STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST CATHERINE SOUTH	**3102 S UNIVERSITY DR , FARGO, North Dakota, 58103**

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F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 06/09/25 and concluded on 06/12/25.	F0000		
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; §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;	F0880	It is the practice of this facility to perform hand hygiene and wear appropriate PPE when required. 1. On 06/10/2025 & 06/11/2025, verbal education was provided to nursing staff working with resident #191 on enhanced barrier precautions. On 06/11/2025 & 06/12/2025 verbal education was provided to staff working with residents #10 and #35 on hand hygiene and glove use. On 06/12/2025, the Quality, Infection, and Learning Coordinator provided re-education to all CNA and nursing staff on hand hygiene, glove use, and enhanced barrier precautions policies and procedures via email and When2Work message. On 06/16/2025 and 06/17/2025, education was provided to staff working with residents #10, #35, and #191 on hand hygiene, glove use, use of portable hand sanitizer pumps, and enhanced barrier precautions. 2. Facility has identified that all residents have the potential to be affected by this practice. 3. On 06/12/2025, the Quality, Infection, and Learning Coordinator provided re-education to all CNA and nursing staff on hand hygiene, glove use, and enhanced barrier precautions policies and procedures via email and When2Work message. On 06/12/2025, the facility implemented use of portable hand sanitizer pumps to be stored in all resident rooms. This change allows staff to perform hand hygiene at the bedside while completing cares without having to walk to wall mounted hand	07/02/2025

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

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F0880 SS = D	Continued from page 1 (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, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 20 sampled residents (#10, #35, and #191) observed during personal cares. Failure to practice infection control standards related to hand hygiene/glove use and enhanced barrier precautions has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene"	F0880	Continued from page 1 sanitizer pumps. The portable hand sanitizer pumps will be safely stored when not in use. All new Nurse and CNA hires will continue to receive mandatory infection prevention training including hand hygiene and EBP procedures during orientation. Competency checks on hand hygiene and EBP/PPE donning/doffing will be completed for all staff annually and upon observed deficiency. 4. A total of two audit tools have been developed to ensure compliance with F880. The first tool ensures proper staff hand hygiene upon entry to the resident room and when changing gloves. The second audit tool has been developed to ensure that appropriate PPE is worn while performing high contact resident activities for residents who have enhanced barrier precautions. Each audit tool will be completed by Quality Nurse or designee 1x weekly for one month, 1x monthly for two months, and then quarterly for a total of 12 months. A summary of completed audits will be provided to the QAPI committee to ensure compliance is achieved and sustained.	07/02/2025

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F0880 SS = D	Continued from page 2 occurred on 06/12/25. This policy, revised May 2024, stated, ". . . Hand hygiene is indicated and will be performed under the conditions listed . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . After assistance with personal body functions (e.g., elimination) . . ." Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 6/12/25. This policy, revised June 2025, stated, ". . . Enhanced barrier precautions (EBP) are used to limit or prevent the spread of resistant organisms during high-contact resident care activities. These may be indicated for residents with . . . indwelling medical devices (e.g. central lines . . .) . . . when performing transfers . . . EBP should be used for the duration of the affected resident's stay in the facility . . . until the resolution or discontinuation of the indwelling medical device that placed them at higher risk . . . " - Observation on 06/10/25 at 9:15 a.m. showed two certified nurse aides (CNAs) (#2 and #3) applied gloves and the CNA (#3) removed Resident #10's brief, soiled with bowel movement, provided perineal cares, and placed a new brief under the resident. The CNA (#3) removed the soiled gloves, and without performing hand hygiene, applied new gloves. Both CNAs (#2 and #3) repositioned Resident #10, adjusted/secured the brief, and removed their gloves. The CNA (#3) handed the phone to the resident, placed a wedge under the resident's legs, placed a nasal cannula, attached the call light to the resident's side pillow, and then performed hand hygiene. - Observation on 06/10/25 at 9:00 a.m. showed a CNA (#1) applied gloves, removed Resident #35's soiled brief, performed perineal cares, and removed the soiled gloves. Without performing hand hygiene, the CNA (#1) applied new gloves, applied barrier cream to the resident's buttocks, and placed a new brief under the resident. The CNA (#1) removed the soiled gloves, and without performing hand hygiene, applied new gloves, adjusted/secured the resident's brief, adjusted the resident's pants, removed the gloves, and then performed hand hygiene. - Review of Resident #191's medical record occurred on all days of survey. Medical diagnoses included osteomyelitis (infection of the bone) and staphylococcus (infection of the skin). The current	F0880		07/02/2025

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F0880 SS = D	Continued from page 3 care plan stated, ". . . on Enhanced Barrier Precautions r/t [related to] indwelling device PICC Line [a peripheral central catheter inserted into a vein in the upper arm] . . . use appropriate PPE when providing high level ADL's [activities of daily living] . . . use hand hygiene when visiting me . . ." Observation on 6/09/25 at 4:04 p.m. showed an EBP sign on Resident #191 door. An unidentified CNA and a nurse (#5) entered Resident #191's room without performing hand hygiene or applying PPE. The CNA assisted Resident #191 out of a chair and the nurse (#5) applied a gait belt, and walked the resident to the bathroom. OPbservation showed the nurse (#5) touched areas of the resident's body, the walker, and the door during toileting cares and transfer assistance. The nurse (#5) admitted she should have performed hand hygiene and applied PPE prior to entering the room. During an interview on 6/11/25 at 3:48 p.m., an administrative nurse (#4) stated she expected staff to follow appropriate EBP.	F0880		07/02/2025
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements.	F0732	It is the practice of this facility to post nurse staffing information in a prominent place daily at the beginning of each shift. As of 06/11/2025, the posted nurse staffing information was moved to a more visible location. As of 06/13/2025, the facility updated the form used for posting nurse staffing information and implemented an updated Nurse Staffing Posting Information policy. On 06/13/2025 the Quality, Infection, and Learning Coordinator provided education to all staff via email on Nurse Staffing Posting Information, including the new form and policy. Education will be provided to responsible staff when a deficiency in posting staffing information is identified. An audit tool has been developed to ensure compliance with F732. The tool ensures proper posting of nurse staffing information at the beginning of each shift. The audit will be completed by Quality Nurse or designee 1x weekly for one month, 1x monthly for two months, and then quarterly for a total of 12 months. A summary of completed audits will be provided to the QAPI	07/02/2025

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F0732 SS = C	Continued from page 4 (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to post the actual hours worked by nursing staff directly responsible for resident care on 2 of 4 days of survey (June 10-11, 2025). Failure to post the actual hours worked by licensed and unlicensed nursing staff per shift and in a visible location does not allow residents and/or their families to be aware of the number of staff on duty. Findings include: Observations on 06/10/25 at 4:10 p.m. and 06/11/25 at 4:05 p.m. showed the posting of staff forms on the unit manager's open door, resulting in the forms inside the office and not visible to residents and/or their families. The forms contained staffing data for the day shift, but not the p.m. shift. During an interview on 06/11/25 at 5:15 p.m., an administrative nurse (#4) confirmed the day shift hours are from 6:00 a.m. to 2:30 p.m. and the p.m. shift hours are from 2:00 p.m. to 10:30 p.m. The facility failed to ensure updated staffing information for every shift and post it in a visible	F0732	Continued from page 4 committee to ensure compliance is achieved and sustained.	07/02/2025

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F0732 SS = C	Continued from page 5 location.	F0732		07/02/2025