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 01/31/2023

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 000	INITIAL COMMENTS An on-site Facility Reported Incident investigation was conducted on January 31, 2023.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies/procedures, review of the facility's investigation reports, review of quality assurance and process improvement (QAPI) audits, and staff interviews, the facility failed to ensure freedom from abuse/neglect for 1 of 1 sampled resident (Resident #1) with a facial injury sustained while residing in the facility. Failure to provide necessary services to protect residents from harm resulted in Resident #1 sustaining pain, facial bruising, and fear after being slapped by a staff member. Findings include:	F 600	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/24/2023

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F 600	Continued From page 1 Review of the facility policy titled "Abuse, Neglect, and Exploitation and Misappropriation of Resident Property" occurred on 01/31/23. This policy, revised date 01/23/23, stated, " . . . All residents at [name of facility] have a right to be free from abuse, neglect, misappropriation of property, and exploitation. No resident shall be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, . . . Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, . . . Physical abuse includes, but is not limited to hitting, slapping, . . ." Review of Resident #1's medical record occurred on 01/31/23. The progress notes contained the following: * 01/19/23 at 7:15 a.m. "During medication pass around 0530-0600 [5:30 a.m. - 6:00 a.m.] this nurse heard resident hollering in his room, "get out" and "leave me alone". Upon entering res [resident] room, a CNA [certified nurse assistant] was noted to be kneeling down in front of resident trying to help him put his pants on. Resident was noted to be sitting in his wheelchair with his underwear at his knees and he was not wearing his oxygen at this time. The resident was hollering out that the CNA hit him across the face and knocked his glasses off. This nurse tried to reassure resident that the staff were only here to help him; in which the resident continued to holler out "get him out of here!" and "he hit me, I want to call the cops, right now!". The CNA was then immediately sent out of the residents' room and told to not come back to his room again. . . . Despite all this nurses' efforts, resident could not	F 600		

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F 600	Continued From page 2	F 600		

be calmed down therefore a different CNA was brought into the room to help deescalate the situation and finish getting the resident ready for the day. While in room with CNA, it was noted that resident had a new skin tear to the left ring finger and new bruising across the left side of face extending to left ear. . . . Bruising to face was not noted to be there during medication pass the evening before. . . ."
* 01/19/23 at 11:22 a.m. "PT [physical therapy] Session - [name of resident] says he is not feeling well enough to do therapy this morning. He still has ringing in his ear since last night. Will check back again tomorrow."
* 01/19/23 at 4:00 p.m. ". . . saw resident's call light on and went to answer it. When asked what he needed, he said he wanted to talk with someone about what happened during the night. The resident went on to ask this author who I was. I told him and he asked what "authority" I had. He said 'Someone came in telling me to do stuff, throwing his weight around- trying to be the boss, I told him to get out.' 'He hit me and knocked my glasses off.' 'Lucky they weren't broken.' This author asked him to describe who slapped him and he said 'I can't, what do you expect when someone hits you in the eye?' The resident said maybe he said something to make the staff mad, but he couldn't remember what. 'He hit me first, but I tried to hit him back.' . . . 'I don't want to be here tonight if that staff is here.'. . ."
* 01/19/23 at 4:30 p.m. "Resident was self-propelling himself down the hallway and told staff he wanted to talk to someone in charge. . . . He said, 'I am scared to go in my room because that man might come in, . . ."
* 01/19/23 at 5:03 p.m. ". . . skin assessment

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F 600	Continued From page 3	F 600		

completed. Noted bruising to lt [left] side of face. bruising measures on lt cheek 1) 2.3 by 3.8 2) 2 by 5.5 3)1.4 by 5.5. 4) Bruising closer to nose next to number 1 measures 3.7 by 3. 5)on res lt ear 3.5 by 3 6) behind rt ear on head 2.9 by 1.4. . . ." [record failed to identify the measurement units]
* 01/20/23 at 5:15 p.m. "[name of nurse practitioner] called after her office visit with [name of resident] . . . She also reported the resident report of being slapped by a staff member and of being thrown around. . . ."
* 01/21/23 at 7:39 a.m. "Resident was calm and quiet the whole NOC. [night] He refused to sleep on his bed and opted to sleep on his recliner. Resident denies pain on the bruise on his left cheek and made a comment to this nurse " Do you see what that guy did? He left quite a mark there."
* 01/22/23 at 2:28 a.m. "Resident has been in and out of nurses station agitated and looking for "help". He states he "needs someone to watch his back" and requested staff check on him every hour. Staff agreed and this seems to have calmed him down. Resident rested in his bed the rest of the NOC."

A skin assessment, completed 01/20/23, identified, " . . .Skin Issue #4 Bruising . . . L [left] cheek, multiple bruises (handprint) . . ."

A provider visit note, dated 01/20/23, stated, ". . . asked what happened to his face and why he has bruising and he states that 'the man working during the night slap [sic] me in the face so hard that it disturb [sic] my hearing for awhile'. . . administration and director or nursing aware of this incident."

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F 600	Continued From page 4 During an interview the morning of 01/31/23, an administrative team member (#1) stated staff informed her of the incident at approximately 9:00 a.m. the morning of 01/19/23, and the facility immediately initiated their investigation of the alleged abuse. Based on the following information, non-compliance at F600 is considered past non-compliance with a correction date of 01/26/23. The facility addressed the corrective action accomplished for the resident affected by the deficient practice as evidenced by the following facility actions: - 01/19/23 the facility staff completed the following: * At 7:35 a.m. the charge nurse documents in the progress notes: ". . . Plan of Action: That particular staff member is to not enter residents' room at any given time. Reassurance will be given to resident when needed. Monitoring of resident will continue." * At 9:00 a.m. the Director of Nursing (DON) and charge nurse interview Resident #1. * At 9:30 a.m. the initial allegation of mistreatment, abuse, neglect, or theft facility reported incident reporting form completed and sent to the State Agency. * At 1:15 p.m. the Valley City Police Department (VCPD) informed of the allegation of abuse, and at 2:00 p.m. an officer from the VCPD along with the facility administrator interviewed Resident #1. * At 1:40 p.m. members of the management staff began interview with staff members. * At 5:05 p.m. members of the management staff interviewed the accused CNA.	F 600		

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F 600	Continued From page 5 - 01/20/23 during the daily morning meeting via zoom, the leadership staff and risk management staff discussed the 01/19/23 incident and reviewed the abuse policy. * Members of the management staff continued with staff interviews. - 01/23/23 the management staff completed revisions to the policy titled, "Abuse, Neglect, and Exploitation and Misappropriation of Resident Property." All staff required to review the revised policy, sign, and date upon completion of review. Review of staff education revealed staff signed and dated, acknowledging review of the policy. - 01/26/23 CNA education meetings held at 7:30 a.m., 2:00 p.m., and 3:30 p.m. to review topics of ADL (activities of daily living) charting and abuse. Review of staff education revealed staff signed the attendance rosters for each meeting. * Review of QAPI audits related to resident abuse showed a facility audit form titled "QA Resident Abuse." The audit form contained the definitions of several types of resident abuse and interview questions specific to identification of signs of abuse, reporting, who to contact, etc. The facility completed one to five audits per day on the following dates, 01/19/23, 01/20/23, 01/23/23, 01/24/23, 01/25/23, 01/30/23 and is ongoing.	F 600		