STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	06/13/2024

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

(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 started on 06/10/24 and concluded 06/13/24.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11) and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 20 sampled residents (Resident #35 and #79). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION & SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, page A6, stated, ". . . Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, Scheduled PPS, or OBRA Discharge) since the Most Recent Admission/Entry or Reentry? . . . Code 1, yes: if this assessment is the first of these assessments since the most recent	F 641	1. It is the practice of this facility to complete the MDS assessment that accurately reflects the resident's status. As of 6/13/24, Resident #35 MDS was modified to identify use of anticoagulant during the look back period. As of 6/25/2024 resident #79 MDS was modified to correctly complete sections A0310E and J1700A. 2. Facility has identified that all residents who receive anticoagulants have the potential to have this high risk medication not identified on their MDS Assessment. The facility also identifies that all residents who have had a re-entry have the potential for errors in MDS Assessments for A0310E and J1700. 3. Education and review of accurate coding of section N0415E1, A0310E, and J1700 completed using the RAI Manual pages A-4 and N-4 to N-9 provided to the MDS coordinator on 6/25/24. 4. An audit tool has been developed to	7/18/24

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

Electronically Signed | 06/26/2024

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F 641	Continued From page 1 admission/entry or reentry." Pages J-30 and J-31, stated, ". . . J1700. Fall History on Admission/Entry or Reentry. Complete only if . . . A0310E = 1 . . . Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry? . . . Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600)." Review of Resident #79's medical record occurred on all days of survey and identified the resident experienced a fall on 04/22/24. An X-ray performed on 05/03/24 identified a left femoral neck fracture. The resident transferred to the hospital on 05/03/24 and returned to the facility on 05/07/24. Review of Resident #79's completed MDSs are as follows: * 05/03/24, Discharge Return Anticipated (an OBRA assessment) * 05/07/24, Entry (back to the facility) * 05/13/24, Quarterly (an OBRA assessment) Review of the 05/13/24 quarterly MDS identified the facility coded A0310E as "0, no" even though this is the first assessment since reentry on 05/07/24. Review of J1700A identified the facility coded "0", no falls in the last month prior to reentry. Resident #79's medical record identified a fall on 04/22/23. The facility failed to accurately code A0310E and J1700A on Resident #79's quarterly MDS. SECTION N: MEDICATIONS	F 641	ensure accurate coding of N0415E1, A0310E, and J1700 on the MDS. The 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. 5. Compliance will occur on or before July 18th, 2024.	

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F 641	Continued From page 2 The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.11, revised October 2023, pages N-6 and N-7, stated, ". . . N0415: High-Risk Drug Classes: Use and Indication . . . Coding Instructions . . . N0415E1. Anticoagulant (e.g., [for example] warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period . . ." Review of Resident #35's medical record occurred on all days of survey and showed a physician's order for Eliquis, an anticoagulant. The annual MDS, dated 06/03/24, showed staff failed to identify Resident #35 received an anticoagulant during the look-back period. During an interview on 06/13/24 at 10:01 a.m., an administrative staff member (#8) confirmed staff failed to code the MDS for an anticoagulant.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received the necessary services to maintain oral hygiene for 1 of 3 sampled residents (Resident #28) dependent on staff for oral cares. Failure to provide oral care for a dependent resident may result in poor hygiene,	F 677	1.It is the practice of this facility for oral cares to be completed for all residents twice daily with cares, or more frequently as care planned. On 6/12/24, nurse manager added oral cares task three times a day, or every shift, for resident #28 care plan. The nurse manager also	7/18/24

