STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - ST RAPHAEL	**979 CENTRAL AVE N , VALLEY CITY, North Dakota, 58072**

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F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 09/22/25 and concluded 09/24/25. During the complaint investigation, the facility was found compliant with regulatory requirements.	F0000		10/06/2025
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of temperature logs, review of professional reference, and staff interview, the facility failed to store food in accordance with professional standards for food service safety in 1 of 1 main kitchen and 6 of 7 food storage areas (Third Floor Kitchenette, First Floor Kitchenette, First Floor Sub-station, Special Care Unit, Sunshine Kitchenette, and Circle of Life Cottage Kitchenette). Failure to	F0812	F812 – Food Safety Requirements 9/24/2025 All improperly stored or handled food items were discarded. 9/24/2025 Grate in storage area, Microwaves, toasters and drawers were cleaned and sanitized. 9/24/2025 All Staff working were re-educated verbally on proper food safety protocols. 9/24/2025 Thermometer was replaced in refrigerators in SCU. 9/24/2025 A local heating and cooling company inspected pipe in storage area, with plan to repair the week of 10/6/2025. All stored food was removed from bottom shelf of storage area to prevent contamination. 9/30/2025 Food Safety Policy updated. 10/2/2025 all kitchenettes were audited and education provided to staff working on proper cleaning of microwaves, toasters and drawers and fridge/freezer temperatures and recording of temps to the temperature logs.10/7/2025 all kitchenettes were audited and staff working were educated regarding cleaning and sanitizing, proper labeling of food and removal of expired food. 10/7/2025 Nursing was educated regarding not storing leftover food from meals in the kitchenette refrigerators. 10/8/2025 all kitchenette refrigerators/freezers thermometers were replaced with new ones. Labels have been purchased for proper labeling of all foods stored in all refrigerators. 10/8/2025 will discuss with a local heating and cooling company to have fans in coolers placed on a maintenance program twice a year or when needed. No residents were affected by this practice. The facility has identified that all residents in the facility have the potential to be affected. All dietary and food service staff will receive mandatory training on:	10/29/2025

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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F0812 SS = E	Continued from page 1 discard expired food, ensure required refrigerator temperatures, ensure functioning of temperature monitoring devices in refrigerator, ensure clean equipment, and ensure protection of dry food storage from leaking pipes has the potential to affect the quality and safety of food served to the residents. Findings include: Review of the Food and Drug Administration (FDA) Food Code 2022, Annex 3 - Public Health Reasons, states . . . Ready-to-Eat, Time/Temperature Control for Safety Food . . . Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microbes. . . ready-to-eat, time/temperature control for safety food . . . kept at 41 degrees Fahrenheit a total of 7 days. Food which is prepared and held, or prepared, frozen, and thawed must be controlled by date marking to ensure its safety based on the total amount of time it was held at refrigeration temperature . . . Time/temperature control for safety refrigerated foods must be consumed . . . or discarded by the expiration date.. . . Manufacturer’s use-by dates . . . Manufacturers assign a date to products for various reasons, and spoilage may or may not occur before pathogen growth renders the product unsafe. . . . the manufacturer's use-by date is its recommendation for using the product while its quality is at its best. Although it is a guide for quality, it could be based on food safety reasons. It is recommended that food establishments consider the manufacturer’s information as good guidance to follow to maintain the quality (taste, smell, and appearance) . . . . If the product becomes inferior quality-wise due to time in storage, it is possible that safety concerns are not far behind . . . Food Storage. . . . FOOD shall be protected from contamination by storing . . . (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . . . FOOD may not be stored: . . . (G) Under leaking water lines . . . (I) Under other sources of contamination. . . . Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate and drafts of unfiltered air can be sources of microbial contamination for stored food. . . . Temperature Measuring Devices. A permanent temperature measuring device is required in any unit storing time/temperature control for safety food because of the potential growth of pathogenic	F0812	Continued from page 1 Refrigerator/freezer temperature monitoring and temperature log recording process. Labeling, dating, and proper discarding of all food items. Proper cleaning of equipment, maintenance of storage areas, and proper cleaning of all kitchenettes. Training will be completed by 10/9/2025 On 10/15/2025 all facility staff will be educated. Facility policies on food safety and sanitation will be reviewed and updated to align with CMS guidelines and FDA Food Code standards. An audit tool has been developed to ensure compliance with food safety requirements. Audit tool will be completed by Director of Food and Nutrition Services or designee 1 X week for 3 months and then monthly going forward added to monthly kitchen inspection. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. Compliance will occur before or on 10/29/2025. Ongoing education will be provided during monthly staff meetings and in-service training. Corrective actions will be taken immediately if audit findings indicate non-compliance.	10/29/2025

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F0812 SS = E	Continued from page 2 microorganisms should the temperature of the unit exceed Code requirements. . . ." Observation with an administrative dietary staff member (#3) occurred on 09/24/25 at 11:15 a.m. and showed the following: Main Kitchen: * Walk-in cooler - a black substance on the grates of the fan and around the outside of the fan. * A black pipe on the ceiling in the dry storage room dripping liquid on the floor next to a rack of food. Third Floor Kitchenette: * Turkey sandwich dated 09/13/25 (expired 11 days prior) * Hard boiled eggs dated 09/12/25 (expired 12 days prior) * Sliced cheese dated 09/15/25 (expired 9 days prior) * Thickened water dated 08/25 and 09/15 (expired 30 days and 9 days prior) * Cheese slices in a plastic bag dated 08/26 (expired 29 days prior) * Shredded American cheese in a plastic bag dated 09/15/25 (expired 9 days prior) * Shredded cheese in a plastic bag dated 09/01/25 (expired 23 days prior) Special Care Unit Kitchenette: * Refrigerator- 52 degrees Fahrenheit * Review of the refrigerator log showed a temperature of 44 degrees Fahrenheit on the morning of 09/24/25 that morning. An unidentified kitchen staff member stated he had not been in the refrigerator recently. Circle of Life Cottage Kitchenette: * Cheese slices in a plastic bag dated 09/01/25 (expired 23 days prior) * Seven yogurt cups with an expiration date of	F0812		10/29/2025

