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 09/14/2023

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 The standard Medicare/Medicaid recertification survey and complaint survey started on 09/11/23 and concluded 09/14/23. During the complaint investigation, the issues identified by the complainant were found in compliance with the regulatory requirements.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		10/19/23

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

Electronically Signed | 10/06/2023

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 09/14/2023

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 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility policy, and staff interview the facility failed to maintain a comfortable temperature level for 1 of 6 units (Valley View). Failure to maintain comfortable room temperature levels can result in resident discomfort. Findings include: Review of the facility policy titled "Safe and Homelike Environment" occurred on 09/14/23. This policy, revised May 2023, stated, " . . . The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit. . . " Observation on 09/12/23 at 4:00 p.m. showed Resident #63 in the Valley View resident common area rubbing their shoulders and making complaints of being cold. An unidentified staff member retrieved a sweater for the resident. Observation on the morning of 09/13/23 showed Resident #60 in the Valley View resident common area leaning forward in their wheelchair. An	F 584	F584 1. Valley View Common resident area temperature will be comfortable for residents. On 9/15/23 maintenance staff members working were educated on comfortable and safe temperature levels and the HVAC system. On 10/6/23 maintenance staff were educated on comfortable and safe temperature levels and the HVAC system at a department meeting. Audits of the Valley View Common resident area temperature started on 9/15/23 and will continue weekly and prn. 2. As rooms have many factors affecting heat including resident equipment that projects heat, windows, position on side of the building, etc., resident common areas may fluctuate in temperature and have the potential to be affected. Room temperatures will be monitored on a regular basis and upon resident request as needed. Adjustments to the	

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 09/14/2023

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 584	Continued From page 2 unidentified staff member asked if the resident was cold, the resident shook their head yes. The unidentified staff member retrieved a warm blanket from the tub room for the resident. Observations of air temperatures taken in the Valley View common resident areas showed the following: *09/12/23 at 11:24 a.m., 66 degrees Fahrenheit (F). *09/12/23 at 5:15 p.m., 66.5 degrees F. *09/13/23 at 8:00 a.m., 66 degrees F. *09/13/23 at 4:52 p.m., 68 degrees F. *09/14/23 at 9:23 a.m., 67 degrees F. During an interview on 09/14/23 at 9:00 a.m., a maintenance staff member (#3) reported their expectation for the temperatures in the resident's room and in the resident common areas would be between 71 degrees Fahrenheit (F) and 81 degrees F. The facility failed to maintain a comfortable temperature on the Valley View common resident areas.	F 584	temperature will be made when possible, according to resident request and within the scope of the HVAC system. 3. All staff education 10/10/23 in safe and comfortable room temperatures to include how to address resident comfort level and report to maintenance if temperatures are outside of the goal 71 to 81F or based on resident comfort level. 4. Checks of the HVAC system will take place at least daily by Environmental Services Coordinator or designee for one month, 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. Adjustments will be made to the heating system as needed. 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 10/19/2023.	
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. §483.80(a) Infection prevention and control	F 880		10/19/23

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 09/14/2023

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 880	Continued From page 3	F 880		

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 must prohibit employees with a communicable

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 09/14/2023

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 880	Continued From page 4 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, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 4 of 17 sampled residents (Resident #12, #13, #15, and #42) observed during personal cares and/or insulin administration. Failure to practice infection control standards related to hand hygiene, glove use, and insulin administration has the potential to spread infection throughout the facility. Findings include: HAND HYGIENE Review of the facility policy titled "Hand Hygiene" occurred on 09/14/23. This policy, dated August 2022, stated, ". . . Procedure: 1. Staff will perform hand hygiene when indicated, using proper	F 880	F880 1. On 9/14/23, all CNAs that were working were educated on Hand Hygiene, and infection prevention and control related to gloves use. On 9/14/23 all Nurses working were given verbal education on proper administration of insulin and hand hygiene with medication pass. On 9/19/23 at Nurses monthly meeting, education was provided on proper hand hygiene with medication pass. Education provided on proper administration of insulin and hand hygiene. On 9/21/23 at Monthly CNA meetings education provided on proper hand hygiene related to glove use and ADL cares. On 9/12/ 9/13 9/14 of 2023 education in weekly Huddles, all CNAs	

