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 08/08/2024

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 survey and complaint survey started on 08/05/24 and concluded 08/08/24. During the complaint investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		9/12/24

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

Electronically Signed | 09/05/2024

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F 585	Continued From page 1	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and

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F 585	Continued From page 2 as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to follow the grievance process for 2 of 2 sampled residents (Resident #99 and #133) with concerns regarding treatment from staff during cares. Failure to act upon resident grievances is a violation of resident's rights and may result in resident dissatisfaction. Findings include: The facility failed to provide a policy.	F 585	F585 Grievances 1. On 8/6/2024 staff were educated on notification of process to address resident concerns. On 8/9/2024 Administrator and Social Worker followed up with residents #133 and #99. 2. The facility has identified that all residents in the facility have the potential to be affected. 3. Systemic change has been made. Review of grievance policy completed. Anyone receiving concerns placed by a resident will email Administrator, DON,	

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F 585	Continued From page 3 - During an interview on 08/05/24 at 1:25 p.m., Resident #133 stated on the night of admission, he/she pushed the call light multiple times. A certified nurse aide (CNA) (#5) came to the doorway and yelled, "What the [explicit comment] do you want?" This happened again the same night. The resident stated he/she did not want to deal with this CNA again, so he/she took himself/herself to the bathroom for the remainder of the night. When asked if the resident reported the incident to staff, Resident #133 replied, "yes". - During an interview on 08/05/24 at 2:36 p.m., Resident #99 stated three weeks ago during the night shift, an unknown CNA came to the doorway and yelled, "What do you want?" The resident stated he/she felt disrespected. When asked if the resident reported the incident to staff, Resident #99 replied, "yes". - During an interview on the afternoon of 08/08/24, administrative staff members (#1 and #2) stated all resident incidents are covered during the management stand up meetings and these incidents were delegated to the unit manager to further review. The staff members reported the staff involved received verbal coaching but failed to follow up with the residents. The facility failed to make a prompt effort to resolve Resident #99 and #133's grievances and keep both residents apprised of progress toward a resolution.	F 585	Unit Nurse Manager and Unit Social Service Designee for resident, indicating what the concern was and what was done to mitigate the concern. Concerns brought up by residents will be recorded once the concern is received via email. These concerns will be discussed daily at Risk Management as appropriate to determine plan of action to address the concern. 4. On 9/12/2024 all staff will be educated. 5. An audit tool has been developed to ensure compliance. 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. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 6. Compliance will occur on or before 9/12/2024	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		9/12/24

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F 658	Continued From page 4 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 residents (Resident #22 and #149) observed for insulin preparation and administrations. Failure to prime insulin pens correctly may result in residents receiving an inaccurate dose. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 08/08/24. This policy, revised July 2023, stated, ". . . Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. . . . screw the pen needle onto the insulin pen. Twist open and remove the outer cover from the pen needle. H. Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. . . ." - Observation on 08/07/24 at 8:08 a.m. showed a nurse (#7) prepared Resident #22's insulin pen for administration. The nurse failed to remove the cover of the needle before priming the insulin pen. - Observation on 08/07/24 at 4:44 p.m. showed a nurse (#8) prepared Resident #149's insulin pen	F 658	F 658 Services Provided Meet Professional Standards 1. On 8/8/2024 education was presented to all nursing staff regarding proper insulin pen use and administration. Nurses on the 3rd floor were educated on proper insulin pen use and administration for residents #22 and #149. 8/7/2024, interdry was discontinued and nystatin was ordered for resident #133. 2. The facility has identified that all residents in the facility have the potential to be affected. 3. Standing order policy reviewed. A systemic change has been implemented. Quality Assurance will pick a sample of 25 standing orders to monitor for clarifications quarterly. On 8/20/2024 all Nurses and Nurse Managers were educated on proper transcription of standing orders and proper insulin pen use and administration during monthly nurse/CMA meetings. On 9/12/2024 all staff will be educated 4. An audit tool has been developed to ensure compliance for transcribing orders. Audit tool will be completed by Director of Nursing or designee, 25 samples quarterly for a total of 12 months. a. A summary of completed audits will	

