STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/22/25 and ended on 09/25/25.	F0000		11/26/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to ensure safety for 2 of 4 sampled residents (Resident #2 and #9) observed during transfers and ambulation. Failure to utilize gait belts and the required staff assistance placed the residents at risk for accidents and/or injury. Findings include: Review of the facility policy titled "Safe Resident Handling/Transfers" occurred on 09/25/25. This policy, dated May 2025, stated, ". . . It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience . . ." Review of the facility policy titled "Standards of Care Policy" occurred on 09/25/25. This policy, dated August 2025, stated, ". . . Gait belt will be used when resident needs assistance with walking and transferring. . . ."	F0689	Education and coaching were immediately provided to staff directly involved with Residents #2 and #9. This training clarified each resident's specific transfer needs and reinforced proper transfer techniques in accordance with their individualized care plans. All residents who require assistance with transfers have the potential to be affected. The facility reviewed all current care plans and ADL sheets to ensure accuracy of transfer instructions. Training on safe resident transfers, gait belt use, and adherence to care plans and ADL sheets was provided on October 16, 2025. Staff were reminded that gait belts must be used for all assisted transfers unless contraindicated in the care plan. Transfer audits will be completed to ensure proper gait belt use, correct technique, and care plan adherence: Weekly for 2 weeks, every other week for 1 month, every other month for 2 months Thereafter as determined by the Quality Assurance and Performance Improvement (QAPI) program. Findings will be reviewed in monthly QAPI meetings, with immediate re-education as needed. 11/26/2025	11/26/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0689 SS = D	Continued from page 1 - Review of Resident #2's medical record occurred on all days of survey. The care plan stated, ". . . MOBILITY: I use a w/c [wheelchair] for mobility. Walker PRN [as needed] when able with staff assist. . . . TRANSFER: I need assist of two [staff] with gait belt and pivot for transfers . . . I have impaired Cognitive Function . . ." A quarterly Minimum Data Set (MDS), dated 09/09/25, identified severely impaired cognition. Observation on 09/23/25 at 4:02 p.m. showed a certified nurse aide (CNA) (#6) assisted Resident #2 to the edge of the bed, applied a gait belt, and assisted to stand in front of a front wheel walker (FWW). The resident lightly held onto the walker handles, leaned back into the CNA's hand and away from the walker, and began to walk towards the bathroom. The resident vocally expressed fear of falling. The CNA (#6) stated, "She [Resident #2] is a walk-to-dine but we will need to use the wheelchair. She didn't do very well [transfer/ambulate]." After toileting, the CNA (#6) assisted the resident to stand with the gait belt and directed him/her to hold onto the walker handles. The CNA utilized the gait belt and pivoted the resident to the wheelchair. Review of Resident #2's ADL care sheet, dated 09/22/25, identified the resident required two staff assistance with a gait belt with pivot transfers. The care sheet failed to identify walk-to-dine. The CNA (#6) failed to follow Resident #2's plan of care for two staff assistance with transfers and utilize a wheelchair for mobility to the bathroom ensuring the resident's safety. During an interview on 09/25/25 at 10:25 a.m., an administrative staff member (#1) confirmed Resident #2 required two staff for transfers. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia and repeated falls. The care plan stated, ". . . I am an assist of one and a pivot transfer. I am unable to walk due to decreased strength and mobility . . . I am at risk for falls r/t [related to] Gait/balance problems and hx [history] of falls. . . ." A quarterly MDS, dated 07/08/25, indicated maximum assistance required with toilet transfer and chair/bed - to - chair transfer. Review of Resident #9's ADL care sheet, dated 09/22/25, showed the resident required one staff assistance and a gait belt for transfers.	F0689		11/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0689 SS = D	Continued from page 2 Observation on 09/22/25 at 1:14 p.m. showed a CNA (#4) placed both hands on Resident #9's buttocks/hips to turn the resident's body when transferring from a wheelchair to the toilet, from the toilet back into the wheelchair, and from the wheelchair into a recliner. The resident was hunched over during the transfers. Observation on 09/23/25 4:46 p.m. showed a CNA (#3) placed both hands on Resident #9's buttocks/hips to turn the resident's body when transferring from a wheelchair to the toilet and from the toilet back into the wheelchair. The CNA (#3) stated, "He [Resident #9] is not one we use the gait belt on. How he does [transfers] depends upon how tired he is." Both CNAs (#3) and (#4) failed to utilize a gait belt when transferring Resident #9. During an interview on 09/25/25 at 12:00 p.m., an administrative staff member (#1) stated, she expected staff to follow the ADL care sheet and use a gait belt for Resident #9's transfers.	F0689		11/26/2025
