STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST RAPHAEL	979 CENTRAL AVE N VALLEY CITY, ND 58072

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F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification and Complaint survey started on 05/03//21 and concluded 05/06/21.	F 000		
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), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Sets (MDSs) for 4 of 9 sampled residents (Resident #44, #55, #67, and #100). 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 M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2019, page M-2 stated, "M0100: Determination of Pressure Ulcer/Injury Risk. Coding Instructions . . . Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device. Review descriptions of pressure ulcers/injuries. . . . " Page M-4 stated, "M0210: Unhealed Pressure Ulcers/Injuries.	F 641	F 641 Accuracy of Assessments 1. As of 5/21/2021 residents #44, #55, #67 and #100, MDS assessments reflect the correct coding in SECTION M: SKIN CONDITIONS for pressure ulcers. Modifications for quarterly assessments have been completed on #44, #55, #67 and #100. 2. Facility has identified that all residents with in the facility that have callouses have the potential to be affected by this practice. 3. Education was provided to nursing staff and MDS Coordinators on 5/18/2021 on how to code and stage callouses for skin conditions. The facility has implemented a systemic change. Wound Nurse will monitor all documentation regarding callouses to make sure that they are not staged as pressure ulcers. PUSH tools will not be completed on callouses. MDS will consult with wound nurse with any questions or concerns regarding callouses. 4. An audit tool has been developed to ensure that all callouses are not being	6/7/21

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

Electronically Signed | 05/21/2021

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F 641	Continued From page 1 Coding Instructions. Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days. Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. . . Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. . . ." Page M-7 stated, "Steps for completing M0300A-G. Step 1: Determine Deepest Anatomical Stage. For each pressure ulcer, determine the deepest anatomical stage. . . ." Page M-8 stated, "Step 2: Identify Unstageable Pressure Ulcers. . . 3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable. . . ." Page M-21 stated, "DEFINITIONS SLOUGH TISSUE Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed." - Review of Resident #44's medical record occurred on all days of survey. The Quarterly MDS, dated 01/30/21, identified three unstageable ulcers. A nursing skin assessment note, dated 01/19/21, stated, ". . . Skin is hard and dry in appearance. Skin is white/yellow in color. . . ." - Review of Resident #55's medical record occurred on all days of survey. The Quarterly MDS, dated 02/13/21, identified two unstageable pressure ulcers coded under Section M. A nurse's note, dated 02/11/21, stated, ". . .	F 641	staged at pressures and not being coded on the MDS as such. Audit tool will be completed by Director of Nursing or designee 1 x week for a month, 2 X a month for three months, and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. 5. Compliance will occur on or before June 7th, 2021.	

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F 641	Continued From page 2 Pressure Ulcer Location: 1) L) [left] palm 2) R) [right] palm Stage: both are considered unstageable calouses [sic]. . . ." - Review of Resident #67's medical record occurred on all days of survey. The Quarterly MDS, dated 02/13/21, identified one unstageable ulcer. A nurse's note, dated 02/15/21, stated, "Resident has a callus to the sole of his let 5th toe. . . ." - Review of Resident #100's medical record occurred on all days of survey. The Quarterly MDS, dated 03/18/21, identified one unstageable ulcer. A nursing skin note, dated 05/05/21, stated, ". . . callus to left outer foot, hard in center and painful to touch, hard corn like callus to right inner foot. . . ." During an interview on 05/05/21 at 1:30 p.m., a MDS licensed nurse (#6) confirmed Residents #44, #55, #67, and #100 did not have pressure ulcers and facility staff coded Section M incorrectly.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents 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, resident interview, and staff interview, the facility failed to provide the necessary services to 2 of 29 sampled residents (Resident #47 and #51) who required staff	F 677	F 677 ADL Care Provided for Dependent Residents 1. As of 5/21/2021 residents #47 and #51 have been receiving baths at least once a week. As of 5/21/2021 nursing staff have	6/7/21