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F 658	Continued From page 5 for administration. The nurse failed to remove the cover of the needle before priming the insulin pen. During an interview the morning of 08/08/24, an administrative staff member (#1) stated she expected staff to remove the cover of the needles when priming insulin pens. 2. Based on observation, record review, policy review, and staff interview, the facility failed to transcribe a treatment order accurately for 1 of 1 sampled resident (Resident #133) observed during a dressing change. Failure to accurately transcribe orders may result in residents receiving the wrong treatment and potentially cause adverse effects. Findings include: Review of the facility policy titled "Standing Orders" occurred on 08/08/24. This policy, dated July 2021, stated, ". . . 1. . . . standing orders must be on PCC [Point click care] MAR [Medication Administration Record] to be implemented. . . . 4. When implementing an order from the standing orders, the nurse will enter it into . . . MAR . . . TAR [Treatment Administration Record] accordingly. . . ." Observation on 08/06/24 at 10:20 a.m. showed a medication aide (#11) removed a soiled Interdry (antimicrobial dressing) from under Resident #133's abdominal folds and replaced with a clean Interdry after bathing.	F 658	be provided quarterly to the quality assurance committee to ensure compliance is achieved and sustained. An audit tool has been developed to ensure compliance with insulin administration. 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. b. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before 9/12/2024	

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F 658	Continued From page 6 Review of Resident #133's medical record occurred on 08/07/24. The recorded failed to identify an order for Interdry and instructions for administration. During an interview on 08/08/24 at 11:00 a.m., an administrative staff member (#1) confirmed the record lack the required information.	F 658		
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:	F 761		9/12/24

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F 761	Continued From page 7 Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications in 1 of 2 medication carts (Union Square) observed. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medication Cart" occurred on 08/08/24. This policy, revised 2023, stated, ". . . Medication cart will be locked when not within complete site of the nurse and/or med aid [medication aide] left unattended . . ." Observation on 08/06/24 at 3:47 p.m. showed a staff nurse (#3) left the medication cart unlocked and unattended for 55 minutes. The medication cart remained by the nurses station unlocked and out of the nurses' view with staff members and residents present. During an interview on 08/08/24 at 10:55 a.m., an administrative nurse (#1) confirmed she expected staff to lock the medication cart when out of eyesight.	F 761	F 761 Label/Store Drugs and Biologicals 1. On date 8/8/2024, all nurses and CMAs working were all educated on proper procedure for locking med carts. 2. The facility has identified that all residents in the facility have the potential to be affected. 3. On 8/20/2024 education was provided to all Nurses and CMAs during the Monthly Nurse/CMA meeting on proper procedure regarding locking med cart. 4. On 9/12/2024 all staff will be educated 5. An audit tool has been developed to ensure compliance. 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. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 6. Compliance will occur on or before 9/12/2024	
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		9/12/24

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F 880	Continued From page 8 §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 §483.70(e) 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 9 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 8 of 25 sampled residents (Resident #9, #28, #70, #79, #92, #96, #260, and #360) observed during cares. Failure to follow infection control practices during resident cares related to hand hygiene, glove use, and enhanced barrier precautions (EBP), has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 08/08/24. This policy, revised September 2023, stated, ". . . Staff will perform hand hygiene when indicated, using proper	F 880	F880 Infection Prevention and Control 1. On 8/5/2024 education was sent out to all staff focusing on Enhanced Barrier Precautions and on 8/7/2024 EBP policy was sent out to all staff. 8/8/2024, all CNAs and Nurses that were working with residents #9, #28, #70, #79, #92, #96, #260 and #360 were educated on infection prevention related to Hand Hygiene, glove use and Enhanced Barrier Precautions. On 8/8/2024 education in weekly CNA Huddles started and will continue, all CNAs and Nurses that were working were educated on infection prevention related to Hand Hygiene, glove use and Enhanced Barrier Precautions.	