F0880 SS = D	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 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 §483.71 and following accepted national standards;	F0880	All Staff who care for Residents #2, #27, and #28 were educated upon survey exit conference. Education addressed proper hand hygiene, glove use, wound care steps, and disinfection of instruments and surfaces (including tables, scissors, and wound cleanser bottles). All residents have the potential to be affected by lapses in infection control practices. Education provided on October 16, 2025, reinforced proper infection control procedures. Education addressed proper hand hygiene, glove use, wound care steps, and disinfection of instruments and surfaces (including tables, scissors, and wound cleanser bottles). Audits of hand hygiene, glove use, wound care steps, and disinfection of instruments and surfaces (including tables, scissors, and wound cleanser bottles) will be done Weekly for 2 weeks every other week for 1 month, every other month for 2 months and ongoing thereafter as directed by the QAPI committee. Results will be reviewed in QAPI meetings. Additional training will occur immediately if non-compliance is found.	11/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0880 SS = D	Continued from page 3 §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 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, review of	F0880	Continued from page 3 11/26/2025	11/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0880 SS = D	Continued from page 4 facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 4 sampled residents (Resident #2, #27, and #28) observed during cares. Failure to practice infection control standards during personal cares has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Infection Prevention and Control Program" occurred on 09/25/25. This policy, revised May 2025, stated, ". . . Institutional factors may also facilitate transmission of infections among residents. . . . Direct/indirect contact with equipment used to provide care. . . . Improper hand hygiene. . . . Improper glove use. . . . Hand hygiene continues to be the primary means of preventing the transmission of infection. . . . Glove Hygiene . . . Remove and discard gloves . . . after every procedure that involves potential exposure to blood or body fluids. . . . Perform hand hygiene immediately after removal of gloves . . . Resident dressings and supplies should be properly stored to maintain their integrity . . . " - Observation on 09/23/25 at 11:10 a.m. showed a certified nurse aide (CNA) (#4) entered Resident #28's room, performed hand hygiene, applied gloves, removed the resident's clothing and a soiled brief, and completed perineal cares. With the same gloves, the CNA (#4) applied a clean brief, washed and dried the resident's legs and feet, applied clean socks and pants, assisted the resident into a wheelchair, removed a shirt, washed the resident's back, and applied a clean shirt. The CNA (#4) then removed the soiled gloves and performed hand hygiene. The CNA (#4) failed to remove their soiled gloves, perform hand hygiene, and apply new gloves between clean and dirty tasks. - Review of Resident #27's medical record occurred on all days of survey and identified the resident on enhanced barrier precautions related to wounds. Observation on 09/23/25 at 1:50 p.m. showed a nurse (#5) applied personal protective equipment (PPE) inside Resident #27's room, obtained wound supplies from a basket in the room, and placed the	F0880		11/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0880 SS = D	Continued from page 5 supplies onto an overbed table visibly soiled with dried liquid/food. While the resident laid on the bed, the nurse sprayed wound cleanser onto a weeping abdominal wound, dried the wound with gauze, and without removing their soiled gloves, opened clean dressing supplies, used the scissors to cut one of the dressings to fit the wound, placed it into the wound, and covered the area with a foam dressing. The nurse then removed the soiled gloves, performed hand hygiene, applied new gloves. After applying another wound dressing, the nurse removed the soiled gloves, performed hand hygiene, applied clean gloves, and placed the bottle of wound cleanser and the scissors back into the wound supply basket without sanitizing them. The nurse placed the overbed table beside the resident without sanitizing the surface, removed their PPE, performed hand hygiene, and exited the room. The nurse (#5) failed to place the wound supplies onto a clean surface, remove their soiled gloves, perform hand hygiene, and apply clean gloves after cleansing a wound and before applying a clean dressing, sanitize the wound cleanser bottle and scissors before placing them back into the basket, and sanitize the overbed table. - Observation on 09/23/25 at 4:02 p.m. showed a certified nurse aid (CNA) (#6) performed hand hygiene, applied gloves, assisted Resident #2 to the bathroom, removed a soiled brief, performed perineal cares, applied a clean brief, pulled up the resident's pants, and transferred the resident into a wheelchair. Without removing their soiled gloves, the CNA combed the resident's hair, adjusted their clothing, and moved the wheelchair from the bathroom to the room doorway. The CNA removed their soiled gloves, performed hand hygiene, and exited the room. The CNA (#6) failed to remove their soiled gloves and perform hand hygiene after perineal care and before to moving onto other tasks and failed to disinfect the wheelchair handles after touching them with soiled gloves. During an interview on 09/25/25 at 10:25 a.m., an administrative staff member (#1) stated she expected staff to place the wound supplies onto a clean surface, remove soiled gloves after cleaning wounds and before applying clean dressings, sanitize the wound cleanser and scissors before placing them	F0880		11/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355108	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	**110 HILLCREST DR , ENDERLIN, North Dakota, 58027**

(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
F0880 SS = D	Continued from page 6 back into the wound supply basket, sanitize the overbed table after wound cares, and remove gloves/perform hand hygiene after perineal care and before moving on to other tasks.	F0880		11/26/2025