STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - AVE MARIA	501 19TH ST NE JAMESTOWN, ND 58401

(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 09/09/24 and concluded 09/11/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		10/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/24/2024

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.

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of the North Dakota Long Term Care Ombudsman Program Guide to Resident Rights, and staff interview, the facility failed to provide care in a manner that promoted, maintained, or enhanced the resident's dignity for 1 of 2 sampled residents (Resident #3) with a wound vacuum. Failure to cover a wound vacuum collection container does not preserve the resident's personal dignity and/or enhance their quality of life and has the potential to affect the resident's psychosocial well-being. Findings include: The North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, updated 03/21/23, page 16, stated, ". . . The facility must treat you courteously, fairly and with dignity. . . ." Observation on 09/10/24 at 11:21 a.m. showed Resident #3 sitting in the hallway in front of the television with the wound vacuum and its contents visible. Observation on 09/10/24 at 11:44 a.m. showed Resident #3 sitting in the hallway in front of the television with a hand towel partially covering the	F 550	1. The facility will ensure that for any residents with wound vacs that the wound vacuum canister will be covered. For resident # 3 staff were educated to ensure that the wound vacuum cannister is covered. 2. All residents who use a wound vacuum have the potential to be affected by this deficient practice. 3. CNA staff were educated at the CNA meeting on 9/12/24. All staff were educated via email on 9/13/24. Nursing staff will be educated at the nurses meeting on 9/26/24. All staff will be educated on 10/1/2024 at the All-Team meeting. 4. A QA tool has been developed and a random audit will begin the week of 9/23/24 for all residents who have a wound vacuum and will be completed weekly for twelve weeks then monthly thereafter ongoing by our QA Nurse Manager, Nurse Manager or designee to ensure that all wound vacuum cannisters are covered. The results will be discussed	

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F 550	Continued From page 2 wound vacuum canister, however, the contents of the wound vacuum canister remained visible. During an interview on 09/11/24 at 3:25 p.m., an administrative nurse (#2) stated wound vacuum containers should be covered when residents are out of their room.	F 550	at the monthly QAPI meetings with action and follow-up completed as necessary. 5. 10/16/2024	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy,	F 761	1. Resident #70's insulin pen was	10/16/24

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F 761	Continued From page 3 and staff interview, the facility failed to ensure accurate labeling of medications for 1 of 4 residents (Resident #70) observed receiving medication from an injector pen. Failure to obtain a label for an insulin pen may result in a resident receiving the wrong medication or an incorrect dose. Findings include: Review of a policy titled "Medication Storage/Labeling" occurred on 09/11/24. This policy, revised July 2024, stated, ". . . Medications are labeled by pharmacy. If receiving medications from any mail order pharmacies that are not labeled individually, label with resident identification information . . ." Observation on 07/10/24 at 8:17 a.m. showed a nurse (#1) prepared Resident #70's Novolog insulin pen for administration. The pharmacy label on the pen lacked a legible label with the resident's name or other identifying information. During an interview on 09/11/24 at 2:44 p.m., an administrative nurse (#2) confirmed Resident #70's Novolog insulin pen lacked a legible label.	F 761	discarded immediately, and a new insulin pen was obtained by pharmacy with a label that was legible. 2. All residents who receive insulin via pens have the potential to be affected by this deficient practice. 3. All Staff were educated via email on 9/13/24. Nurses will be educated on 9/26/24 at the nurses meeting. All staff will be educated on 10/1/2024 at the All-Team Meeting. 4. A QA tool has been developed and a random audit will begin 9/23/24 for 10 residents who receive insulin via pens and completed weekly for twelve weeks then monthly thereafter ongoing by QA Nurse Manager, Nurse Manager, or designee to ensure that insulin pen labels are legible. The results will be discussed at the monthly QAPI Meetings with action and follow-up completed as necessary. 5. 10/16/2024	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/16/24

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F 880	Continued From page 4 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 5 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standards of infection control for 2 of 9 sampled residents (Resident #3 and #25) and 2 supplemental residents (Resident #50 and #70) observed during cares/dressing change and glucose monitoring. Failure to follow infection control practices during resident cares related to hand hygiene, enhanced barrier precautions (EBP), and cleaning of a glucometer has the potential to spread infection throughout the facility. Findings include: HAND HYGIENE	F 880	1. All staff caring for resident #50 were educated that during peri-cares, hand hygiene must be completed after glove changes. All staff caring for resident #25, were educated that during wound care, hand hygiene must be completed after glove changes. All staff caring for resident #3 were educated that staff caring for residents requiring enhanced barrier precautions, must wear a gown and gloves for transfers and toileting needs. All staff utilizing resident #70's glucometer were educated to clean glucometer after use with Oxiver wipe. 2. All residents who receive peri-cares and wound cares, require Enhanced	

