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 08/18/2022

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 08/15/22 and concluded 08/18/22.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		9/22/22

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

Electronically Signed | 09/12/2022

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 08/18/2022

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 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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 08/18/2022

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 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident or their representative and the State Long Term Care Ombudsman written notice of transfer for 1 of 2 resident closed records (Resident #120) with hospital transfers. Failure to provide a written notice of transfer does not allow the resident and/or representative to make an informed choice regarding the resident's rights. Failure to notify the Ombudsman does not allow the Ombudsman to know the resident was transferred and be alerted to possible assistance to the resident and/or representative if needed.	F 623	It is the practice of this facility to provide notice to the resident and resident's representative of transfer/discharge in writing, as well as the State Long Term Care Ombudsman. 1. Re-education was provided to care managers and will be provided to nurses caring for residents on all units to provide notice of transfer/discharge in writing. Resident #120 is no longer a resident of the facility. 2. All residents residing in the facility have	

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 08/18/2022

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 623	Continued From page 3 Findings include: Review of Resident #120's medical record identified hospitalizations on 07/22/22 and 07/26/22. The medical records lacked evidence of written transfer notices given to the resident and/or their representative, or the Ombudsman. During an interview on 08/17/22 at 5:45 p.m., an administrative staff member (#3) confirmed there were no written transfer notices completed for the transfers on 07/22/22 and 07/26/22.	F 623	the potential to be affected if they are not provided a written notice of transfer/discharge allowing the resident and/or their representative to make an informed choice regarding the resident's rights. In addition, failing to notify the Ombudsman does not allow the Ombudsman to know the resident was transferred and possibly provide assistance to the resident and/or their representative. 3. It was determined that the current Transfer Notice and Bed Hold form being utilitzed by the facility did not sufficiently meet the requirement to provide notice. The forms were separated into individual Transfer/Discharge Notice and Bed Hold forms. Education was provided to Care Managers on the use of the new forms on 09-07-22. Education will be provided to nurses at a nurses meeting on 09-22-22. 4. The Quality Nurse or designee will audit up to 5 resident transfers weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for written transfer/discharge notice provided to the resident and their representative and that a copy was sent to the Office of the State Long-Term Care Ombudsman.	
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	F 641		9/15/22

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 08/18/2022

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 641	Continued From page 4 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 complete a Minimum Data Set (MDS) that accurately reflected the residents' status for 2 of 25 sampled residents (Resident #4 and #68). Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include: Section E: Behaviors The Long-Term Care Facility RAI Manual, revised October 2019, page E-5, stated, ". . E0200: Behavioral Symptom - Presence & Frequency . . . Steps for Assessment . . . 1. Review the medical record for the 7-day look-back period. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident. 3. Observe the resident in a variety of situations during the 7-day look-back period. . . ." Review of Resident #68's medical record occurred on all days of survey. The quarterly MDS, dated 06/23/22, identified Resident #68 verbal behaviors occurred on 4-6 days, "other" behaviors occurred daily, and wandering occurred daily during the seven-day look-back period. Resident #68's medical record lacked evidence of the behaviors occurring as	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 E for resident #68 and section N for resident #4. The inaccurate assessments for residents #68 and #4 were corrected on 08-18-22 and submitted and accepted on 08-22-22. 2. All residents have the potential to be affected when the MDS assessment is not completed accurately and may negatively affect the development of a comprehensive care plan and the care provided to the residents. 3. Re-education will be provided to all staff that complete the MDS assessment including section E and section N of the MDS on 09-15-22. 4. The Quality Nurse or designee will audit at least 1 MDS completed on each unit, total of 5, weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for accurate completion of section E0200 and section N0350.	

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 08/18/2022

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 641	Continued From page 5 documented on the MDS. During an interview on the morning of 08/18/22, an administrative nurse (#1) verified Resident #68's medical record lacked necessary documentation for behavior coding. Section N. Medications The Long-Term Care Facility RAI Manual, revised October 2019, page N-3, stated, ". . . N0350: Insulin . . . Steps for Assessment 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed. . . ." Review of Resident #4's medical record occurred on all days of survey. The quarterly MDS, dated 05/03/22, identified Resident #4 had an order for insulin and received one insulin injection in the seven-day look-back period. Resident #4's medical record lacked a physician's order for insulin and evidence of insulin administration. During an interview on 08/18/22 at 10:27 a.m., an administrative nurse (#4) confirmed she inaccurately coded the insulin and injection for Resident #4.	F 641		
F 677	ADL Care Provided for Dependent Residents	F 677		9/12/22