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F 677	Continued From page 3 assistance with Activities of Daily Living (ADL) for bathing. Failure to provide assistance with bathing as scheduled may result in poor personal hygiene and decreased self-esteem. Findings include: Review of the facility policy titled "Standard of cares" occurred on 05/06/21. This policy, revised November 2020, stated, "Each of the following is part of the routine care provided by caregivers, unless otherwise directed. . . . Resident will receive/be offered a bath/shower at least weekly. . . ." - Review of Resident #51's medical record occurred on all days of survey. The current care plan stated, "It is important to me to make choices in regards to my preferences with activities and daily living. . . . It is very important for me to have choices in regards to: . . . choosing my bathing needs . . . I have an ADL Self Care Performance Deficit r/t [related to] Paraplegia . . . BATHING: I require 1 staff participation with bathing. . . ." During an interview on the afternoon of 05/03/21, Resident #51 stated she didn't get a bath today (Monday) as the facility had no staff to do it. The resident stated she often does not get two baths per week as scheduled on Mondays and Fridays. Observation on 05/04/21 at 8:32 a.m. showed a bath aide/certified nurse aide (CNA) (#4) bringing Resident #51 to her room from the tub room. The CNA stated she made up Resident #51's bath today (Tuesday) as the bath aid needed to fill in on the floor yesterday. The CNA stated Resident	F 677	been educated that residents are to receive or be offered at least one bath a week per standard of care and nursing staff have been educated on the proper way to chart refusals of baths and residents receiving baths. 2. Facility has identified that all residents requesting baths/showers have the potential to be affected by this practice. 3. Facility has implemented a systemic change. All certified nursing assistants will be trained on how to give baths, including using the tub and proper bed bath procedures. 4. An audit tool has been developed to ensure that residents receive or offered a bath at least once a week. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. 5. Compliance will occur on or before June 7th, 2021.	

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F 677	Continued From page 4 #51 normally gets a bath every Monday and Friday. During an interview on 05/06/21 at 10:31 a.m., a nurse manager (#5) stated the facility scheduled all residents for twice weekly baths, unless a resident only wanted one. The manager confirmed Resident #51's scheduled bath days as Monday and Friday. She stated the facility tried to schedule two bath aides on Mondays, Wednesdays, and Fridays (noting the facility often pulled one aide to work on the floor) and one bath aide on Tuesdays and Thursdays. Review of Resident #51's bathing records for 13 weeks from 02/01/21 to 05/02/21 showed the resident received two baths per week on one occasion (March 21-27), otherwise she received one bath weekly with the exception of no bath during the week of February 28-March 6. - Review of Resident #47's medical record occurred on all days of survey. The current care plan stated, ". . . I have an ADL Self Care Performance Deficit r/t Dementia, Impaired balance . . . BATHING: I require physical assist staff participation with bathing. . . ." During an interview on 05/03/21 at 1:24 p.m., Resident #47 stated it had been over a week since she had received a bath. The resident stated she has not been getting her bath twice a week as scheduled and sometimes it has been longer than a week. Observation on the morning of 05/05/21 showed an unidentified CNA attempting to start morning cares for Resident #47 when the resident told the	F 677		

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F 677	Continued From page 5 CNA about her bath today. The CNA left the room to verify the bath and upon the CNA's return she confirmed Resident #47 was scheduled for a bath today. During an interview on 05/06/21 at 8:45 a.m., a CNA supervisor (#8) confirmed Resident #47 is scheduled for a bath twice a week, Sundays and Thursdays. Review of Resident #47's bathing records for 13 weeks from 02/01/21 to 05/05/21 showed the resident received one bath a week during that time, and identified Resident #47's last bath occurred on 04/18/21 and she did not have another bath until 05/05/21 (16 days).	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement pressure ulcer prevention	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. As 5/19/2021 resident #55 has had	6/7/21

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F 686	Continued From page 6 measures for 1 of 4 sampled residents with pressure-relieving devices (Resident #55). Failure to provide pressure-relieving boots as ordered/care planned may result in the development of new pressure ulcers. Findings include: Review of the facility policy titled "Skin Care" occurred on 05/06/21. This policy, revised October 2019, stated, ". . . Braden scale [a tool used to identify pressure ulcer risk] plan of action: LOW RISK (18-15) actions: . . . Assess the need for pressure relieving measures such as heel and elbow protectors . . . Care plan to identify interventions . . ." Review of Resident #55's medical record occurred on all days of survey. Diagnoses included paraplegia, history of traumatic brain injury, and history of heel pressure ulcers. Current physician's orders included, "Apply socks and heelbos [a type of padded heel protector] after applying daily moisturizers to bilat [bilateral] heels in the morning and up for the day. Remove at bedtime. . . ." Resident #55's care plan stated, ". . . I have, potential/actual impairment to skin integrity r/t [related to] Hx [history of] of ulcers, impaired mobility, rejection of cares. . . . Apply minerin [a moisturizer] bilateral feet/heels and cover with heelbos to protect from rubbing on wheelchair. . . ." A nurse's note, dated 02/12/21, stated, ". . . Braden Evaluation . . . Result: At Risk . . . Score: 17.0 . . . Clinical Suggestions: . . . Heel/elbow pads or socks utilized. . . ." Observation on the mornings of 05/04/21 and 05/05/21 showed a certified nursing assistant	F 686	order changes made to wearing Prevalon boots to both feet at all times, is followed by wound nurse, and a referral to podiatry has been made. Boots have been on at all times. As of 5/21/2021 all nursing staff have been educated not to chart something that they have not completed. 2. Facility has identified that all residents at risk for pressure ulcers have the potential to be affected by this practice. 3. Facility has implemented a systemic change. CRA supervisors will be performing audits specifically to skin integrity treatments/pressure reducing interventions and whether they are implemented. Charting will also be audited to make sure that it is accurate related to interventions being completed. 4. An audit tool has been developed to ensure that interventions are being completed and charted accordingly. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. 5. Compliance will occur on or before June 7th, 2021.	