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F0812 SS = E	Continued from page 3 09/16/25 (expired 8 days prior) The administrative dietary staff member (#3) threw the expired food away. Sunshine Kitchenette: * A broken and unreadable refrigerator thermometer. Review of the refrigerator/freezer log showed staff failed to log temperatures since 08/16/25. * Silverware drawer with several crumbs scattered throughout the drawer. First Floor Kitchenette: * Microwave with pieces of cooked eggs on the inside and side wall. * Toaster with numerous scattered crumbs on the top First Floor Substation: * Microwave with food debris inside The administrative dietary staff member (#3) stated she expected staff to discard expired foods and stated their policy is to discard after five days.	F0812		10/29/2025
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	F0880	F880 Infection Prevention and Control 9/24/2025, all CNAs and Nurses that were working with residents were given verbal education on infection prevention related to Hand Hygiene, glove use with perineal care, and proper glove use with dressing changes. No residents were affected by this practice. The facility has identified that all residents in the facility who require assistance with ADLs and dressing changes have the potential to be affected. Audits were performed on CNAs and nurses on infection prevention related to Hand Hygiene and glove use while performing ADL cares and dressing changes on residents starting on 9/24/2025 and will continue weekly. Education in weekly CNA Huddles started and will continue. CRA supervisors will	10/29/2025

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F0880 SS = D	Continued from page 4 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. §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.	F0880	Continued from page 4 continue to educate staff through 1:1 visit after audits with concerns. On 9/25/2025 at Monthly CNA meetings CNAs were educated on infection prevention related to Hand Hygiene and glove use during perineal cares. 9/24/2025 Nurses on 2nd floor were verbally educated on proper glove use when performing dressing changes. 10/7/2025 Clean Dressing Change policy was sent out to all nursing staff to review. 10/7/2025 Audits of nurses performing dressing changes started and will occur weekly On 10/15/2025 all facility staff will be educated. An audit tool has been developed to ensure compliance. Audit tool will be completed by Director of Nursing or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for a total of 12 months. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. Compliance with infection prevention protocols is expected to be achieved and sustained by 10/29/2025, as verified through audit results and staff education completion. Ongoing education will be provided during monthly staff meetings and in-service training. Corrective actions will be taken immediately if audit findings indicate non-compliance.	10/29/2025

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F0880 SS = D	Continued from page 5 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 2 of 7 sampled residents (Resident #16 and #73) observed during cares. Failure to remove gloves and perform hand hygiene during wound care and perineal care has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Glove Usage" occurred on 09/24/25. This policy, revised November 2018, stated, "Purpose: To reduce the risk of exposure, prevent the spread of infection, identify situations where usage of gloves is appropriate and incorporating proper usage of gloves. . . Procedure: . . . 2. Once gloves are contaminated, they must be changed before touching clean items or proceeding to perform clean procedure. . .. 7. Hand hygiene must be performed prior to gloving and after removing gloves. . . ." Review of the facility policy titled "Hand Hygiene" occurred on 09/24/25. This policy, revised September 2023, stated, "Purpose: . . . Hand hygiene . . . an effective method for preventing the spread of pathogens, such as bacteria and viruses, which cause infections. . .. Condition: Hands are visibly soiled with blood or other body fluids. . . After handling contaminated objects. . . Before and after handling clean or soiled dressing. . ." -Observation on 09/23/25 at 9:39 a.m. showed the nurse (#1) performed a dressing change for Resident #73. The nurse applied personal protective equipment (PPE), a gown and gloves and entered the resident's room. The nurse removed a soiled abdominal (ABD) pad from the left hip of Resident #73. Without removing her gloves, the nurse (#1) cleaned the area with wound cleanser, placed a new ABD, and applied tape. The nurse (#1) then removed the gown and gloves and washed her hands. The nurse failed to remove gloves, perform hand hygiene, and apply new gloves prior to applying the clean dressing. -Observation on the afternoon of 9/23/2025 showed two certified nurse aides (CNAs #2 and #5) applied	F0880		10/29/2025

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F0880 SS = D	Continued from page 6 gowns and gloves and transferred Resident #16 from the wheelchair to the bed using the mechanical lift. The CNA (#2) wore gloves and completed Resident #16's perineal care after a soft bowel movement. With the same gloves, the CNA reached into a container of ointment and applied it to the resident's bottom, fastened the new brief, pulled up his pants, opened up a drawer to retrieve a bandana and placed it by the resident's mouth. The CNA (#2) removed her gown, and with same gloves still on plugged in a pump, tied a garbage bag, lowered the bed, turned the television on, took the pillowcase off the resident's neck pillow, tied a garbage bag, and then removed gloves and performed hand hygiene. The CNA (#2) failed to remove gloves and perform hand hygiene after perineal care and prior to doing other tasks in the resident's room. During an interview on the afternoon of 09/24/25, an administrative nurse (#4), confirmed staff should remove gloves and performed hand hygiene after removing a soiled dressing and after performing perineal cares.	F0880		10/29/2025