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 _____	06/22/2023

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 06/19/23 and concluded 06/22/23.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		7/27/23

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

Electronically Signed | 07/10/2023

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F 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to ensure the completion of the Centers for Medicare/Medicaid Services (CMS) Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form CMS-10055 for 1 of 2 residents (Resident #78) discharged from Medicare Part A services who remained in the facility. Failure to ensure the resident and/or resident representative received all available options for care and the option to appeal the termination of coverage has the potential to hinder the residents' right to an expedited review of a service termination. Findings include:	F 582	1. On 6/21/23, facility representative re-confirmed via phone call resident #78 representative's wishes regarding Medicare Part A coverage. 2. Facility has identified that all residents discharging from Medicare part A coverage have the potential to be affected by this practice. 3. As of 7/20/23, education will be provided to nursing leadership and business office team members to ensure the proper completion of forms prior to a resident's discharge from Medicare part A services. 4. An audit tool has been developed to ensure residents receive the Notice of Non-Coverage Form, all available options	

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F 582	Continued From page 2 Review of the Medicare Part A letters/notices for Resident #78 occurred the afternoon of 06/21/23 and identified the facility provided the SNFABN form to Resident #78's representative on 03/21/23. The facility failed to obtain documentation of the resident's wishes for continued services and/or the option to appeal the termination of Medicare Part A coverage prior to termination of Medicare Part A coverage on 03/25/23. During an interview on 06/21/23 at 3:05 p.m., a business office staff member (#1) confirmed staff failed to obtain the resident/resident representative option on the SNFABN form for Resident #78.	F 582	for care, and the option to appeal the termination of coverage. The audit tool will be completed by the Business office manager 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 27, 2023	
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify a resident's history of trauma, and/or triggers for 1 of 3 sampled residents (Resident #26) reviewed for Post-Traumatic Stress Disorder (PTSD) and/or Trauma. Failure to identify a resident's history of trauma, and/or triggers may cause re-traumatization.	F 699	1. As of 6/22/23, Resident #26 trauma assessment was completed and care plan was updated to reflect the current care needs. 2. Facility has identified that all residents with a history of trauma have the potential to be affected by this practice. 3. Education and review of the trauma	7/27/23

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F 699	Continued From page 3 Findings include: Review of the facility policy and procedure titled "Trauma Informed Care" occurred on 06/21/23 at 2:04 p.m. This policy/procedure dated November 2019, stated, ". . .The facility will account for residents' experiences, preferences, and cultural differences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. . ." Review of Resident #26's medical record occurred on all days of survey and identified a diagnosis of PTSD. The record lack documentation of an assessment and the development of a plan of care that identified the resident's history of trauma, and/or potential triggers which may cause re-traumatization. During an interview on 06/21/23 at 10:21 a.m. an administrative staff member (#5) confirmed the facility failed to address Resident #26's PTSD and/or trauma diagnosis and potential triggers.	F 699	informed care policy was provided to all care managers and nurse managers at IDT team meeting on 7/10/23. 4. An audit tool has been developed to ensure trauma informed care policy is followed. 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 27, 2023.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		7/27/23

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F 761	Continued From page 4 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications for 1 of 2 medication carts (Friendship Unit) observed during medication storage review. Failure to correctly label an insulin pen increases the risk of the wrong resident receiving the insulin. Finding include: Review of the facility policy titled "Insulin Pen" occurred on 06/22/23. This policy, dated February 2018, stated, ". . . Insulin pens must be clearly labeled with the resident name. . . ." Observation of the medication cart on the Friendship Unit with staff nurse (#7) occurred on 06/21/23 at 4:36 p.m., and showed the following insulin pen for Resident #18: * Basaglar Kwik pen [a long acting insulin], displayed a label with only the first name visible.	F 761	1. As of 6/21/23, Resident #18's insulin pens are accurately labeled. 2. Facility has identified that all residents in facility receiving insulin pens from the VA and alternative pharmacies have the potential to be affected by this practice. 3. Facility has implemented a process change to label Insulin pens received from the VA and alternative pharmacies upon delivery to ensure accurate labeling. As of 7/20/23, education will be provided to all nursing staff who handle insulin pens with the updated policy and procedure. 5. An audit tool has been developed to ensure resident insulin pens are labeled accurately. 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	

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F 761	Continued From page 5 During an interview on 06/21/23 at 5:50 p.m., two administrative nurses (#4 and #6) confirmed the insulin pen failed to contain the full name of Resident #18.	F 761	committee to ensure compliance is achieved and sustained. 6. Compliance will occur on or before July 27, 2023.	
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, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		7/27/23

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F 880	Continued From page 6 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 and review of facility	F 880	1. On 6/21/23, Nurse manager was made	

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F 880	Continued From page 7 policy, the facility failed to follow standards of infection control for 1 of 1 sampled resident (Resident #46) observed during personal cares and application of a dressing. Failure to follow infection control practices regarding hand hygiene during cares and dressing application has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy and procedure titled "Hand Hygiene" occurred on 06/22/23. This policy/procedure, dated December 2017, stated, "Procedure: Hand hygiene is to be performed: . . . h) After removing gloves. . . ." Review of the facility policy and procedure titled "Dressing Change: Nonsterile" occurred on 06/22/23. This policy/procedure, dated June 2023, stated, ". . . Procedure: . . . 2. Assemble all equipment in apartment [resident room]. 3. Establish clean field for dressing change. . . . 5. Perform hand hygiene and apply and change gloves as appropriate during procedure. . . ." Observation on 06/20/23 at 9:10 a.m. showed a certified nurse aide (CNA) (#2) performed morning cares for Resident #46. The CNA (#2) changed gloves while providing care but failed to complete hand hygiene before donning clean gloves. When the CNA (#2) completed the resident's cares and cleaned up the supplies removed her gloves. Without performing hand hygiene, the CNA (#2) handed Resident #46, the phone, bed controls, call light, moved the overbed table, and handed the resident a drink,	F 880	aware of the failure to comply with standards of practice with glove removal and hand hygiene, along with an observation of failure to provide a clean surface for clean wound care supplies. On 6/22/23, the nurse manager educated nursing staff on that unit with the proper procedure to perform hand hygiene after glove removal and in between glove changes. Education was provided to nurses to have a clean field for dressing supplies to prevent contamination. 2. Facility has identified that all residents have the potential to be affected by this practice. 3. As of 7/27/23, education will be provided to all facility staff on hand hygiene and proper glove use procedures. As of 7/27/23, education and skills training on wound/dressing procedure will be provided to all nursing staff. 4. An audit tool has been developed to ensure proper hand hygiene after glove removal. 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. An additional audit tool has been developed to ensure that while performing dressing changes, a clean surface is provided for dressing supplies. 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	

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F 880	Continued From page 8 which the resident drank. The CNA (#2) failed to perform hand hygiene after and before performing other tasks. During this same observation, the nurse (#3) provided the application of a new dressing to Resident #46's sacral area. The nurse (#3), upon entering the room, set the clean supplies for the dressing on top of the soiled linen hamper. When the CNA (#2) finished, the nurse (#3) moved the supplies to the bedside stand. The nurse (#3), working from the bedside stand, donned gloves, cleansed the skin with sterile saline and gauze, removed gloves, donned clean gloves, and applied the foam dressing. The nurse (#3) failed to set up a clean field and failed to perform hand hygiene between glove changes.	F 880	ensure compliance is achieved and sustained. 5. Compliance will occur on or before July 27th, 2023.	