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 _____	09/21/2023

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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 survey started on 09/18/23 and concluded 09/21/23.	F 000		
F 640 SS=D	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. (ii) Annual assessment.	F 640		10/6/23

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

Electronically Signed | 10/06/2023

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F 640	Continued From page 1 (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 and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), the facility failed to ensure timely electronic data submission of required Minimum Data Sets (MDS) discharge assessments for 3 of 3 supplemental residents (Resident #18, #56, and #98). 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, revised October 2019, page 2-37 stated, "Discharge Assessment-Return Not Anticipated . . . Must be submitted within 14 days after the MDS completion date. . . ." Review of Resident #18, #56, and #98's medical	F 640	It is the practice of this facility to ensure timely electronic data submission to CMS and the State of required Minimum Data Sets (MDS) for all types of MDS data. 1. Re-education regarding timely electronic data submission was provided on 9/21/23 to the facility MDS nurse who manages MDS scheduling, completion and submission for all MDS assessments completed for all residents in the facility. 2. All MDS data submissions have the potential to be affected and could result in failure to meet regulatory requirements. 3. It was determined that the current submission practice did not include a process for a double check to ensure MDS data was submitted timely to both	

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F 640	Continued From page 2 records occurred on 09/21/23. The MDSs showed a discharge date of 06/07/23 for Resident #18, 06/07/23 for Resident #56, and 06/15/23 for Resident #98. On the morning of 09/21/23, a nurse (#1) reviewed validation reports and confirmed CMS did not receive the above discharge assessments. The facility failed to submit the discharge assessments to Center for Medicare and Medicaid Services (CMS).	F 640	the State and CMS. A new tracking form was developed to track submission and acceptance of MDS data for the State and CMS separately. The facility MDS nurse was educated on this new form and practice on 10/4/23. 4. The Quality Nurse or designee will audit up to 5 MDS submissions weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for timely submission to CMS.	
F 641 SS=E	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 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 24 sampled residents (Resident #9, #19 and #24). 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: SECTION K: SWALLOWING/NUTRITIONAL STATUS	F 641	It is the practice of this facility to complete the MDS assessment that accurately reflects the residents status. 1. Re-education was provided to staff that completed the MDS assessment including section K for resident #9 and #19; Section N and O for resident #24. The inaccurate assessment for resident #24 was corrected on 9/21/23 and submitted and accepted on 9/30/23. The inaccurate assessments for residents #9 and #19 were corrected, submitted and accepted on 10/4/23. 2.All residents have the potential to be affected when the MDS assessment is	10/6/23

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F 641	Continued From page 3 The Long-Term Care Facility RAI User's Manual, revised October 2019, pages K-5 through K-12, stated, ". . . K0300: Weight Loss . . . Coding Instructions . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. . . . K0510: Nutritional Approaches . . . K0510D, therapeutic diet (e.g., low salt, diabetic, low cholesterol) . . . Therapeutic diets are not defined by the content of what is provided . . . but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration. . . . to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition). . . . " - Review of Resident #9's medical record occurred on all days of survey. A dietary progress note, dated 06/27/23 at 5:04 p.m., stated, ". . . Weight of 195 lb [pounds] from 6/23/23 is down significantly 22 lb or 10.1% in the past 6 months. . . . " A quarterly MDS, dated 06/23/23, identified section K0300: Weight Loss coded "no" and K0310: Weight Gain, coded "2", yes, not on physician-prescribed weight-gain regimen. During an interview on 09/21/23 at 10:19 a.m., an administrative staff member (#3) confirmed staff failed to correctly code Section K as weight loss	F 641	not completed accurately and may negatively affect the development of a comprehensive care plan and the care provided to the residents. 3.Re-education was provided to all staff that complete the MDS assessment sections K, N and O on 9/21/23. 4. The Quality Nurse or designee will audit up to 5 MDSs completed weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for accurate completion of section K0300, K0510D, N0410E and O0100K.	

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F 641	Continued From page 4 on Resident #9's MDS. - Review of Resident #19's medical record occurred on all days of survey. Provider orders indicated a regular diet with thin liquids. A dietary progress note, dated 08/04/23 at 9:09 a.m., stated, ". . . Nutritional CAA [care area assessment] triggered r/t [related to] use of therapeutic diet (dx [diagnosis] mild malnutrition). . . ." A significant change MDS, dated 08/03/23, identified section K0510D coded for a therapeutic diet. Resident #19's medical record failed to identify a provider's diagnosis of mild malnutrition or other diagnoses to support coding of a therapeutic diet on the MDS. During an interview on 09/21/23 at 10:19 a.m., an administrative staff member (#3) confirmed staff should not have coded a therapeutic diet in Section K on Resident #19's MDS. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2019, pages N-6 and N-7, stated, ". . . Coding Instructions . . . 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). . . ."	F 641		

