STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST CATHERINE NORTH	**1351 N BROADWAY , FARGO, North Dakota, 58102**

(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 02/09/26 and concluded 02/11/26.	F0000		03/11/2026
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure physician's orders were followed for 3 of 24 sampled residents (Resident #71, #107, and #124). Failure to follow physician orders for medication administration, and application of compression socks and ace wraps, may result in adverse health effects for the residents. Findings include: Review of professional standards included: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. . . " -Review of Resident #71's medical record occurred on all days of survey. A physician's order, dated 12/30/25, stated, ". . . Beige knee high Jobst compression [socks] . . . on in AM [morning] off HS [at bedtime] edema [swelling] . . ." Resident #71's current care plan failed to identify the use of Jobst	F0684	It is the practice of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Verbal coaching was given to medication aide #6 on 2/10/26 to follow physician orders for direction on how to administer residents medication. Verbal coaching was given to nurse #11 on 2/11/26 to follow facility diabetic protocol and ensure insulin is not administered more than 10 minutes prior to meal and if resident will not eat within that time to offer juice or a small snack to prevent hypoglycemia. An email was sent to all staff nurses on 2/13/26 to inform them of change in practice to provide 4oz of juice at the time of administration of rapid and short acting insulin. Compression socks for resident #71 were added to the plan of care and the electronic treatment record for nurse confirmation of placement and removal on 2/11/26. All residents have the potential to be affected and could have negative outcomes as a result of failure to follow physician orders for medication administration and application of compression socks and ace wraps. Facility practice was updated to include routine review of additional instructions by nurse manager or clinical support nurse or designee to ensure they match current physician orders, completed at Nursing Leadership Meeting on 2/19/26. Diabetic protocol was updated to include adding a nursing order to give 4oz of juice with rapid or short acting insulin administration for all residents receiving rapid or short acting insulin, completed on 2/13/26. Application and removal of compression socks will be added to the treatment administration record (TAR) for nurse verification of placement and	02/24/2026

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: 355047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

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F0684 SS = E	Continued from page 1 compression socks. Observations of Resident #71 on 02/09/2026 at 12:46 p.m. and 02/10/26 at 10:02 a.m., showed facility staff failed to apply the compression socks. During an interview on 2/11/26 at 5:13 p.m., an administrative nurse (#1) confirmed staff failed to apply Resident #71's compression socks and update Resident #71's care plan. -Review of Resident #107's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dysphagia (swallowing impairment). A physician's order, dated 06/27/18, stated, "CRUSH MEDICATIONS in pureed." A quarterly Minimum Data Set (MDS), dated 12/26/25, identified, "Coughing or choking during meals or when swallowing medications." Observation of Resident #107 identified the following: *02/10/26 at 9:45 a.m. a medication aide (MA) (#6) carried a clear medicine cup containing several whole pills into the resident's room. The MA exited the room with the pills and stated the resident refused to take them. *02/10/26 at 11:10 a.m. a nurse (#3) readministered the morning medications crushed in pudding and stated, "I am readministering resident 's a.m. medications crushed in pureed per physician orders due to [CMA #6] had attempted to administer medications whole and resident spit them out." The CMA (#6) failed to follow the physician's order to crush Resident #107's medications for administration. - Review of Resident #124's medical record occurred on all days of survey. A physician's order, dated 02/06/26, stated "ACE wrap to R [right] upper extremity, on in AM & [and] off HS one time a day for lymphedema [tissue swelling] and remove per schedule." The electronic medication administration record (EMAR) for February 2026 identified the Ace wrap on at 8:00 a.m. and removed at 10:00 p.m.	F0684	Continued from page 1 removal, completed at Nursing Leadership Meeting on 2/19/26. Education was provided to all nurses and CNAs at the Nursing Department Meeting held on 2/24/26. The Quality Nurse or designee will audit up to 5 medication or treatment administrations weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for proper administration of treatment and care that follows physician orders.	02/24/2026

