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	02/11/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure physician's orders were followed for 3 of 24 sampled residents (Resident #71, #107, and #124). Failure to follow physician orders for medication administration, and application of compression socks and ace wraps, may result in adverse health effects for the residents. Findings include: Review of professional standards included: [NAME], [NAME], and Frandsen's Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, . Carrying Out a Physician's Orders . If the order is neither ambiguous not apparently erroneous, the nurse is responsible for carrying it out. -Review of Resident #71's medical record occurred on all days of survey. A physician's order, dated 12/30/25, stated, . Beige knee high [NAME] compression [socks] . on in AM [morning] off HS [at bedtime] edema [swelling] . Resident #71's current care plan failed to identify the use of [NAME] compression socks. Observations of Resident #71 on 02/09/2026 at 12:46 p.m. and 02/10/26 at 10:02 a.m., showed facility staff failed to apply the compression socks. During an interview on 2/11/26 at 5:13 p.m., an administrative nurse (#1) confirmed staff failed to apply Resident #71's compression socks and update Resident #71's care plan. -Review of Resident #107's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and dysphagia (swallowing impairment). A physician's order, dated 06/27/18, stated, CRUSH MEDICATIONS in pureed. A quarterly Minimum Data Set (MDS), dated [DATE], identified, Coughing or choking during meals or when swallowing medications. Observation of Resident #107 identified the following: *02/10/26 at 9:45 a.m. a medication aide (MA) (#6) carried a clear medicine cup containing several whole pills into the resident's room. The MA exited the room with the pills and stated the resident refused to take them. *02/10/26 at 11:10 a.m. a nurse (#3) readministered the morning medications crushed in pudding and stated, I am readministering resident 's a.m. medications crushed in pureed per physician orders due (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to [CMA #6] had attempted to administer medications whole and resident spit them out. The CMA (#6) failed to follow the physician's order to crush Resident #107's medications for administration. - Review of Resident #124's medical record occurred on all days of survey. A physician's order, dated 02/06/26, stated ACE wrap to R [right] upper extremity, on in AM & [and] off HS one time a day for lymphedema [tissue swelling] and remove per schedule. The electronic medication administration record (EMAR) for February 2026 identified the Ace wrap on at 8:00 a.m. and removed at 10:00 p.m. Observations on 02/09/2026 at 11:16 A a.m., 2:00 p.m., and 4:30 p.m., and 02/10/26 at 10:00 a.m. and 1:32 p.m., showed no ace wrap on Resident #124's right arm. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of care for 1 of 1 supplemental resident (Resident #115) observed during administration of rapid-acting insulin. Failure to administer rapid-acting insulin within 5 to 10 minutes of a meal may result in a hypoglycemic (low blood sugar) reaction. Findings include: Review of the facility policy titled Diabetic Protocol occurred on 02/11/26. This policy, dated September 2017, stated, Administration of Rapid/Short Acting Insulin: a. Must be given 5-10 minutes before mealtime. If given to [sic] early a hypoglycemic episode could occur. Review of Resident #115's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. Observation on 02/10/26 at 4:00 p.m., showed a nurse (#11) administered 18 units of Novolog insulin (rapid-acting insulin) to Resident #115 per physician's order and left the room. The resident went by herself to the dining room, arrived at 4:15 p.m., and received the meal tray at 4:40 p.m., 40 minutes after receiving Novolog insulin. During an interview on 02/11/26 at 2:02 p.m., an administrative nurse (#1) confirmed a beverage, juice, or small snack should be given within 10 minutes of administering rapid-acting insulin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 17 sampled residents (Resident #11, #57, and #107) and 1 supplemental resident (Resident #81) observed during cares. Failure to practice infection control standards related to disinfecting shared equipment, glove changes, and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 02/11/26. This policy, dated 01/17/18, stated, . Hand hygiene is performed: . Before and after direct resident contact . Before and after assisting a resident with toileting . After removing gloves . Review of the facility policy titled Standard Precautions occurred on 02/11/26. This policy, dated 03/24/18, stated, . All health care workers will routinely use appropriate precautions