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F 641	Continued From page 5 - Review of Resident #24's medical record occurred on all days of survey. Medications included Eliquis (an anticoagulant) 5 milligrams (mg) twice per day with an order date of 04/19/23. Resident #24's quarterly MDS, dated 07/11/23, failed to identify the use of an anticoagulant under Section N. SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2019, page O-5, stated, ". . . Hospice care . . . Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. . . ." - Review of Resident #24's medical record occurred on all days of survey. The record identified Resident #24 admitted to Hospice on 01/19/23. A significant change MDS, dated 01/25/23, failed to identify the Hospice admission under Section O. During an interview on 09/21/23 at 9:48 a.m., an administrative nurse (#1) confirmed staff failed to code anticoagulant use and hospice services for Resident #24.	F 641		
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	F 689		10/6/23

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F 689	Continued From page 6 §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 supervision for 1 of 5 sampled residents (Resident #97) observed during a gait belt transfer. Failure to provide adequate assistance during a transfer places the resident at risk for accidents, falls, or injuries. Findings include: Review of Resident #97's medical record occurred on all days of survey. The current care plan stated, ". . . I have an ADL [activities of daily living] self-care performance deficit r/t [related to] deconditioning, impaired mobility, arthritis . . . Transfer: I require 1 [assist of one] with a 4WW [four-wheel walker] for pivot transfers." Observation on 09/19/23 at 9:08 a.m. showed a certified nurse aide (CNA) (#4) applied a gait belt and brought the 4WW to Resident #97. The CNA walked beside the resident holding on to the gait belt until the entrance of the bathroom. The CNA then left the resident standing unattended to move the scale chair closer. Observation showed the resident swayed from side to side while holding the 4WW. The CNA failed to remain by the resident's side during a transfer. During an interview on 09/19/23 at 10:01 a.m., an administrative nurse (#2) confirmed staff should not leave the resident unattended.	F 689	It is the practice of this facility to ensure residents have adequate supervision and assistance during transfers to prevent accidents, falls, and/or injuries. 1. Re-education was provided on 10/5/23 to CNAs and nurses who work with resident #97 that he requires assist of one staff and gait belt for all transfers and that he cannot be left unattended for any amount of time during a transfer. CNAs and nurses were also re-educated to ensure all required equipment/supplies are ready and available to prevent the need to leave the resident during the task. 2. All residents who require assistance with transfers have the potential to be affected. 3. Re-education was provided to CNAs and Nurses on 9/28/23 that any resident who requires assistance with transfers cannot be left unattended for any amount of time during a transfer. CNAs and nurses were also re-educated to ensure all required equipment/supplies are ready and available to prevent the need to leave the resident during the task. Any CNAs or Nurses that were not in attendance at the re-education on 9/28/23 will be provided one-on-one education by 10/20/23.	

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F 689	Continued From page 7	F 689	4. The Quality Nurse or designee will audit 5 residents who require assistance with transfers for proper supervision/assistance provided by CNA or Nurse weekly for 4 weeks, monthly for 3 months and quarterly for 1 year.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide.	F 849		10/6/23

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F 849	Continued From page 8 (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation	F 849		

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F 849	Continued From page 9 of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.	F 849		

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F 849	Continued From page 10 The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F 849		

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F 849	Continued From page 11 §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents' records contained the hospice plan of care and certification of a terminal illness for 1 of 3 sampled residents (Resident #106) receiving hospice services. Failure to obtain these documents limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: Review of Resident #106's medical record occurred on all days of survey. Diagnoses included hypertensive [high blood pressure] heart disease with heart failure, congestive heart failure and myocardial infarction [type of heart attack]. The resident elected and received hospice services at home for five months prior to admission to the facility in July 2023. The medical record lacked the hospice certification of terminal illness and plan of care until the hospice recertification plan of care completed on 08/16/23. During an interview on 09/21/23 at 9:30 a.m., an administrative nurse (#2) confirmed Resident	F 849	It is the practice of this facility to ensure each resident record contains the hospice plan of care and certification of terminal illness for each resident receiving hospice services. This practice will ensure coordination of care between the facility and hospice. 1. The hospice certification and plan of care for resident #106 was obtained from the hospice and added to the resident facility record on 9/21/23. 2. All residents receiving hospice services have the potential to be affected. 3. Re-education was provided to all Nurse Managers, Clinical Support Nurses, Medical Records, Admissions Nurse and Admission Coordinator on 10/5/23 that all residents receiving hospice services must have included in their record the hospice plan of care and certification of terminal illness. 4. The Quality Nurse or designee will audit records for new admissions with	

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	355047	A. BUILDING _____ B. WING _____	09/21/2023

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 849	Continued From page 12 #106's medical record lacked the hospice certification and plan of care for three weeks after admission.	F 849	hospice services or current residents who elect hospice services up to 5 total weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for the hospice plan of care and certification of terminal illness.	