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F0684 SS = E	Continued from page 2 Observations on 02/09/2026 at 11:16 A a.m., 2:00 p.m., and 4:30 p.m., and 02/10/26 at 10:00 a.m. and 1:32 p.m., showed no ace wrap on Resident #124's right arm. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of care for 1 of 1 supplemental resident (Resident #115) observed during administration of rapid-acting insulin. Failure to administer rapid-acting insulin within 5 to 10 minutes of a meal may result in a hypoglycemic (low blood sugar) reaction. Findings include: Review of the facility policy titled "Diabetic Protocol" occurred on 02/11/26. This policy, dated September 2017, stated, "Administration of Rapid/Short Acting Insulin: a. Must be given 5-10 minutes before mealtime. If given to [sic] early a hypoglycemic episode could occur. . . ." Review of Resident #115's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. Observation on 02/10/26 at 4:00 p.m., showed a nurse (#11) administered 18 units of Novolog insulin (rapid-acting insulin) to Resident #115 per physician's order and left the room. The resident went by herself to the dining room, arrived at 4:15 p.m., and received the meal tray at 4:40 p.m., 40 minutes after receiving Novolog insulin. During an interview on 02/11/26 at 2:02 p.m., an administrative nurse (#1) confirmed a beverage, juice, or small snack should be given within 10 minutes of administering rapid-acting insulin.	F0684		02/24/2026
F0880 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 program.	F0880	It is the practice of this facility to 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. Verbal coaching was provided to medication aide #6 on 2/10/26 to thoroughly clean shared equipment including all touched areas and base of equipment. CNAs #4 and #5 were provided verbal coaching on 2/10/26 regarding performing hand hygiene after removing gloves. Verbal coaching was provided to	02/24/2026

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F0880 SS = E	Continued from page 3 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; §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.	F0880	Continued from page 3 nurse #3 on 2/11/26 regarding performing hand hygiene when going from soiled to clean and after removing gloves. All residents have the potential to be affected if the facility fails to practice infection control standards. Failure to disinfect shared equipment, change gloves, and perform hand hygiene has the potential to spread infection throughout the facility. It was determined that infection control practices observed did not conform to facility policy. Re-education was provided to all nurses and CNAs of facility infection control policy specific to hand hygiene, glove use and disinfection of shared equipment. This education was provided at the Nursing Department Meeting held on 2/24/26. The Quality Nurse or designee will audit up to 5 infection control observations weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for proper hand hygiene, glove use and share equipment disinfection.	02/24/2026

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F0880 SS = E	Continued from page 4 §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 facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 17 sampled residents (Resident #11, #57, and #107) and 1 supplemental resident (Resident #81) observed during cares. Failure to practice infection control standards related to disinfecting shared equipment, glove changes, and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 02/11/26. This policy, dated 01/17/18, stated, ". . . Hand hygiene is performed: . . . Before and after direct resident contact . . . Before and after assisting a resident with toileting . . . After removing gloves . . ." Review of the facility policy titled "Standard Precautions" occurred on 02/11/26. This policy, dated 03/24/18, stated, ". . . All health care workers will routinely use appropriate precautions to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. . . . Gloves are to be removed: 1. Promptly after use. 2. before touching non-contaminated items or surfaces. . . . Hand hygiene is always performed after glove removal. . . ." Review of the facility policy titled "Clean Dressing Change" occurred on 02/11/26. This undated policy, stated, ". . . It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. . . . Wash hands and put on clean gloves. . . . remove the existing dressing. . . . Remove gloves . . . wash hands and put on clean gloves. . . . cleanse the	F0880		02/24/2026

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F0880 SS = E	Continued from page 5 wound as ordered . . . Wash hands and put on clean gloves. . . . dress the wound as ordered. . . ." Review of the facility policy titled "Isolation Precautions (Transmission-based-precautions)" occurred on 02/12/26. This policy, revised 11/22/21, stated, ". . . When possible, dedicate the use of noncritical equipment and items such as stethoscope, sphygmomanometer [blood pressure cuff], thermometer to the resident during the infectious process. If use of common equipment is unavoidable, clean and disinfect surfaces and/or items before us on another resident. . . ." -Review of Resident #107's medical record occurred on all days of survey. The care plan stated. ". . . I have tested positive for COVID-19 on 2/3/2026. . . . Follow droplet isolation precautions. . . ." Observation on 02/10/26 at 9:45 a.m. showed a sign on Resident #107's door that identified airborne contact precautions and a cart containing appropriate personal protective equipment (PPE) supplies outside the room. A medication aide (MA) (#6) entered the room with an electronic vitals machine. Upon exiting the room, the MA (#6) wiped down the BP cuff and cord and the top of the vitals machine but failed to wipe down the entire machine. During an interview on 02/10/2026 at 9:52 a.m., an administration nurse (#1) confirmed the vitals machine should not be taken into the COVID transmission-based room, and if taken into the room, would need to be sanitized top to bottom. Observation on 02/10/26 at 10:15 a.m. showed a facility nurse (#7) prepare to enter resident's room to confirm Resident #107 had designated equipment for taking vitals. Upon exiting the resident's room, the facility nurse (#7) did confirm the designated equipment was in Resident #107's room for use and also stated he/she had cleaned and disinfected the electronic vitals machine used in Resident #107's room earlier and clarified he/she had disinfected the machine top to bottom. - Observation on 02/10/26 at 10:50 a.m. showed two certified nurse aides (CNAs) (#4 and #5) assisted Resident #11 to the shower room. The CNA (#4) applied one glove and disinfected the toilet seat and grab bars with a disinfecting wipe. The CNA (#4) removed the soiled glove, and without performing hand hygiene touched hygiene items on a storage	F0880		02/24/2026