to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. Gloves are to be removed: 1. Promptly after use. 2. before touching non-contaminated items or surfaces. Hand hygiene is always performed after glove removal. Review of the facility policy titled Clean Dressing Change occurred on 02/11/26. This undated policy, stated, . It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Wash hands and put on clean gloves. remove the existing dressing. Remove gloves . wash hands and put on clean gloves. cleanse the wound as ordered . Wash hands and put on clean gloves. dress the wound as ordered. Review of the facility policy titled Isolation Precautions (Transmission-based-precautions) occurred on 02/12/26. This policy, revised 11/22/21, stated, . When possible, dedicate the use of noncritical equipment and items such as stethoscope, sphygmomanometer [blood pressure cuff], thermometer to the resident during the infectious process. If use of common equipment is unavoidable, clean and disinfect surfaces and/or items before us on another resident. -Review of Resident #107's medical record occurred on all days of survey. The care plan stated. I have tested positive for COVID-19 on 2/3/2026. Follow droplet isolation precautions. Observation on 02/10/26 at 9:45 a.m. showed a sign on Resident #107's door that identified airborne contact precautions and a cart containing appropriate personal protective equipment (PPE) supplies outside the room. A medication aide (MA) (#6) entered the room with an electronic vitals machine. Upon exiting the room, the MA (#6) wiped down the BP cuff and cord and the top of the vitals machine but failed to wipe down the entire machine. During an interview on 02/10/2026 at 9:52 a.m., an administration nurse (#1) confirmed the vitals machine should not be taken into the COVID transmission-based room, and if taken into the room, would need to be sanitized top to bottom. Observation on 02/10/26 at 10:15 a.m. showed a facility nurse (#7) prepare to enter resident's room to confirm Resident #107 had designated equipment for taking vitals. Upon exiting the resident's room, the facility nurse (#7) did confirm the designated equipment was in Resident #107's room for use and also stated he/she had cleaned and disinfected the electronic vitals machine used in Resident #107's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room earlier and clarified he/she had disinfected the machine top to bottom. - Observation on 02/10/26 at 10:50 a.m. showed two certified nurse aides (CNAs) (#4 and #5) assisted Resident #11 to the shower room. The CNA (#4) applied one glove and disinfected the toilet seat and grab bars with a disinfecting wipe. The CNA (#4) removed the soiled glove, and without performing hand hygiene touched hygiene items on a storage cupboard. Both CNAs (#4 and #5) applied gloves, placed a gait belt on Resident #11, and transferred the resident to the toilet. The CNA (#5) performed perineal cares, adjusted the resident's clothing and then both CNAs transferred Resident #11 to the wheelchair. The CNA (#5) removed the soiled gloves and without performing hand hygiene, exited the bathroom to retrieve wheelchair foot pedals. The CNA (#5) returned to the shower room with the foot pedals and applied them to the wheelchair. The CNA (#4) removed her soiled gloves, both CNAs performed hand hygiene, and assisted Resident #11 from the shower room to his room. Both CNAs (#4 and #5) failed to perform hand hygiene before assisting the resident with toileting. The CNA (#4) failed to perform hand hygiene after removing gloves and before touching the other items in the shower room. The CNA (#5) failed to perform hand hygiene after removing gloves and before exiting the shower room. - Observation on 02/10/26 at 12:12 p.m. showed an enhanced barrier precaution sign on Resident #57's door and the resident lying in bed. The nurse (#3) entered the room, performed hand hygiene, applied a gown and gloves, and placed dressing change supplies on the over the bed table. The nurse (#3) removed the soiled dressing, removed the soiled gloves, and without performing hand hygiene applied clean gloves. The nurse cleansed Resident #57's wound with wound wash, removed the soiled gloves, and without performing hand hygiene, applied clean gloves, placed treatment medications in the wound bed, covered the wound with border foam dressing, and without removing the soiled gloves, adjusted the resident pants, placed pillows under the resident's legs, covered the resident with a blanket, and turned off the overbed light. The nurse (#3) removed the soiled gown and gloves, performed hand hygiene, collected the garbage and exited the room. The nurse (#3) failed to perform hand hygiene after removing soiled gloves and before applying clean gloves during the dressing change, failed to