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 08/18/2022

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 677 SS=D	Continued From page 6 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services to maintain oral hygiene for 1 of 8 sampled residents (Resident #33) observed during morning cares. Failure to provide oral care for a dependent resident may result in poor hygiene, increased dental problems, decline in oral intake, and a decreased quality of life. Findings include: Review of the facility policy and procedure titled "Standards of care" occurred on 08/18/22. This policy, reviewed/revised 08/11/20, stated, ". . . Procedure: 1. All staff are expected to provide services and care for all residents that meet the defined Standards of Care. . . . Routine Care Each of the following is part of the routine care provided by care givers, unless otherwise directed. . . . General Standards: . . . Oral care will be done in the morning and at bedtime. . . ." Observation on 0816/22 at 8:45 a.m. showed two certified nurse aides (CNAs) (#5 and #6) provided morning personal care, dressed, and transferred Resident #33 to his wheelchair using a full body lift. Prior to leaving the room, the CNA (#5) directed CNA (#6) to brush Resident #33's teeth. The CNA (#5) failed to provide oral care	F 677	It is the practice of this facility to ensure residents who are unable to carry out activities of daily living independently receive the necessary services to maintain good oral hygiene. 1. Re-education was provided to staff caring for residents on all units to provide oral care to all dependent residents with am and hs cares. Re-education was provided for staff assisting resident #33 to provide oral cares with am and hs cares. 2. All dependent residents have the potential to be affected when staff do not assist with maintaining good oral hygiene. 3. Re-education was provided to all staff at meetings on 09-08-22 that dependent residents must be assisted with oral hygiene with am and hs cares at minimum. The Standards of Care policy was also reviewed with staff at these meetings. 4. The Quality Nurse or designee will audit that 5 dependent residents received oral care on each unit weekly for 4 weeks, monthly for 3 months and quarterly for 1 year.	

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 08/18/2022

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 677	Continued From page 7 prior to removing the resident from his room. Review of Resident #33'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 [related to] impaired mobility . . . dementia . . . Personal Hygiene/Oral Care: I require assist of one staff with personal hygiene and oral care. . . ." Resident #33 saw the dentist on 07/14/22, the report stated, "#3 [and] #27 [dental descriptor for individual teeth] appear like probable decay. Numerous areas of likely decalcification. Tissues generalized red [and] inflamed . . . should have full evaluation. Needs help brushing after meals and before bed. Do the best you can." During an interview on 08/18/22 at 10:59 a.m., an administrative nurse (#7) identified oral cares are to be completed, at least, in the morning and at bedtime which is their standard of care.	F 677		
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 record review, review of facility policy, and staff interview, the facility failed to ensure a safe environment for 1 of 2 sampled residents	F 689	It is the practice of this facility to ensure residents who utilize an electric wheelchair are able to do so in a safe	9/12/22

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 08/18/2022

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 689	Continued From page 8 (Resident #34) who utilized an electric wheelchair. Failure to reassess safe use of an electric wheelchair places residents at risk for pain and/or injury. Findings include: Review of the facility policy titled "Therapy Services" occurred on 08/18/22. This policy last reviewed/revised dated 03/23/12, stated ". . . If therapy is warranted after screening, the therapist or nursing will write their recommendations after evaluation and treatment. . . . Therapists and nurses will make a notation in the progress notes any time there is a status change related to therapy. . . ." Review of Resident #34's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, dementia with behavioral disturbance, paraplegia, multiple sclerosis and visual hallucinations. Review of Resident #34's progress notes identified the following: * 05/10/22 at 5:38 p.m. "Resident was noted to bump into the corner of the front desk with his power chair. The arm on the right side of the chair hit the counter hard enough to break off a piece of the cosmetic plastic. . . ." * 07/06/22 at 9:44 a.m. ". . . Resident then came out to dining room and ran into a table causing his power chair to get stuck under the table. Resident yelled and hit at table and accidentally hit joy stick on chair causing chair to lift table off the ground and tip table on its side. . . . Resident then ran into door frame of his room bumping his L) [left] foot on wall. . . ."	F 689	manner and to reassess safe use to prevent risk for pain and/or injury. 1. An OT evaluation was requested for resident #34 and electric wheelchair was brought to the VA to reduce speed and evaluate for modification to protect feet. Re-education provided to all nurse managers on 09-08-22 that an assessment must be completed when a resident in an electric wheelchair is noted to be unsafe and to request a referral to OT for assessment if needed. 2. All residents using electric wheelchairs have the potential to be affected. 3. Re-education was provided to all nurses on 08-25-22 that any observation of unsafe use of an electric wheelchair should be documented and reported to nurse manager. Re-education to nurse managers on 09-08-22 that an assessment must be completed when a resident in an electric wheelchair is noted to be unsafe and to request a referral to OT for assessment if needed. 4. The Quality Nurse or designee will audit 5 residents using an electric wheelchair for unsafe use and subsequent assessment and therapy referral weekly for 4 weeks, monthly for 3 months and quarterly for one year.	