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F 677	Continued From page 3 increased oral/dental problems, and potential for adverse health effects. Findings include: Review of the facility policy titled "STANDARDS OF CARE" occurred on 06/13/24. This policy, dated May 2023, stated, "Each of the following is part of the routine care provided by caregivers . . . Oral care will be done in the morning and at bedtime. . . . Daily Morning Cares . . . Provide oral care . . ." Review of Resident #28's medical record occurred on all days of survey. The current care plan stated, ". . . I have ADL [activities of daily living] deficit related to: inability to communicate needs, Impaired mobility . . . ORAL CARE: I require complete help with mouth care. . . ." Observation on 06/11/24 at 8:51 a.m. showed two certified nurse aides (CNAs) (#3 and #4) provided Resident #28's morning cares. The CNAs failed to provide oral cares. Observations on 06/12/24 at 8:23 a.m., 8:52 a.m., and 11:21 a.m. showed a nurse (#5) provided cares to Resident #28. A dry white substance covered part of the resident's upper and lower lips and a wet white substance on the inside of the lips when he/she opened his/her mouth on each of these observations. The nurse failed to provide oral cares. During an interview on 06/12/24 at 3:18 p.m., an administrative staff member (#1) stated she expects staff to provide oral cares twice a day and as needed.	F 677	provided verbal education to nursing staff working with resident #28 on proper oral care procedure for resident #28. 2. Facility has identified that all residents who are dependent for oral care have the potential to be affected by this practice. 3. On 6/18/2024 the facility updated their oral care policy to include oral care procedure specific to residents who are NPO. On 6/20/24 education was provided to CNAs at the monthly CNA meeting. As of 7/18/24, education will be provided to all CNAs to ensure the proper completion of oral care to dependent residents. 4. An audit tool has been developed to ensure residents who are dependent with oral care receive oral care two times a day or more frequently if care planned. The audit tool will be completed by the Quality Nurse or designee 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. 5. Compliance will occur on or before July 18th, 2024.	

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 1 of 3 sampled residents (Resident #28) observed receiving insulin. Failure to administer insulin according to a physician's order may result in adverse health effects for the residents. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 06/13/24. This policy, revised June 2024, stated, ". . . Prime the insulin pen . . . Set the insulin dose: a. Turn the dose selector to ordered dose. A click will be heard for each unit dialed. . . . Check the dose a second time. . . ." Review of Resident #28's medical record occurred on all days of survey. Diagnoses included type-2 diabetes mellitus with hyperglycemia (high blood sugar). Physician's orders included 46 units of aspart insulin at 12:00 p.m. Observation on 06/11/24 at 11:39 a.m. showed a nurse (#6) primed Resident #28's aspart insulin pen by the medication cart in the hallway outside the resident's room. The nurse entered the resident's room, cleansed an area of the abdomen, and without dialing up the ordered	F 760	1. It is the practice of this facility to administer insulin per provider orders. On 6/12/2024 the Quality Nurse emailed the Insulin Pen Policy to all nurses with specific instructions on reviewing setting the dose of insulin prior to entering the resident's room. 2. Facility has identified that all residents in facility receiving insulin have the potential to be affected by this practice. 3. On 06/13/2024 the facility initiated competency validation checklists for insulin administration for all nurses and medication aides that included education and policy review prior to demonstration of competency. All nurses and medication aides will demonstrate competency by 7/18/2024. 4. An audit tool has been developed to ensure that insulin is administered correctly. The 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.	7/18/24

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F 760	Continued From page 5 dose of insulin (46 units), removed the insulin pen needle cover, inserted the needle into the resident's abdomen, and pushed the pen's plunger. When asked by the surveyor, the nurse (#6) acknowledged she failed to prepare and administer the ordered 46 units of insulin. The nurse (#6) then attached a new needle to the pen, primed the pen, dialed up the 46 units of insulin, and administered the insulin.	F 760	5. Compliance will occur on or before July 18th, 2024.	
F 880 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		7/18/24

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F 880	Continued From page 6 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	F 880		

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F 880	Continued From page 7 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 12 sampled residents (Resident #28 and #79) and one supplemental resident (Resident #43) observed during cares. Failure to practice infection control standards related to use of personal protective equipment (PPE) and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 06/13/24. This policy, revised April 2024, stated,". . . Enhanced barrier precautions will be implemented for residents with any of the following . . . indwelling medical devices (e.g. [for example], . . . feeding tubes [G-tube, a tube inserted into the gastrointestinal tract], tracheostomy [a surgical opening in the trachea that allows a tube to assist with breathing] . . .) . . . Infection or colonization with a CDC [Centers for Disease Control and Prevention]-targeted MDRO [multidrug resistant organism] . . . face protection may also be needed if performing activity with risk of splash or spray (i.e. [that is], . . . tracheostomy care). PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . . . High-contact resident care activities include . . . Device care or use . . . feeding tubes, tracheostomy . . ."	F 880	1. It is the practice of this facility to perform hand hygiene and wear appropriate PPE when required. On 06/13/2024 nurse manager provided verbal education to staff working with resident #28 on EBP with use of face shield and gown use per facility policy. On 06/13/2024 nurse manager provided verbal education to staff working with resident #79 on offering resident hand hygiene after ostomy cares. On 06/14/2024 nurse manager provided verbal education to staff working with resident #43 on hand hygiene and glove use. On 6/20/24 education was provided to CNAs at the monthly CNA meeting regarding staff and resident hand hygiene and proper glove use with a review of Hand Hygiene Policy completed. 2. Facility has identified that all residents have the potential to be affected by this practice. 3. On 06/13/2024 nurse manager provided verbal education to staff working with resident #28 and #79 on EBP and resident hand hygiene. On 06/14/2024 nurse manager provided verbal education to staff working with resident #43 on hand hygiene and glove use. On 6/25/2024 an email was sent to all nurses with the facility's Enhanced Barrier Precautions policy attached with a review of face shield use during tracheostomy cares and	