remove soiled gloves and perform hand hygiene before touching other items. -Observation on 02/11/26 at 4:15 p.m. showed Resident #81 in bed. A CNA (#9) and a nurse (#10) entered the room and applied gloves. The CNA (#9) removed the resident's soiled brief, performed perineal cares, and without removing the soiled gloves or performing hand hygiene, applied a clean brief, adjusted Resident #81's dress and blanket, removed the soiled gloves and without performing hand hygiene, exited the room. The nurse (#10) removed the soiled gloves, assisted the CNA (#9) to reposition Resident #81's dress, placed a pillow between the resident's legs, adjusted the blankets, and without performing hand hygiene, exited the room. The CNA (#9) failed to remove the soiled gloves and perform hand hygiene prior to touching other items and before exiting the room. The nurse (#10) failed to perform hand hygiene after removing soiled gloves, after touching soiled items, and before exiting the room. During an interview on 02/11/26 at 12:49 p.m., an administrative nurse (#1) confirmed she expected staff to perform hand hygiene after removing gloves and prior to touching other items or applying new gloves.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 2 of 5 sampled residents (Resident #6 and #11) selected for medication review. Failure to attempt a gradual dose reduction (GDR) or identify contraindications for a GDR may result in residents receiving unnecessary medications and experiencing adverse consequences related to their use.Findings include: Review of the facility policy titled Drug Regimen Review occurred 02/11/26. This policy, dated 06/09/23, stated, . The consultant pharmacist will provide a written review for each resident on an antipsychotic . antidepressant . The review will evaluate dose, duration, continued need, and emergence of adverse side effects. This information will be used to assist in assessment of effectiveness of drug therapy regimens. Medication tapering should be attempted when the resident's clinical condition has improved or stabilized or the underlying cause of the symptoms has resolved . Tapering of antipsychotic [sic] should be attempted at least once in the first year followed by a 2nd attempt in a subsequent quarter that same year unless clinically contraindicated. After the 1st year tapering should be attempted once a year. The physician must document the clinical rationale for why additional attempts at dose reduction would impair the resident's function. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included schizoaffective disorder, psychosis and depression. The current physician's orders included Lurasidone, an antipsychotic medication, daily since 7/17/2024. The medical record lacked documentation to show the provider attempted a GDR or reasons why a GDR would be contraindicated from 2024 through February of 2026. - Review of Resident #11's medical record occurred on all days of survey. Diagnoses included Parkinson's Disease, dementia, and depression. The current physician's orders identified Sertraline, an antidepressant medication, daily since 11/14/24. The medical record lacked documentation to show the provider attempted a GDR reasons why a GDR would be contraindicated from November 2024 to February of 2026. During an interview on 2/11/26 at 5:45 pm, an administrative nurse (#1) confirmed Resident #6 and #11's medical records lacked a gradual dose reduction.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review, review of the North Dakota Provider Manual Preadmissions Screening and Resident Review (PASARR), Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #13) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness and new medication may result in the delivery of care and services inconsistent with residents' needs. Findings include:The North Dakota PASARR Provider Manual revised December 2020 stated, . Change in Status Process . Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered.Review of Resident #13's medical record occurred on all days of survey and identified the following: *A PASARR dated 07/17/25, identified diagnoses of major depression, generalized anxiety and panic disorder. Medication for mental health included Mirtazapine (antidepressant).*A progress note dated 11/28/25, stated, Medication/Dx [diagnosis]: Seroquel (antipsychotic) 25 mg [milligrams] at bedtime for paranoia, dx delusional disorder. Target Behavior monitored: Paranoia, delusions, anxiety.Resident #13's medical record lacked evidence the facility completed a PASARR related to the new diagnoses of paranoia, delusional disorder, and new order for Seroquel. During an interview on 02/11/26 at 4:55 p.m. a social services staff member (#8) confirmed the facility failed to complete a change in status Level 1 screen for Resident #13.