

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                  |                                                                                                                                                                                                |                                                                            |  |                                                                                         |                                                                                                                          |                                                        |                            |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355108</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                    |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/09/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SMP HEALTH - MARYHILL</b> |                                                                                                                                                                                                |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>110 HILLCREST DR<br/>ENDERLIN, ND 58027</b> |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                   |                                                                            |  | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| E 000                                                            | <p>Initial Comments</p> <p>A recertification survey conducted on October 9, 2023 found Maryhill Manor in compliance with the requirements of 483.73 Long Term Care Emergency Preparedness.</p> |                                                                            |  | E 000                                                                                   |                                                                                                                          |                                                        |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/18/2023

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  |                                                                                             |                                                                                                                          |                                                        |                            |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355108</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____ |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/09/2023</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SMP HEALTH - MARYHILL</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>110 HILLCREST DR<br/>ENDERLIN, ND 58027</b>     |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |  | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| K 000                                                            | <p><b>INITIAL COMMENTS</b></p> <p>This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b).</p> <p>The facility was located in a one-story building of Type V (111) construction with no basement. The facility was protected throughout by a wet/dry automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.</p> <p>Observation and records review determined the facility to be in compliance with the minimum requirements of the 2012 Life Safety Code and NFPA 99.</p> |                                                                            |  | K 000                                                                                       |                                                                                                                          |                                                        |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/18/2023

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.