STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	110 HILLCREST DR ENDERLIN, ND 58027

(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
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/19/21 and concluded on 07/22/21.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 1.16), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 13 sampled residents (Resident #18). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: Section N: Medications The Long-Term Care Facility RAI Manual, revised October 2019, pages N6-N7 states, ". . . N0410E, Anticoagulant (e.g.., warfarin, heparin, or low molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended	F 641	Fed - F - 0641 - 483.20 (g) – Accuracy of Assessments S-S= D 1. Corrective Action: It is the practice of the facility to accurately complete the MDS to reflect the current status/needs of the resident in accordance with current regulations and RAI manual, specifically section N0410E, Anticoagulant. On 7/26/21, Resident #18's MDS correction was made in section N0410 E anticoagulant to reflect that she is not a low molecule weight heparin, warfarin, or heparin. 2. Identify other residents: All residents who are not on an anticoagulant have the potential to be affected by this deficient practice. 3. Measures put in place: Re-education was provided to MDS nurse on 7/22/2021, regarding information on proper coding of anticoagulant medications. 4: Monitoring: A quality audit will be conducted to ensure any N0410E, Anticoagulant miscodes are identified and	8/18/21

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

Electronically Signed | 08/04/2021

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F 641	Continued From page 1 release, dipyidamole, or clopidogrel here . . . ." Review of Resident #18's medical record occurred on all days of survey. A quarterly MDS, dated 05/20/21, identified the resident received an anticoagulant seven of seven days during the look-back period. Physician's orders identified aspirin and clopidogrel (antiplatelets) and lacked an order for anticoagulants. During an interview on 07/22/21 at 9:45 a.m., an administrative nurse (#2) and an administrative staff member (#1 acknowledged staff coded the MDS incorrectly.	F 641	corrected. These audits will be conducted by checking the coding on 5 random residents to assure accuracy. Audits will be done weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Director of Nursing and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by August 18, 2021.	
F 657 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	F 657		8/18/21

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F 657	Continued From page 2 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 record review, the facility failed to review and revise the comprehensive care plan for 2 of 13 sampled residents (Resident #17 and #137). Failure to review and revise the care plan limits the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD) (persistent respiratory symptoms) and Heart Failure. A physician's order, dated 06/12/21 stated, "OXYGEN AT 2-4L [liter] PRN [as needed] for dyspnea [shortness of breath] per nasal cannula to keep oxygen sats [saturation levels] up to 90% . . ." Resident #17's care plan failed to include a problem, goal, or interventions related to oxygen use. - Review of Resident #137's medical record occurred on all days of survey. Diagnoses included atrial fibrillation and long term use of an anticoagulant (blood thinner). Physician's orders, dated 07/16/21 stated, "Coumadin Tablet (Warfarin Sodium) [blood thinner] Give 2.5 mg	F 657	Fed - F - 0657 - 483.21(b)(2)(i)-(iii)– Care Plan Timing and Revision S-S= D 1. Corrective Action: It is the practice of the facility to review and revise the care plan accurately and timely in order to ensure continuity of care for each resident. On 7/22/21, the care plans of resident #17 and #137 were reviewed and updated to address current medical needs and diagnosis including respiratory symptoms and oxygen, and anticoagulation therapy, respectfully. 2. Identify other residents: All residents with respiratory symptoms requiring oxygen and all residents on an anticoagulant have the potential to be affected by this deficient practice. 3. Measures put in place: Re-education will be provided to nursing staff responsible for care planning oxygen and anticoagulants at the plan of correction meeting on 8/17/21 and will include the importance of accuracy of the resident's care plan to ensure continuity of care for each resident 4. Monitoring: A quality audit will be conducted to ensure care plans are reflecting residents' current needs for oxygen and anticoagulants. These audits	

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F 657	Continued From page 3 [milligrams] by mouth in the afternoon every Mon [Monday], Sat [Saturday] . . . Give 5 mg by mouth in the afternoon every Fri [Friday], Sun [Sunday] . . .", and physician's orders, dated 07/20/21 stated, "Coumadin Tablet (Warfarin Sodium) Give 5 mg by mouth in the afternoon every Wed [Wednesday], Thu [Thursday] . . . Give 7.5 mg by mouth in the afternoon every Tue [Tuesday] . . ." Resident #137's care plan failed to identify signs/symptoms of blood clot formation and possible adverse reactions secondary to anticoagulant use.	F 657	will be conducted weekly for four weeks, then monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. These audits will be conducted by the Director of Nursing and/or designee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by August 18, 2021.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide appropriate equipment to prevent accidents for 1 of 4 sampled residents (Resident #16) observed during a mechanical lift transfer. Failure to safely utilize a mechanical lift with the correct sling placed the resident at risk for accidents and/or injury and caused the resident avoidable pain. Findings include: Review of Resident #16's medical record	F 689	Fed - F - 0689 - 483.25(d)(1)(2) – Free of Accident Hazards/Supervision/Devices S-S= D 1. Corrective Action: It is the practice of the facility to ensure the resident environment remains free of accident hazards as possible, and to ensure each resident receives proper assistant devices to prevent accidents. On 7/22/21, Resident #16's sling was updated immediately to match manufacture	8/18/21

