| 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 07/21/2022 |

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

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| F 000 | INITIAL COMMENTS<br><br>The Standard Medicare/Medicaid recertification and Complaint survey started on 07/18/22 and concluded 07/21/22. | F 000 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and | F 583 | | 8/25/22 |

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

Electronically Signed | 08/05/2022

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| F 583 | Continued From page 1<br>administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to ensure dignity and provide privacy for 1 of 19 sampled residents (Resident #64) observed during personal cares. Failure to maintain a resident's privacy during cares is a violation of residents' rights and may decrease their quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled "Routine Cares" occurred on 07/20/22. This policy, dated November 2020, stated, ". . . Provide privacy with cares (close shade, pull privacy curtain, use towel/bath blanket to coverage.) . . ."<br><br>On 07/18/22 at 1:22 p.m. observation showed a certified nursing assistant (CNA) (#2) provided toileting cares for Resident #64 and failed to close the bedroom door, bathroom door, and window coverings prior to the cares.<br><br>During an interview on 07/21/22 at 1:30 p.m., an administrative nurse (#1) confirmed staff failed to follow facility policy for privacy. | F 583 | 1. On 7/22/2022, all CNAs that were working were educated on Standard Cares specific to personal privacy with ADLs cares. On 7/26/22 in weekly Huddles, all CNAs that were working were educated on Standard Cares specific to personal privacy with ADLs cares. On 7/28/22 in CRA meetings for all shifts and units, education was provided on Standard Cares specific to personal privacy with ADLs cares. Audits were performed on CNAs performing ADL cares on residents on 7/22/22 and 7/25/22 and continue weekly starting 7/26/22.<br><br>2. The facility has identified that all residents have the potential to be affected by this practice.<br><br>3. As of 8/11/2022 all staff will be educated on Personal Privacy.<br><br>4. An audit tool has been developed to ensure resident□s personal privacy. Audit tool will be completed by Director of Nursing or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for a total of 12 months.<br>a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. | |

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| F 583 | Continued From page 2 | F 583 | 5. Compliance will occur on or before August 25th, 2022 | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the | F 657 | 1. As of 08/04/22 Resident #132 Care Plan reflects the current status specific to care needs. | 8/25/22 |

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| F 657 | Continued From page 3<br>current status for 1 of 32 sampled residents (Resident #132). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care.<br><br>Findings include:<br><br>Review of the facility policy titled "Care Plan" occurred on 07/21/22. This policy, revised May 2022, stated, "Care plans will be developed and updated in PCC (electronic health record) for each resident on admission, quarterly and annually, as well as post hospital and if a significant change in the resident's status occurs. They also must be updated on a continual basis as resident's needs change to ensure that the care plan adequately reflects the resident's status at that point and time."<br><br>Review of Resident #132's medical record occurred on all days of survey. The current care plan stated, "TOILET USE: I am independent with toileting. . . DRESSING: I require assistance with set up with dressing. . . BED MOBILITY: I am independent with repositioning and turning in bed. . . PERSONAL HYGIENE/ORAL CARE: I require supervision and reminders to complete hygiene and oral care."<br><br>A progress note, dated 06/28/22, stated, "Resident requires extensive assistance with bed mobility, dressing, toileting, and personal hygiene." Review of the resident's CNA charting showed staff provided extensive assistance for bed mobility, dressing, toileting, and personal hygiene throughout the period of June 21, 2022-July 20, 2022. | F 657 | 2. Facility has identified that all residents with in the facility have the potential to be affected by this practice.<br><br>3. Education was provided to all Nurse Managers 7/27/22 at Nurse Leadership Monthly meeting on timeliness and accuracy of care planning to reflect the current status of resident needs.<br><br>4. An audit tool has been developed to ensure that resident status has been updated timely and accurately. Audit tool will be completed by Director of Nursing or designee weekly for one month, 1 X a week for two months, and then quarterly for total of 12 months.<br>a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained.<br><br>5. Compliance will occur on or before August 25th, 2022. | |

