STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smp Health - St Catherine North	1351 N Broadway Fargo, ND 58102

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40488 Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 7 residents (Resident #97 and #110) observed during medication administration. Two medication errors occurred during staff administration of 28 medications, resulting in a seven percent error rate. Failure of staff to properly prepare and administer medications may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled Medication Administration occurred on 10/17/24. This policy, dated 10/07/24, stated, . Medications are administered . as ordered by the physician and in accordance with professional standards of practice . Policy Explanation and Compliance Guidelines . Compare medication source . with MAR [medication administration record] to verify . dose . Administer medication as ordered in accordance with manufacturer specifications. Prescribing information found at https://www.drugs.com/pro/depakote.html, page 2, stated, . Depakote is administered orally in divided doses. Depakote should be swallowed whole and should not be crushed or chewed . and page 63, stated, . Depakote Sprinkle Capsules may be swallowed whole, or the capsule may be opened and the contents may be mixed into a small amount of soft food, such as applesauce or pudding. - Review of Resident #97's medical record occurred on 10/16/24. A physician's order, dated 07/03/24, stated. Meclizine HCl Oral Tablet . Give 25 mg [milligrams] . for Vertigo . Observation on 10/16/24 at 8:36 a.m., showed a medication aide (MA) (#3) prepared Resident #97's medications for administration. The MA referred to the resident's MAR, obtained a bottle of meclizine from the medication cart, dispensed one pill from the bottle, and placed the pill in a medication cup along with the resident's other scheduled medications. When asked to confirm the dosage of the meclizine, he/she prepared and dispensed into the cup, the MA again referred the Resident #97's MAR and compared the dosage listed on the pill bottle (which listed 12.5 mg per tablet). The MA confirmed he/she should have dispensed two meclizine pills from the bottle to equal the ordered dose of 25 mg. - Review of Resident #110's medical record occurred on all days of survey. A physician's order, dated 05/01/24, stated, Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG . Give 2 capsule by mouth three times a day . Okay to open . (continued on next page)

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 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smp Health - St Catherine North	1351 N Broadway Fargo, ND 58102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/16/24 at 1:30 p.m. showed a staff nurse (#4) dispensed two Depakote Sprinkle capsules from Resident #110's medication card, placed the capsules into a cup along with other scheduled medications, poured the medications from the cup into a plastic sleeve, and crushed the medications. The nurse then poured the crushed contents into applesauce and administered the medications to Resident #110. The nurse (#4) failed to follow manufacturers prescribing instructions and crushed the Depakote Sprinkle delayed release capsules. During an interview on 10/16/24 at 3:41 p.m., an administrative staff member (#5) confirmed Depakote Sprinkles should not be crushed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. Building B. Wing	10/17/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40488 Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 or 1 sampled resident (Resident #110) with a significant medication error. Failure of staff to administer medications per manufacturer recommendations may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled Medication Administration occurred on 10/17/24. This policy, dated 10/07/24, stated, . Medications are administered . as ordered by the physician and in accordance with professional standards of practice . Administer medication as ordered in accordance with manufacturer specifications. Prescribing information found at https://www.drugs.com/pro/depakote.html, page 2, stated, . Depakote should be swallowed whole and should not be crushed or chewed . Page 63, stated, . Depakote Sprinkle Capsules may be swallowed whole, or the capsule may be opened and the contents may be mixed into a small amount of soft food, such as applesauce or pudding. - Review of Resident #110's medical record occurred on all days of survey. A physician's order, dated 05/01/24, stated, Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG . Give 2 capsule by mouth three times a day . Okay to open . Observation on 10/16/24 at 1:30 p.m. showed a staff nurse (#4) dispensed two Depakote Sprinkle delayed release capsules from Resident #110's medication card, placed the capsules into a cup along with other scheduled medications, poured the medications from the cup into a plastic sleeve, and crushed the medications. The nurse then poured the crushed contents into applesauce and administered the medications to Resident #110. The nurse (#4) failed to follow manufacturers prescribing instructions and crushed the Depakote Sprinkle capsules. During an interview on 10/16/24 at 3:41 p.m., an administrative staff member (#5) confirmed Depakote Sprinkles should not be crushed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 13101 Based on observation, review of facility policy/procedure, review of manufactures' label, and staff interview, the facility failed to date time sensitive thickened beverages with an opened date and to store food in a sanitary manner in 2 of 8 unit kitchenettes (3 South and 3 North). Failure to label beverages with an open date may compromise the safety and quality of the item and failure to store food in a sanitary manner can affect safety. Findings include: Review of the facility policy/procedure titled Storage of multi-use ice pack in freezers, occurred on 10/17/24. This policy, dated 07/16/24, stated . 2. Separation of Ice Packs and Food: a) Ice packs may be stored in the same freezer as food but must not be in direct contact with any food items. Ice packs should be stored on separate shelves or in containers that keep them distinct from food products. b) If separate shelves are not available, ice packs must be placed in a way to prevent them from touching food. Observations of the main kitchen and unit kitchenettes occurred on 10/16/24 at 1:45 p.m. with two administrative staff members (#1 and #2) and showed the following: - Three South kitchenette refrigerator, contained an undated opened container of thickened juice, the product label stated use within 10 days of opening. The freezer compartment contained an ice pack not separated from food items. - Three North kitchenette freezer, contained two ice packs not separated from food items. The facility staff failed to store ice packs on separate shelves from food items or in a distinct container. During the observation, an administrative staff member (#2) stated, she expected ice packs to be stored in a plastic bag. The administrative staff member (#1) disposed of the unlabeled juice and confirmed it should be dated when opened.