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F0880 SS = E	Continued from page 6 cupboard. Both CNAs (#4 and #5) applied gloves, placed a gait belt on Resident #11, and transferred the resident to the toilet. The CNA (#5) performed perineal cares, adjusted the resident's clothing and then both CNAs transferred Resident #11 to the wheelchair. The CNA (#5) removed the soiled gloves and without performing hand hygiene, exited the bathroom to retrieve wheelchair foot pedals. The CNA (#5) returned to the shower room with the foot pedals and applied them to the wheelchair. The CNA (#4) removed her soiled gloves, both CNAs performed hand hygiene, and assisted Resident #11 from the shower room to his room. Both CNAs (#4 and #5) failed to perform hand hygiene before assisting the resident with toileting. The CNA (#4) failed to perform hand hygiene after removing gloves and before touching the other items in the shower room. The CNA (#5) failed to perform hand hygiene after removing gloves and before exiting the shower room. - Observation on 02/10/26 at 12:12 p.m. showed an enhanced barrier precaution sign on Resident #57's door and the resident lying in bed. The nurse (#3) entered the room, performed hand hygiene, applied a gown and gloves, and placed dressing change supplies on the over the bed table. The nurse (#3) removed the soiled dressing, removed the soiled gloves, and without performing hand hygiene applied clean gloves. The nurse cleansed Resident #57's wound with wound wash, removed the soiled gloves, and without performing hand hygiene, applied clean gloves, placed treatment medications in the wound bed, covered the wound with border foam dressing, and without removing the soiled gloves, adjusted the resident pants, placed pillows under the resident's legs, covered the resident with a blanket, and turned off the overbed light. The nurse (#3) removed the soiled gown and gloves, performed hand hygiene, collected the garbage and exited the room. The nurse (#3) failed to perform hand hygiene after removing soiled gloves and before applying clean gloves during the dressing change, failed to remove soiled gloves and perform hand hygiene before touching other items. -Observation on 02/11/26 at 4:15 p.m. showed Resident #81 in bed. A CNA (#9) and a nurse (#10) entered the room and applied gloves. The CNA (#9) removed the resident's soiled brief, performed perineal cares, and without removing the soiled	F0880		02/24/2026

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F0880 SS = E	Continued from page 7 gloves or performing hand hygiene, applied a clean brief, adjusted Resident #81's dress and blanket, removed the soiled gloves and without performing hand hygiene, exited the room. The nurse (#10) removed the soiled gloves, assisted the CNA (#9) to reposition Resident #81's dress, placed a pillow between the resident's legs, adjusted the blankets, and without performing hand hygiene, exited the room. The CNA (#9) failed to remove the soiled gloves and perform hand hygiene prior to touching other items and before exiting the room. The nurse (#10) failed to perform hand hygiene after removing soiled gloves, after touching soiled items, and before exiting the room. During an interview on 02/11/26 at 12:49 p.m., an administrative nurse (#1) confirmed she expected staff to perform hand hygiene after removing gloves and prior to touching other items or applying new gloves.	F0880		02/24/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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	F0605	It is the practice of this facility to ensure residents are free from chemical restraints. Request for GDR or appropriate rationale indicating clinical contraindication to GDR sent to provider for resident #6 on 3/9/26 and #11 on 3/4/26. Awaiting response for both. All residents receiving a psychotropic medication have potential to be affected and experience adverse consequences due to failure to attempt a GDR or identify contraindications for a GDR. It was determined that the practice observed did not conform to facility policy. Verbal education was provided to facility consultant pharmacist at Quality meeting on 2/17/26 to provide recommendation for GDR earlier so that providers have additional time to address the need for GDR. Quality Nurse will track next GDR due with facility psychotropic medication tracking. The Quality Nurse or designee will audit up to 5 residents receiving psychotropic medication weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for attempted GDR or appropriate rationale indicating clinical contraindications for a GDR.	03/09/2026

