within 5-10 minutes before a meal . . ." Review of Resident #3's medical record occurred on 02/18/26. Diagnoses included diabetes mellitus.	F0684	All residents have the potential to be affected by the deficient practices identified. The facility conducted a comprehensive review of all residents to identify any additional concerns related to the cited deficiencies. Any identified issues were addressed, and systemic changes including staff education and monitoring processes have been implemented to ensure ongoing compliance. The nurse involved received education regarding timing of rapid-acting insulin administration relative to meals. All residents receiving insulin were reviewed to ensure insulin orders and administration practices align with physician orders and manufacturer recommendations. Medication administration practices were reviewed and education was commenced for all clinical staff on timely administration (within 15 minutes prior to meal) March 18 and to be completed April 6 The Director of Nursing or designee commenced medication administration observation audits March 18 (weekly for 4 weeks) and monthly for 6 months. Results of audits will be shared with the quality assurance committee at the April 15 meeting and quarterly thereafter.	04/06/2026

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F0684 SS = D	Continued from page 7 Observation on 02/18/26 at 11:30 a.m. showed a nurse (#2) administered 6 units of Insulin Aspart to Resident #3 per physician's order. When asked when the resident will have lunch the nurse replied, “At noon.” Staff assisted the resident to the dining room table at 11:44 a.m., at 12:08 p.m. an unidentified dietary aide assisted the resident to drink half a glass of unsweetened lemonade. The resident received the noon meal at 12:14 p.m., 44 minutes after receiving a rapid acting insulin. During an interview on 2/19/26 at 12:30 p.m., an administrative nurse (#1) stated she expected staff to administer a rapid acting insulin no sooner than 15 minutes prior to a meal.	F0684		04/06/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F0883	Residents #4 and #22 will be assessed for pneumococcal vaccine eligibility and education will be provided to the resident and/or responsible party within 30 days. Pneumococcal vaccination will be offered according to CDC recommendations, and the outcome will be documented in the medical record. All current residents have the potential to be affected by this practice. An audit of all residents’ immunization records will be conducted by the consultant pharmacist to ensure pneumococcal vaccination status has been assessed, offered when appropriate, and documented according to CDC recommendations. An audit of all current Resident's pneumococcal vaccination status was started and completed on March 12 The facility will implement an immunization tracking tool to monitor influenza and pneumococcal vaccination status within 30 days. Audits for pneumococcal vaccination status will be conducted for all new Residents within 30 days of admission to the facility and all Residents will be evaluated every 6 months thereafter indefinitely. Results of the ongoing vaccination status audits will be shared at quarterly QA committee meetings. Education commenced for all clinical staff Mardh 18 regarding CDC pneumococcal vaccine recommendations, eligibility assessment, and documentation requirements and will be completed by April 13 The immunization tracking tool and vaccination status will be reviewed during bi-monthly Infection	04/13/2026

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F0883 SS = D	Continued from page 8 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, review of the Centers for Disease Control and Prevention (CDC) guidelines and recommendations, and staff interview, the facility failed to offer the pneumococcal vaccine to 2 of 5 residents (Resident #4 and #22) reviewed for immunization status. Failure to offer the recommended pneumococcal conjugate vaccines (PCV) and pneumococcal polysaccharide vaccine (PPSV) to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contract pneumonia and spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 02/19/26. This policy, dated 01/02/25, stated, ". . . Influenza and Pneumococcal Immunization: . . . b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.	F0883	Continued from page 8 prevention and control meetings, or more frequently if required in response to outbreaks, infection trends, or identified concerns.	04/13/2026

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F0883 SS = D	Continued from page 9 c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. d. Residents will have the opportunity to refuse the immunizations. e. Documentation will reflect the education provided and details regarding whether or not the residents received the immunizations. . . ." Review of the CDC: Pneumococcal Vaccine Recommendations webpage https://www.cdc.gov/pneumococcal/hcp /vaccine-recommendations/index.html, "Clinical guidance for implementing pneumococcal vaccine recommendations for adults aged 19 years or greater," dated October 2024, stated, for adults aged 50 years or older who previously received the following vaccines: *"PCV13 at any age and PPSV23 at age [less than] 65 years," CDC recommended: "A single dose of PCV21 or PCV20 [more than or equal to] 5 years after the last pneumococcal vaccine dose." *"PCV13 at any age and PPSV23 at age [more than or equal to] 65 years," CDC recommended: "Shared clinical decision-making . . . of either a single dose of PCV21 or PCV20 . . . " - Review of Resident #4's medical record occurred on 02/19/26 and identified the resident received the PCV13 and PPSV23 vaccines more than 5 years ago and the PPSV23 prior to age 65. The record lacked evidence the facility assessed Resident #4's pneumococcal immunization status and offered the PCV21 or PCV 20 vaccine. - Review of Resident #22's medical record occurred on 02/19/26 and identified the resident received the PCV13 and PPSV23 vaccines more than 5 years ago after age 65. The record lacked evidence the facility assessed Resident #22's pneumococcal immunization status, discussed further vaccination with the provider, or offered the PCV21 or PCV20 vaccine. The facility failed to follow the CDC recommendations for pneumococcal vaccine administration. During an interview on 02/19/26 at 12:50 p.m., an administrative nurse (#1) stated she was not aware if the facility offered the PCV 21 or PCV 20 vaccines to Residents #4 and #22.	F0883		04/13/2026