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F 880	Continued From page 10 technique consistent with accepted standards of care. . . . The use of gloves does not replace hand hygiene. Practice hand hygiene before donning and after doffing gloves. . . ." Review of the facility policy titled "Skin and Wound Management Program" occurred on 08/08/24. This policy, revised June 2024, stated, ". . . Cleaning a Wound and Applying a Dressing . . . Carefully remove the soiled dressings. . . . Place soiled dressings in the appropriate waste receptacle. Remove your gloves and dispose of them in an appropriate waste receptacle. Perform hand hygiene. Put on gloves . . . Apply any topical medications, foams, gels, and/or gauze to the wound . . . Gently place a layer of dry, . . . or other prescribed cover dressing . . . Apply tape . . . Remove and discard gloves. . . . Perform hand hygiene. . . ." Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 08/08/24. This policy, revised June 2024, stated, ". . . Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities. . . . Standing orders will be implemented for enhanced barrier precautions for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and /or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, . . .) even if the resident is not known to be infected or colonized with a MDRO. . . . make gowns and gloves available immediately	F 880	2. The facility has identified that all residents in the facility who require assistance with ADLs and dressing changes have the potential to be affected. 3. On 8/15/2024 at Monthly CNA meetings CNAs were educated on infection prevention related to Hand Hygiene, glove use and Enhanced Barrier Precautions. 8/20/2024 education on infection prevention related to Hand Hygiene, glove use and Enhanced Barrier Precautions was given to all nurses attending the Monthly nurses meetings. On 9/12/2024 all staff will be educated. 4. Audits were performed on CNAs and nurses on infection prevention related to Hand Hygiene, glove use and Enhanced Barrier Precautions, performing ADL cares and dressing changes on residents starting on 8/8/2024 and will continue weekly. An audit tool has been developed to ensure compliance with infection prevention and control. 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. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before 9/12/2024	

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in or outside of the resident's room. . . . In general, gowns and gloves would not be required for resident care activities other than those listed below, . . . Device care or use: . . . feeding tube . . . Wound care: any skin opening requiring a dressing . . ."

HAND HYGIENE/GLOVE USE

- Observation on 08/06/24 at 3:08 p.m. showed the CNA (#12) assisted Resident #9 who is on enhanced barrier precautions with transferring to the wheelchair from the bed. When completed CNA (#12) removed her gown, gloves and grabbed the resident's blanket and placed on resident's lap. The CNA (#12) pushed Resident #9 out of the room and failed to perform hand hygiene.

- Observation on 08/06/24 at 1:12 p.m. showed two CNAs (#4 and #10) assisted Resident #70 with incontinent cares. The CNA (#4) removed her gloves and without performing hand hygiene exited the resident's room with the Hoyer lift.

WOUND CARE

- Observation on 08/06/24 at 3:24 p.m. showed the nurse (#3) removed the soiled dressing from Resident 260's foot, removed the soiled gloves, and without performing hand hygiene donned new gloves, applied a clean dressing to the wound, and wrapped the resident's foot with a protective dressing.

- Observation on 08/06/24 at 3:24 p.m. showed the nurse (#13) removed the soiled dressing from Resident #360's right knee, cleansed the area

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 08/08/2024

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 880	Continued From page 12	F 880		

with soap and water, and without removing the soiled gloves and performing hand hygiene, applied a clean dressing and a compression sleeve to the wound.

- Observation on 08/07/24 at 1:55 p.m. showed the nurse (#7) removed Resident #92's wound dressing. Without removing the soiled gloves and performing hand hygiene, inserted a foam dressing into the wound, secured the outer dressing with tape, and then removed her gloves.

During an interview on 08/08/24 at 10:55 a.m., an administrative nurse (#1) confirmed she expected staff to follow policy and procedures for hand hygiene and dressing changes.

ENHANCED BARRIER PRECAUTIONS:

- Review of Resident #28's medical record occurred on all days of survey. Physician's orders included a dressing change to a surgical wound twice daily. The care plan stated, "Enhanced Barrier Precautions (EBP) related to Chronic Wounds (unhealed surgical wound) . . . Personal Protective Equipment (PPE) use during wound care . . ."

Observation on 08/06/24 at 10:27 a.m., showed a nurse (#14) removed a soiled dressing from Resident #28's wound, cleansed the wound, and applied a clean dressing. The nurse (#14) failed to apply a gown before providing wound care.

- Observation on 08/07/24 at 1:30 p.m. showed a nurse (#9) applied gloves and entered Resident #79's room with medications. A sign on the resident door indicated EBP. The nurse

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F 880	Continued From page 13 administered the medications and water flushes through the resident's feeding tube. The nurse (#9) failed to wear the appropriate enhanced barrier precautions PPE. - Review of Resident #96's medical record occurred on all days of survey. Physician's orders included wound care to a right ankle pressure ulcer daily. The care plan stated, "Enhanced Barrier Precautions (EBP) related to Chronic Wounds (pressure ulcer) and Indwelling Medical Device urinary catheter . . . Enhanced Barrier Precautions (EBP) should be used for the duration of the affected residents [sic] stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. . . ." Observation on 08/06/24 at 9:33 a.m., showed a nurse (#14) performed a dressing change to Resident #96's wound. The nurse failed to wear the appropriate enhanced barrier precautions PPE.	F 880		