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 09/14/2023

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 880	Continued From page 5 technique consistent with accepted standards of care. . . . 6. Additional considerations: . . . b. The use of gloves does not replace hand hygiene. Practice hand hygiene before donning and after doffing gloves. . . . hand hygiene should be performed for the following conditions . . . between resident contacts, After Handling contaminated objects, . . . Before applying and after removing personal protective equipment [PPE], including gloves . . . Before and after handling clean or soiled dressings, linens, Before and after resident care procedures . . . during resident cares, moving from a contaminated body site to a clean body site . . . After assistance with personal body functions (e.g., [example] elimination, hair grooming . . ." - Observation on 09/12/23 at 11:00 a.m. showed a certified nurse aide (CNA) (#4) performed perineal cares on Resident #13. The CNA (#4) performed hand hygiene, donned gloves, closed the resident's privacy curtain, removed the resident's brief, and performed perineal cares. Without removing the gloves, the CNA (#4) opened the privacy curtain to obtain more supplies from the bathroom and continued to assist Resident #13. The CNA (#4) removed the gloves and exited the room without performing hand hygiene. - Observation on 09/12/23 at 4:41 p.m. showed two CNAs (#6 and #7) donned gloves to assist Resident #12 with incontinent cares. The CNA (#6) removed the soiled incontinent product, cleansed the perineal area, applied a skin protectant cream, and a clean brief. Without removing the gloves, the CNA (#6) assisted the resident out of the bed into the wheelchair	F 880	that were working were educated on Hand Hygiene with ADL cares. Audits were performed on CNAs performing ADL cares on residents starting on 9/14/2023 and will continue weekly. Audits were performed on Nurses administering Insulin, eye drops, and other medication passes to residents starting on 9/15/23 and will continue weekly. 2. The facility has identified that all residents in the facility who require assistance with ADLs have the potential to be affected by this practice. The facility has also identified that all residents who receive insulin injections, eye drops, and other medications have the potential to be affected by this practice. 3. As of 10/10/2023 all staff were educated in Hand Hygiene. 4. 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. 5. Compliance will occur on or before 10/19/2023.	

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 09/14/2023

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 880	Continued From page 6	F 880		

utilizing the mechanical lift. With the same gloves on, the CNA (#6) combed the resident's hair, gave the resident her purse, repositioned the wheelchair, and made the bed. The CNA (#6) collected the garbage and dirty linen, and exited the resident's room without performing hand hygiene. While walking down the hallway removed her gloves and stopped at the soiled utility room door, utilized the keypad for entry, disposed of the linen and garbage, and performed hand hygiene.

- Observation on 09/13/23 at 1:37 p.m. showed two CNAs (#7 and #8) donned gloves to assist Resident #12 with incontinent cares. The CNA (#7) removed the wet brief, cleansed the resident's perineal area, placed a medicated pad in the resident's perineal area, applied a new product, and doffed her gloves. Without performing hand hygiene, the CNA moved the resident's purse, collected the garbage, exited the resident's room, utilized the key pad for entry into the soiled utility room, disposed the garbage, and performed hand hygiene.

- Observation on 09/12/23 at 5:01 p.m. showed two CNAs (#6 and #7) donned gloves to assist #15 with incontinent cares. The CNA (#7) removed the soiled incontinent product, cleansed the resident's perineal area and applied a new product. Both CNAs assisted the resident from the bed to the recliner utilizing the mechanical lift. The the CNA (#7) doffed her gloves, picked up the garbage bag, exited the resident's room, utilized the keypad for entry into the soiled utility room, disposed of the garbage bag, and performed hand hygiene.

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 09/14/2023

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 880	Continued From page 7 During an interview on 09/14/23 at 10:22 a.m., an administrative nurse (#1) stated she expected staff to remove gloves after perineal care, perform hand hygiene prior to performing other tasks and prior to exiting a resident's room. INSULIN ADMINISTRATION Review of the facility policy titled "Insulin Pen" occurred on 09/14/23. This policy, revised July 2023, stated, ". . . Injecting the insulin: i. Cleanse the skin with an alcohol pad. . . k. Remove gloves and perform hand hygiene. . . . " Review of the facility policy titled "Medication Administration" occurred on 09/14/23. This policy, revised on July 2023, stated, ". . . Procedure: . . . 4. Wash hands prior to administering medication per facility protocol and product . . . Eye medications are administered as ordered by the physician and in accordance with professional standards of practice . . . " - Observation of medication administration on 09/13/23 at 8:26 a.m., showed a nurse (#2) wore gloves to prime an insulin pen and prepare medications for Resident #42. The nurse failed to change the gloves, perform hand hygiene, or cleanse the resident's skin with alcohol prior to administering the insulin. While wearing the same gloves the nurse (#2) administered two different eye drops, removed the gloves, and without performing hand hygiene exited the room. During an interview on 09/13/23 at 4:30 p.m., an administrative staff member (#1) stated, she expected staff to use proper hand hygiene and	F 880		

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 09/14/2023

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 880	Continued From page 8 glove use during medication administration. .	F 880		