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| F 657 | Continued From page 4<br>During an interview on 07/21/22 at 1:38 p.m., an administrative nurse (#1) confirmed staff failed to revise Resident #132's care plan to reflect current care needs. | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure appropriate care and services for 1 of 6 sampled residents (Resident #71) with an order for thickened liquids. Failure to provide appropriate thickened liquids has the potential to negatively impact a resident's overall swallow safety and placed Resident (#71) at risk for aspiration.<br><br>Findings include:<br><br>Review of the facility policy "Thickened Liquids" occurred on 7/21/22. This policy, dated July 2022, stated, "POLICY: Residents requiring thickened liquids per MD [medical doctor] order will be provided beverages of appropriate consistency to prevent aspiration . . . 7. All staff are responsible to assure beverages they serve residents for meals, snacks, or med passes are | F 684 | 1. On 7/19/22, Nurse Manager was made aware that □special instructions□ on the MAR for resident #71 reflected nectar liquids for fluid consistency, Nurse Manager immediately corrected and changed nectar liquids to moderately thick liquids under the heading: □special instructions□ on MAR. Nurse manager educated charge nurse of correct fluid consistency and proper way to administer fluid of resident #71. On 7/19/22, CNA cheat sheet was corrected for resident #71 with correct liquid consistency and redistributed out to staff. CNAs on that unit were educated of correction made and proper way to administer fluids to resident #71. On 7/19/22, IDDSI diet education was competed by Dietary Manger and Registered Dietician for all CNAs and nurses working on the units for | 8/25/22 |

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| F 684 | Continued From page 5<br>the ordered consistency. . . ."<br><br>Review of Resident #71's medical record occurred on all days of survey. Diagnoses included cerebral infarct (stroke) and dysphagia (difficulty swallowing). A speech assessment, dated 04/18/22, recommended liquids by spoon and one-to-one feeding supervision. A dietary assessment, dated 04/18/22, identified honey thick liquids given by spoon. A physician's order, dated 05/26/22, identified moderate thickened (honey) consistency fluids per dietary recommendations.<br><br>Observation showed the following:<br>* 07/19/22 at 8:25 a.m., a nurse (#7) identified Resident #71's medication administration (MAR) stated, " . . . crush medications, mix in pudding, give nectar thick liquids, liquids to be given to him by spoon . . ." The nurse crushed the medications and mixed them in pudding, poured a small cup of Med Pass 2.0 nectar consistency (a fortified nutritional vanilla shake), and gave it to Resident #71. The resident drank a small amount of the fluid from a nosey cup (not from a spoon) and the resident started to cough.<br>* 07/19/22 at 8:40 AM an unidentified certified nursing assistant (CNA) assisted Resident #71 to drink using a nosey cup instead of a spoon and the resident coughed throughout the observation. When asked about Resident #71's diet for liquids, the CNA stated she thinks the resident is to receive nectar thick fluids as written on the CNA care sheets, but was unsure.<br>* 07/19/22 at 10:02 a.m., a staff nurse (#7) obtained three more containers of nectar thick vanilla shakes from the kitchen and stated she will be using these for Resident #71. | F 684 | all shifts. On 7/19/22, audits were completed of all CNA cheat sheets, diet cards and care plans for each resident on all units to ensure accuracy of cheat sheets for all special diets. On 7/19/22, audits performed by Nurse Managers, of all MARs for all residents in facility; specific to heading: special instructions; were completed to reflect accuracy of fluid consistency of residents to ensure nurses know the correct fluid consistency of residents while administering medications. On 7/19/22, IDDSI education was added to Travel CNA and Nurse orientation packets.<br><br>2. The facility identified that any resident with a special diet order for thickened liquids has the potential to be affected by this practice.<br><br>3. Facility has implemented a change. IDDSI diet education has been added to annual skills education for CNAs and Nurses, travel staff orientation education, and annual education for activities. Dieticians are notifying Nurse Managers and CNA Supervisors with updates on all resident□s diets to ensure MARs and cheat sheets are updated and accurate. Diet changes will be discussed in IDT weekly.<br>a. AS of 8/11/22 all staff will be educated on Quality of Care specific to thickened liquids, accuracy of MARs, cheat sheets and proper administration.<br><br>4. An audit tool has been developed to | |