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F0605 SS = D	Continued from page 8 symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used	F0605		03/09/2026

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F0605 SS = D	Continued from page 9 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 5 sampled residents (Resident #6 and #11) selected for medication review. Failure to attempt a gradual dose reduction (GDR) or identify contraindications for a GDR may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of the facility policy titled "Drug Regimen Review" occurred 02/11/26. This policy, dated 06/09/23, stated, ". . . The consultant pharmacist will provide a written review for each resident on an antipsychotic . . . antidepressant . . . The review will evaluate dose, duration, continued need, and	F0605		03/09/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST CATHERINE NORTH	**1351 N BROADWAY , FARGO, North Dakota, 58102**

(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
F0605 SS = D	Continued from page 10 emergence of adverse side effects. This information will be used to assist in assessment of effectiveness of drug therapy regimens. . . . Medication tapering should be attempted when the resident's clinical condition has improved or stabilized or the underlying cause of the symptoms has resolved . . . Tapering of antipsychotic [sic] should be attempted at least once in the first year followed by a 2nd attempt in a subsequent quarter that same year unless clinically contraindicated. . . . After the 1st year tapering should be attempted once a year. . . . The physician must document the clinical rationale for why additional attempts at dose reduction would impair the resident's function. . . ." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder, psychosis and depression. The current physician's orders included Lurasidone, an antipsychotic medication, daily since 7/17/2024. The medical record lacked documentation to show the provider attempted a GDR or reasons why a GDR would be contraindicated from 2024 through February of 2026. - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease, dementia, and depression. The current physician's orders identified Sertraline, an antidepressant medication, daily since 11/14/24. The medical record lacked documentation to show the provider attempted a GDR reasons why a GDR would be contraindicated from November 2024 to February of 2026. During an interview on 2/11/26 at 5:45 pm, an administrative nurse (#1) confirmed Resident #6 and #11's medical records lacked a gradual dose reduction.	F0605		03/09/2026
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F0644	It is the practice of this facility to coordinate assessments with the pre-admission screening and resident review (PASARR) program. A level 1 screen for resident #13 was completed on 2/12/26 and accepted on 2/20/26. All residents have the potential to be affected and could result in the delivery of care and services inconsistent with residents' needs due to failure to complete a change in status assessment with a	02/20/2026

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F0644 SS = D	Continued from page 11 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmissions Screening and Resident Review (PASARR), Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #13) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness and new medication may result in the delivery of care and services inconsistent with residents' needs. Findings include: The North Dakota PASARR Provider Manual revised December 2020 stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #13's medical record occurred on all days of survey and identified the following: *A PASARR dated 07/17/25, identified diagnoses of major depression, generalized anxiety and panic disorder. Medication for mental health included Mirtazapine (antidepressant). *A progress note dated 11/28/25, stated, "Medication/Dx [diagnosis]: Seroquel (antipsychotic) 25 mg [milligrams] at bedtime for paranoia, dx	F0644	Continued from page 11 newly diagnosed mental illness and new medication. Facility practice was updated to include tracking a new diagnosis of serious mental disorder, intellectual disability or a related condition for level II resident review with a significant change in status assessment on facility psychotropic medication tracking. Tracking will also include the due date for next PASAAR. The Quality Nurse or designee will audit up to 5 residents with a newly diagnosed mental illness and new medication weekly for 4 weeks, monthly for 3 months and quarterly for 1 year for completion of a change in status assessment.	02/20/2026

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F0644 SS = D	Continued from page 12 delusional disorder. Target Behavior monitored: Paranoia, delusions, anxiety. . . ." Resident #13's medical record lacked evidence the facility completed a PASARR related to the new diagnoses of paranoia, delusional disorder, and new order for Seroquel. During an interview on 02/11/26 at 4:55 p.m. a social services staff member (#8) confirmed the facility failed to complete a change in status Level 1 screen for Resident #13.	F0644		02/20/2026