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F 689	Continued From page 4 occurred on all days of survey and include the diagnoses of dementia and Parkinson's disease. Resident #16's care plan identified ". . . Transfer: I need assistance of 2 and hoyer lift [mechanical lift transfer] for transfers. . . ." Observation on 07/20/21 at 4:07 p.m., showed two certified nurse assistants (CNAs) (#3 and #4) transferred Resident #16 from the bed to the wheelchair using a hoyer lift. The CNA (#4) stated she did not have the correct sling. The CNAs utilized Resident #16's roommate's sling during the transfer. During the transfer, Resident #16 was stated "ow" several times. Once seated in the wheelchair, the CNA (#4) asked the resident if something hurt and Resident #16 stated, "Yes, my penis." The CNA (#4) asked the resident if it (his penis) was pinched during the transfer and the resident stated "Yes". The CNA (#4) told the resident she would inform the charge nurse that staff could not use this sling due to pain. Observation on 07/21/21 at 3:47 p.m., showed two CNAs (#5 and #6) transferred Resident #16 from the bed to the wheelchair using a hoyer lift. The CNAs utilized the roommates sling for the transfer. During an interview on 07/22/21 at 10:55 a.m., an administrative nurse (#2) stated the sling used to transfer Resident #16 came back from the hospital with Resident #16's roommate and it is not the facility's sling. The facility failed to ensure the availability of appropriate transfer equipment necessary to avoid pain and/or injuries.	F 689	recommendations as the most appropriate fitting sling. Education was provided in communication and individually with staff working with resident. 2. Identify other residents: All residents requiring use of a full body lift have the potential to be affected by this deficient practice. 3. Measure put in place: Additional slings were ordered, and re-education will be provided to staff who assist with transfers on 8/17/21 regarding proper sling sizing and sling use. 4. Monitoring: Quality audits will be conducted to ensure proper sling size for all residents who require use of full body lifts for transfer. The audit will be conducted by the Director of Nursing and/or designee. This audit will be conducted weekly for four weeks, monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by August 18, 2021.	

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to offer fluids to 2 of 3 sampled residents (Resident #16 and #20) who required staff assistance for fluid intake and are at risk for dehydration. Failure to provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Fluid Intake Monitoring" occurred on 07/22/21. This form,	F 692	Fed - F - 0692 - 483.25(g)(1)-(3) – Nutrition/Hydration Status Maintenance S-S= D 1. Corrective Action: It is the practice of the facility to offer fluids to residents who require assistance with fluid intake and are at risk for dehydration. On 7/22/21, the Director of Nursing re-educated the CNA team on the importance of offering fluids with interactions to assure residents are hydrated. 2. Identify other residents: All residents	8/18/21

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F 692	Continued From page 6 revised November 2014 stated, ". . . Procedure: 1. Residents dependent on staff for assistance with hydration will be offered fluids to maintain proper hydration and health. . . ." - Review of Resident #16's medical record occurred on all days of survey and included a diagnosis of dementia. The quarterly Minimum Data Set (MDS), dated 05/07/21, identified the resident requires extensive assist with eating. Observation on 07/20/21 at 3:47 p.m. showed two certified nursing assistants (CNAs) (#5 and #6) assisted Resident #16 with cares. Staff failed to offer fluids before or after cares. - Review of Resident #20's medical record occurred on all days of survey and included the diagnosis of Alzheimer's Disease. The quarterly MDS dated 05/27/21, identified dependent assist with eating. The current care plan stated, " . . . I need help with eating . . . " A nursing progress note, dated 07/21/21 at 12:14 p.m., indicated Resident #20 was admitted to the local hospital with a diagnosis of septic (body's extreme response to an infection) UTI [urinary tract infection]. Observation on 07/20/21 at 9:13 a.m. showed two staff members (#7 and #8) provided cares to Resident #20 and failed to offer fluids during or after cares. Observation on 07/20/21 at 4:07 p.m. showed a CNA (#3) provided cares to Resident #20 and failed to offer fluids during or after cares.	F 692	who require staff assistance for fluid intake have the potential to be affected by this deficient practice. 3. Measure put in place: Re-education will be provided to all staff on 8/17/21 and will include the importance of offering fluids to residents during interactions. 4. Monitoring: Quality audits will be performed focusing on hydration being offered with cares on 5 random residents. The audit will be conducted by the Director of Nursing and/or designee. This audit will be conducted weekly for four weeks, monthly for three months and continued auditing will be scheduled per discretion of the Quality Assurance Committee. Audits will be reviewed by the Quality Assurance Committee monthly to ensure continued compliance. 5. The facility will be in substantial compliance by August 18, 2021.	

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F 692	Continued From page 7 During an interview on 07/22/21 at 10:40 a.m., an administrative nurse (#2) stated she expected staff to offer fluids to dependent residents frequently.	F 692		