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| F 684 | Continued From page 6<br><br>During an interview on 07/19/22 at 10:04 a.m., the nurse (#7) stated, "I'm not sure what the fluid consistency is for Resident #71 . . I assume it is what the MAR instructions state . . . (Nectar thick) . . . and that is what I follow to give . . ."<br><br>During an interview on 07/19/22 at 11:15 a.m., a nurse manager (#8) stated Resident #71 is to follow a moderately thickened (honey) consistency fluid diet and staff should use a spoon to assist with fluids. | F 684 | ensure that resident fluid consistency is accurate on MAR and cheat sheet. 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 total of 12 months.<br>a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained.<br><br>5. Compliance will occur on or before August 25th, 2022. | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by: | F 812 | | 8/25/22 |

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| F 812 | Continued From page 7<br>Based on observation, review of facility policy, and staff interview, the facility failed to maintain food and dishware storage areas in a sanitary manner for 1 of 1 kitchen (main kitchen). Failure to store food and dishware in a sanitary environment has the potential to result in contamination of food and dishware and could result in a foodborne illness.<br><br>Findings Include:<br><br>Review of the policy, "Purchasing, Receiving and Storage" occurred on 07/21/22. This policy, revised May 2018, stated, "Policy: Food will be properly stored to preserve . . . safety. . . ."<br><br>The initial observation of the kitchen, with an administrative dietary staff member (#3) and a supervisory dietary staff member (#5), occurred on 07/18/22 at 10:50 a.m. Observation showed the following:<br>- Walk in Cooler #1 - accumulation of thick, dark black dust/dirt on the fan and heavy accumulation of dust clumps on walls, ceiling, and light above the door.<br>- Walk in Cooler #2 - accumulation of dark black dust/dirt on the fan and accumulation of dust clumps on the wall, ceiling, and light above the door.<br><br>Observation of the kitchen, with an administrative dietary staff member (#3) and a supervisory dietary staff member (#5) occurred on 07/21/22 at 8:30 a.m. and showed the following:<br>- Dishwashing Room (clean dish side) - accumulation of dust on the dishwashing machine, walls, and ceiling. Observation showed | F 812 | 1. AS of 7/27/22 Walk in Cooler #1, Walk in Cooler #2, and dishwashing area have been cleaned of all accumulation of dust/dirt on the fans, walls, ceilings, and above the doors.<br><br>2. The facility has identified that all residents in the facility have the potential to be affected by this practice.<br><br>3. As of 8/11/22 all staff will be educated on Food Procurement, Store/Prepare/Serve-Sanitary specific to storing food or dishware in a sanitary and clean environment to prevent food born illness.<br><br>4. An audit tool has been developed to ensure cleanliness of food storage areas and dishware areas. Audit tool will be completed by Dietary Manager or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for total of 12 months.<br>a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained.<br><br>5. Compliance will occur on or before August 25th, 2022. | |

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| F 812 | Continued From page 8<br>clean dishes stored in this area.<br>- Walk in Cooler #1 - accumulation of thick, dark black dust/dirt on the fan and heavy accumulation of dust clumps on the walls, ceiling, and light above the door.<br>- Walk in Cooler #2 - accumulation of dark black dust/dirt on the fan and accumulation of dust clumps on the wall, ceiling, and light above door.<br><br>During an interview on 07/21/22 at 9:30 a.m., both dietary staff members (#3) and (#5) confirmed staff need to clean the dust from the walls, ceilings, and fans, and they had not included these areas on the cleaning schedule. | F 812 | | |
| F9999 | FINAL OBSERVATIONS<br><br>The complaints investigated in conjunction with the standard Medicare/Medicaid survey were unsubstantiated. | F9999 | | |