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 08/18/2022

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 689	Continued From page 9 * 07/18/22 at 7:53 a.m. ". . . Area between great toe and second toe on L) foot has an open area. Some bruising noted to top of great toe and a patch of red noted to skin at 2nd joint of great toe. . . . Wife stated resident had an injury similar to open area that resulted from toe being bumped and bent to the side. Previous injury was in same location current open area is noted. . . ." * 07/18/22 at 10:51 a.m. "Physician Orders: ok to send to [name of facility] ER [emergency room] for assessment of skin issue . . . open area great to L) foot . . ." * 07/18/22 at 12:31 p.m. "Return from Appointment . . . Physician Orders: 1. Keflex [oral antibiotic] 500mg BID [twice a day] x [times] 7 days 2. dressing to remain in place until next visit on 7/22 Comments: Wound flushed, sutured, dressing applied. . . ." * 07/26/22 at 7:57 p.m. "Resident very spasmatic and jerky this shift causing him to [sic] unable to control his power chair in a smooth and safe manner. At one point, resident bumped hard into his closet doors. . . ." * 08/01/22 at 10:42 p.m. ". . .1930-2030 [7:30 p.m. to 8:30 p.m.] Observed Behavior: . . . Resident then paced dining room (in power chair) and then the unit halls. Resident then turned chair up full speed and slammed through the double doors at end of unit and through the lobby/office areas. Resident attempted to push through door at north end of building by offices and then turned around and headed back towards unit. . . . Resident then forcefully bumped front door with chair several times attempting to open front door. . . ." * 08/02/22 at 3:23 p.m. ". . . abrasion Location: R) [right] shin 3x3cm [centimeters] . . . RA noted during cares . . . resident unaware of abrasion . .	F 689		

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 08/18/2022

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 689	Continued From page 10 . Resident has been noted to be bumping into things with power chair recently. It is thought resident may have bumped leg into something causing abrasion . . ." * 08/15/22 at 4:45 p.m. ". . . Laceration to dorsal second left toe at first joint. Approximately 1.25cm in length. Skin tear to left second toe medial aspect at last tarsal joint. Blood blister and loose nail to third left toe tip. Abrasion to left first toe to nail bed(nail not present) . . . Area cleansed with sterile saline and gauze. Wrapped with sterile 2x2's and wrapped with gauze wrapping for transport to ER for evaluation. . . . noted blood dripping from resident's left sock . . . . Resident description: States he doesn't know what happened. . . . Appears as if resident's toes rubbed across/caught on something. . . ." * 08/15/22 at 5:14 p.m. ". . . Physician Orders: Ok to send resident to [name of facility] ED [emergency department] for evaluation of L) foot injury to Great toe & [and] index toe . . ." During an interview on 08/18/22 at 9:37 a.m., an administrative nurse (#1) reported facility staff are expected to complete a nursing assessment if an incident occurred where the resident ran into objects in the environment and staff would monitor the resident with independent use of the electric wheelchair. If another incident occurred, a referral to therapy would be requested. During an interview on 08/18/22 at 8:07 a.m., a facility nurse (#2) confirmed an Occupational Therapy evaluation had not been completed for Resident #34's safe use of the electric wheelchair since 02/28/22.	F 689		
F9999	FINAL OBSERVATIONS	F9999		

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 08/18/2022

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
F9999	Continued From page 11 The complaints investigated in conjunction with the standard Medicare/Medicaid survey were unsubstantiated.	F9999		