STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST CATHERINE NORTH	**1351 N BROADWAY FARGO, ND 58102**

(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 and complaint survey started on 10/14/24 and concluded 10/17/24. During the complaint investigation, the facility was found in compliance with regulatory requirements.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 7 residents (Resident #97 and #110) observed during medication administration. Two medication errors occurred during staff administration of 28 medications, resulting in a seven percent error rate. Failure of staff to properly prepare and administer medications may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled "Medication Administration" occurred on 10/17/24. This policy, dated 10/07/24, stated, ". . . Medications are administered . . . as ordered by the physician and in accordance with professional standards of practice . . . Policy Explanation and Compliance	F 759	It is the practice of this facility to ensure medication error rates are not 5 percent or greater. 1. Verbal coaching was given to medication aide #3 on 10/16/24. Coaching included verifying the dose dispensed matches the dose ordered. Verbal coaching was given to staff nurse #4 on 10/17/24 that Depakote Sprinkles Oral Capsules should not be crushed and instead should be opened and mixed into a small amount of food. 2. All residents have the potential to be affected and could potentially have negative outcomes due to inaccurate dose or impaired efficacy related to failure to follow manufacturer prescribing instructions. 3. It was determined that the medication	11/20/24

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

Electronically Signed | 11/01/2024

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F 759	Continued From page 1 Guidelines . . . Compare medication source . . . with MAR [medication administration record] to verify . . . dose . . . Administer medication as ordered in accordance with manufacturer specifications. . . ." Prescribing information found at https://www.drugs.com/pro/depakote.html, page 2, stated, ". . . Depakote is administered orally in divided doses. Depakote should be swallowed whole and should not be crushed or chewed . . ." and page 63, stated, ". . . Depakote Sprinkle Capsules may be swallowed whole, or the capsule may be opened and the contents may be mixed into a small amount of soft food, such as applesauce or pudding. . . ." - Review of Resident #97's medical record occurred on 10/16/24. A physician's order, dated 07/03/24, stated. "Meclizine HCl Oral Tablet . . . Give 25 mg [milligrams] . . . for Vertigo . . ." Observation on 10/16/24 at 8:36 a.m., showed a medication aide (MA) (#3) prepared Resident #97's medications for administration. The MA referred to the resident's MAR, obtained a bottle of meclizine from the medication cart, dispensed one pill from the bottle, and placed the pill in a medication cup along with the resident's other scheduled medications. When asked to confirm the dosage of the meclizine, he/she prepared and dispensed into the cup, the MA again referred the Resident #97's MAR and compared the dosage listed on the pill bottle (which listed 12.5 mg per tablet). The MA confirmed he/she should have dispensed two meclizine pills from the bottle to equal the ordered dose of 25 mg.	F 759	administration practice observed did not conform to facility policy. Re-education will be provided to all staff nurses and medication aides of facility medication administration policy. 4. The Quality Nurse or designee will audit up to 5 medication passes weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for facility medication error rate.	

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F 759	Continued From page 2 - Review of Resident #110's medical record occurred on all days of survey. A physician's order, dated 05/01/24, stated, "Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG . . . Give 2 capsule by mouth three times a day . . . Okay to open . . ." Observation on 10/16/24 at 1:30 p.m. showed a staff nurse (#4) dispensed two Depakote Sprinkle capsules from Resident #110's medication card, placed the capsules into a cup along with other scheduled medications, poured the medications from the cup into a plastic sleeve, and crushed the medications. The nurse then poured the crushed contents into applesauce and administered the medications to Resident #110. The nurse (#4) failed to follow manufacturers prescribing instructions and crushed the Depakote Sprinkle delayed release capsules. During an interview on 10/16/24 at 3:41 p.m., an administrative staff member (#5) confirmed Depakote Sprinkles should not be crushed.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 or 1 sampled resident (Resident #110) with a significant medication error. Failure of staff to administer medications per	F 760	It is the practice of this facility to ensure residents are free of any significant medication errors. 1. Verbal coaching was given to staff nurse #4 on 10/17/24 that Depakote Sprinkles Oral Capsules should not be	11/20/24