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F 880	Continued From page 8 Review of the facility policy titled "Hand Hygiene" occurred on 06/12/24. This policy, dated May 2024, stated, ". . . Hand hygiene is indicated and will be performed . . . after assistance with personal body functions (e.g. elimination . . .) . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 678, stated, ". . . Hand hygiene is important in every setting . . . It is important for both the nurses' and the clients' hands to be cleansed . . . after the hands have come in contact with any body substances . . ." ENHANCED BARRIER PRECAUTIONS Review of Resident #28's medical record occurred on all days of survey. The current care plan stated, "I am on enhanced barrier precautions r/t [related to] indwelling device: Tracheostomy, G-Tube, and a history of a MDRO. . . . Use appropriate PPE when providing high levels of ADLs [activities of daily living]. . . ." Observation on 06/12/24 at 8:52 a.m. showed a nurse (#5) gathered supplies to complete Resident #28's G-tube dressing change. The nurse donned gloves, and without donning a gown, removed the soiled G-tube dressing, cleansed the G-tube site with warm soapy water, removed his/her gloves, performed hand hygiene, donned new gloves, and emptied the basin. The nurse (#5) then donned a gown and acknowledged he/she forgot to apply it earlier and continued with cares. Observation on 06/12/24 at 11:21 a.m. showed a	F 880	gown use during indwelling device care or use. As of 7/18/24, education will be provided to all nursing staff on staff and resident hand hygiene and proper glove use procedures. As of 7/18/24, education will be provided to all nurses on face shield use with enhanced barrier precautions and gown use with G-tube dressing changes. 4. A total of three audit tools have been developed to ensure compliance with F880. The first tool ensures proper staff hand hygiene and glove removal. The second tool has been developed to ensure staff assist with/offer hand hygiene to residents after toileting/ostomy cares. The third audit tool has been developed to ensure that while performing trach cares the nurse will wear a face shield and while performing G-tube site care a gown will be worn. 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. 5. Compliance will occur on or before July 18th, 2024.	

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F 880	Continued From page 9	F 880		

nurse (#5) performed tracheostomy cares for Resident #28. During the cares, the resident began to cough and expelled mucus through the cannula (tube inserted into the tracheostomy hole) across the foot of his/her bed. The nurse (#5) failed to apply face protection before providing tracheostomy cares.

During an interview on 06/12/24 at 3:18 p.m., an administrative staff member (#1) stated she expected staff to follow enhanced barrier precaution as stated in the facility policy.

HAND HYGIENE

Review of Resident #79's medical record occurred on all days of survey. The record identified a colostomy and dependence on staff for colostomy cares.

Observation on 06/10/24 at 12:50 p.m. showed a certified nurse aide (CNA) (#7) performed colostomy cares for Resident #79. The resident periodically assisted the CNA by touching/positioning the colostomy bag and the graduate the bowel emptied into. After completing the cares, the CNA removed his/her gown and gloves and performed hand hygiene. The CNA failed to offer/provide hand hygiene to Resident #79.

Observation on 06/11/24 at 11:22 a.m. showed a CNA (#2) performed incontinence cares for Resident #43 after a bowel movement. The CNA (#2) transferred the resident to a recliner, unhooked the leg straps and the mechanical lift sling, collected the garbage, and then removed the soiled gloves and performed hand hygiene.

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F 880	Continued From page 10 During an interview on 06/12/24 at 3:18 p.m., an administrative staff member (#1) confirmed she expected staff to provide Resident #79 hand hygiene after the colostomy cares and expected staff to remove gloves and perform hand hygiene after incontinence cares.	F 880		