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F 686	Continued From page 7 (CNA) (#1) assisted Resident #55 with morning cares and transferred the resident to his wheelchair. The CNA failed to apply moisturizer/heelbos to Resident #55's feet. Observations throughout the survey showed Resident #55 did not wear heelbo heel protectors. During an interview on the morning of 05/06/21, a nurse manager (#2) verified Resident #55 did not have heelbo heel protectors on, and staff should be putting them on in the morning and removing them at night.	F 686		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		6/7/21

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F 732	Continued From page 8 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to ensure posting of accurate and complete staffing information for 2 of 5 care areas (first floor-Union Square and second floor-Prairie Rose) on all days of survey. Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift. Findings include: Review of the facility's policy titled "Daily staffing report" occurred on 05/06/2021. This policy, dated December 2005, stated, ". . . Nursing staffing hours and resident census will be updated and posted on a daily basis on each unit/floor. . . ." Observation of the daily staffing reports occurred on all days of survey. The posted staffing information located on first floor - Union Square	F 732	F 732 Posted Nurse Staffing Information 1. As of 5/21/2021 all Nurses station have accurate and up to date Nurse Staffing Information posted. 2. Facility has identified that all residents with in the facility have the potential to be affected by this practice. 3. Education was provided to nursing staff to post nurse staffing information daily. The facility has implemented a systemic change. Night nursing staff are to complete the Nurse Staffing information for current day and Day nursing staff are responsible to update nurse staffing information with any changes for current day. 4. An audit tool has been developed to ensure that all nurses stations have up to date and accurate Nurse Staffing information posted. Audit tool will be completed by Director of Nursing or designee 1 x week for a month, 2 X a	

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F 732	Continued From page 9 showed the date May 2, 2021 all days of survey (May 3-6, 2021). The posted staffing information located on second floor - Prairie Rose showed the date April 25, 2021 on the days of May 3-5, 2021. During an interview on 05/06/21 at 11:45 a.m., an administrative nurse (#3) reported she expected the posting of staff to be updated daily. The facility failed to ensure the posted staffing information was accurate and complete.	F 732	month for three months, and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. 5. Compliance will occur on or before June 7th, 2021.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		6/7/21

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F 758	Continued From page 10 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 1 sampled resident (Resident #76) receiving a PRN antipsychotic medication. Failure to ensure the physician renewed the PRN order after 14 days may result in the resident receiving an unnecessary medication. Findings include: Review of the facility's policy titled "Psychotropic	F 758	F 758 Free from Unnecessary Psychotropic Meds/PRN use 1. Resident #76 MAR as 5/6/2021 reflects that the psychotropic medication has been discontinued. 2. Facility has identified that all residents that receive PRN psychotropic medications have the potential to be affected by this practice. 3. All licensed nursing staff that are responsible for taking/entering orders for PRN psychotropic medications have all been educated as of 5/18/2021 that PRN	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST RAPHAEL	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 758	Continued From page 11 Drug Use" occurred on 05/06/21. This policy, revised March 2020, stated, ". . . PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. . . ." Review of Resident #76's medical record occurred on 05/06/21. Diagnoses included dementia and anxiety. The physician's orders dated 02/17/21 included Olanzapine (antipsychotic) five milligrams by mouth as needed for agitation, delirium, and aggression, one tablet PRN twice a day. The record lacked evidence the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication after14 days. During an interview on the morning of 05/06/21, an administrative nurse (#3) confirmed the provider had not reviewed the PRN medication since the initial order received on 02/17/21.	F 758	psychotropic medications must have an end date of 14 days. 4. Implementation of Systemic change: The automatic end date of 14 days will be entered into eMAR with initial order entry. 5. An audit tool has been developed to assure that all PRN psychotropic medications do not exceed 14 days unless orders by physician state otherwise. These audits will be performed by Director of Nursing or designee 2 X a week for one month, 1 x week for 2 months and 1x a month for 3 months and then quarterly for a year. a. A summary of completed audits will be provided monthly to the quality assurance committee to confirm compliance and is maintained. 6. Compliance will occur on or before June 7th, 2021	
F9999	FINAL OBSERVATIONS Based on observation, record review, policy review, resident and staff interview, the complaints investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		