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F 760	Continued From page 3 manufacturer recommendations may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled "Medication Administration" occurred on 10/17/24. This policy, dated 10/07/24, 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. . . ." Prescribing information found at https://www.drugs.com/pro/depakote.html, page 2, stated, ". . . Depakote should be swallowed whole and should not be crushed or chewed . . ." Page 63, stated, ". . . Depakote Sprinkle Capsules may be swallowed whole, or the capsule may be opened and the contents may be mixed into a small amount of soft food, such as applesauce or pudding. . . ." - Review of Resident #110's medical record occurred on all days of survey. A physician's order, dated 05/01/24, stated, "Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG . . . Give 2 capsule by mouth three times a day . . . Okay to open . . ." Observation on 10/16/24 at 1:30 p.m. showed a staff nurse (#4) dispensed two Depakote Sprinkle delayed release capsules from Resident #110's medication card, placed the capsules into a cup along with other scheduled medications, poured	F 760	crushed and instead should be open and mixed into a small amount of food. 2. All residents have the potential to be affected and could potentially have negative outcomes due to inaccurate dose or impaired efficacy related to failure to follow manufacturer prescribing instructions. 3. It was determined that the medication administration practice observed did not conform to facility policy. Re-education will be provided to all staff nurses and medication aides of facility medication administration policy. 4. The Quality Nurse or designee will audit up to 5 medication passes weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for significant medication errors.	

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F 760	Continued From page 4 the medications from the cup into a plastic sleeve, and crushed the medications. The nurse then poured the crushed contents into applesauce and administered the medications to Resident #110. The nurse (#4) failed to follow manufacturers prescribing instructions and crushed the Depakote Sprinkle capsules. During an interview on 10/16/24 at 3:41 p.m., an administrative staff member (#5) confirmed Depakote Sprinkles should not be crushed.	F 760		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, review of manufactures' label,	F 812	It is the practice of this facility to ensure food is stored, prepared, distributed and	11/20/24

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F 812	Continued From page 5 and staff interview, the facility failed to date time sensitive thickened beverages with an opened date and to store food in a sanitary manner in 2 of 8 unit kitchenettes (3 South and 3 North). Failure to label beverages with an open date may compromise the safety and quality of the item and failure to store food in a sanitary manner can affect safety. Findings include: Review of the facility policy/procedure titled "Storage of multi-use ice pack in freezers," occurred on 10/17/24. This policy, dated 07/16/24, stated ". . . 2. Separation of Ice Packs and Food: a) Ice packs may be stored in the same freezer as food but must not be in direct contact with any food items. Ice packs should be stored on separate shelves or in containers that keep them distinct from food products. b) If separate shelves are not available, ice packs must be placed in a way to prevent them from touching food. . . ." Observations of the main kitchen and unit kitchenettes occurred on 10/16/24 at 1:45 p.m. with two administrative staff members (#1 and #2) and showed the following: - Three South kitchenette refrigerator, contained an undated opened container of thickened juice, the product label stated "use within 10 days of opening." The freezer compartment contained an ice pack not separated from food items. - Three North kitchenette freezer, contained two ice packs not separated from food items. The facility staff failed to store ice packs on	F 812	served in accordance with professional standards for food service safety. 1. Undated opened containers of thickened liquids were immediately disposed of on 10/16/24 and ice packs were removed from all kitchenette freezers. 2. All residents have the potential to be affected and could potentially have negative outcomes due to failure to label beverages with an open date to ensure use within appropriate time frame and failure to store food in a sanitary manner to prevent contamination. Use outside of the indicated time frame may compromise the safety and quality of the item and failure to store food in a sanitary manner can potentially affect safety. 3. It was determined that the practice observed did not conform to facility policy and/or facility practice was not sufficient to ensure safety. Facility policy and procedure were updated to include standardized dating of thickened beverages and storage container type was changed to prevent ice pack from coming into contact with food. Education will be provided to all dietary staff and direct care staff regarding policy and practice changes. 4. The Quality Nurse or designee will audit up to 5 refrigerators weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for proper labeling of	

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F 812	Continued From page 6 separate shelves from food items or in a distinct container. During the observation, an administrative staff member (#2) stated, she expected ice packs to be stored in a plastic bag. The administrative staff member (#1) disposed of the unlabeled juice and confirmed it should be dated when opened.	F 812	thickened liquids and proper storage of ice packs.	