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F 880	Continued From page 6 Review of the facility policy titled "Hand Hygiene" occurred on 09/11/24. This policy, revised July 2024, stated, ". . . Hand Hygiene Should Be Practiced: . . . Before applying and after removing gloves. . . ." Review of the facility policy titled "Dressing: Clean" occurred on 09/11/24. This policy, dated June 2024, stated, ". . . Don [put on] clean gloves and remove the dressing. . . . Dispose of the gloves, perform hand hygiene and don a clean pair of gloves. . . . Apply dressing to the area as ordered. . . ." - Observation on 09/09/24 at 4:30 p.m. showed two certified nurse aides (CNAs) (#5 and #6) assisted Resident #50 into bed and removed the soiled brief. The CNA (#5) performed perineal care, removed her gloves, adjusted the resident's clothing, arranged the resident's blankets, applied the resident's glasses, and adjusted the pillow. The CNA (#5) failed to perform hand hygiene after removing her gloves and prior to completing other tasks. - Observation on 09/10/24 at 1:35 p.m. showed a nurse (#1) changed Resident #25's dressing. The nurse removed the old dressing, removed her right glove, donned a clean glove, cleansed the wound with a perineal wipe, removed the right glove, donned a clean glove, and applied the clean dressing. The nurse (#1) failed to perform hand hygiene after removing soiled gloves and prior to donning clean gloves. During an interview on 09/11/24 at 3:15 p.m., an administrative nurse (#2) stated she expected staff to perform hand hygiene after glove removal	F 880	Barrier Precautions, and those who use a glucometer have the potential to be affected by this deficient practice. 3. All staff were educated via email on 9/13/24, CNA's were educated at the CNA meeting on 9/12/24, Nurses will be educated at nurses meeting on 9/26/24, and all staff will be educated on 10/1/2024 at the All-Team Meeting. 4. A QA tool has been developed and a random audit will begin 9/23/24 for 10 residents who receive perineal cares, 10 residents who receive wound cares, 10 residents who require Enhanced Barrier Precautions, and for 10 residents who require Glucometers, and completed weekly for twelve weeks then monthly thereafter ongoing by QA Nurse Manager, Nurse Manager, or designee to ensure that hand hygiene is completed after glove removal during perineal cares and wound cares, ensuring proper PPE is worn by staff caring for residents who require Enhanced Barrier Precautions and those residents who require glucometer checks. The results will be discussed at the monthly QAPI Meetings with action and follow-up completed as necessary. 5. 10/16/2024	

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F 880	Continued From page 7	F 880		

when doing perineal care and a dressing change.

ENHANCED BARRIER PRECAUTIONS

Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 09/11/24. This policy, dated March 2024, stated, ". . . "It is the policy of SMP [Sisters of the Mary Presentation] Health-Ave Maria to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. . . . PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident activities include: a. Dressing . . . c. Transferring d. Providing hygiene . . . f. Changing briefs . . . h. Wound care . . ."

Observation on 09/10/24 at 8:14 a.m. showed an EBP sign on Resident #3's door and isolation carts inside the resident's room. Observation showed a CNA (#7) wore gloves and assisted Resident #3 with changing her brief, personal hygiene, and dressing. At 8:17 a.m., a second CNA (#6) entered the resident's room, donned gloves and assisted with transferring the resident from bed to the wheelchair. The CNAs (#6 and #7) failed to wear a gown as required.

During an interview on 09/11/24 at 3:25 p.m., an administrative nurse (#2) stated she expected staff to wear a gown when providing cares to residents in enhanced barrier precautions.

CLEANING OF GLUCOMETER

Review of policy titled "Testing Blood Glucose and Meter Use" occurred on 09/11/24. This

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F 880	Continued From page 8 policy, revised July 2024, stated, ". . . In between uses, clean the Glucose meter using a Oxivir [disinfectant] wipe, allow surface to remain wet for one minute to ensure kill time and allow to air dry. Place monitor back in Ziploc bag." - Observation on 09/10/24 at 11:56 a.m. showed a nurse (#1) performed a glucose check on Resident #70. The nurse failed to disinfect the glucose meter using a Oxivir wipe prior to placing it back in the Ziploc bag. During an interview on 09/11/24 at 2:44 p.m., an administrative nurse (#2) confirmed she expected staff to disinfect the glucose meter prior to placing back in the Ziploc bag.	F 880		