

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Smp Health - St Raphael		STREET ADDRESS, CITY, STATE, ZIP CODE 979 Central Ave N Valley City, ND 58072	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from abuse for 1 of 4 sampled residents (Resident #1) who exhibited and/or were subjected to physical abuse by and/or to other residents. Failure to prevent resident to resident physical abuse resulted in pushing, hitting, and kicking and placed all residents at risk for serious injury, pain, mental anguish, and emotional distress. Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation and Misappropriation of Resident Property occurred on 07/07/26. This policy, dated January 2026, stated, . Verbal abuse is defined as any use of oral . communication . that willfully includes disparaging and derogatory terms to residents . within their hearing distance, regardless of their . ability to comprehend . Physical abuse includes, but is not limited to hitting, slapping, punching . Resident-to-Resident Abuse of Any Type . A resident-to-resident altercation should be reviewed as a potential situation of abuse . Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions in these situations . Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with agitation, depression, severe psychotic disorder with delusions, and wandering. The current care plan stated, . I have behaviors s/t [secondary to] dementia. I have a history of elopement attempts, agitation, restlessness, physical aggression, verbal aggression, and barricading. I wander and may enter my peers' room. I sometimes take items and refuse to let them go . Resident #1's progress notes identified the following:* 01/15/26 at 3:46 p.m., . Resident came up to another resident and placed her hands on his arm and was trying to move him or just hang on to him. The other resident then turned and pushed her away from him. She lost her footing and started to twist a little with her left knee/leg. In doing this she fell to the floor with partial assistance from a dietary staff that tried to keep her from falling and kept resident from hitting the floor as hard. She c/o [complained of] her left knee hurting but when asked again she said nothing hurt.* 01/26/26 at 9:40 p.m., . Resident was in the activity room . Another resident started wheeling into her. Staff in the room . stopped the other resident from running into her and as she was being pulled back, she pulled her left leg up and kicked this resident in the right leg.* 01/31/26 at 3:44 p.m., Resident wandering the dining room. Resident walked up to peer, scowled and flicked her in the forehead. Interaction was unprovoked as other resident was sitting quietly at the table. PRN [as needed] hydrocodone given to rule out pain . treat pain as able . * 03/13/26 at 5:44 p.m., . Another resident was standing by her. This resident hit the other resident in the face. * 04/03/26 at 6:53 p.m., . Resident was sitting at a table in the dining room close to another resident. She was seen reaching out and touching one of the toys the other resident had. The other resident swung and hit the resident on the right side of her head. Resident appears to be teary by this and upset.* 04/10/26 at 6:27 p.m., . Resident had walked up to a table and started to (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 0600 Level of Harm - Actual harm Residents Affected - Few	pull out a chair to sit down. Another resident at the table grabbed the chair away from her and pushed it in under the table. Resident started pointing a finger and 'scold' the other resident. The other resident picked up a paperback book and hit this resident in the hand, told her to 'Go Away'. No injuries noted.* 04/19/26 at 8:10 p.m., . Resident walked up to another table next to another resident. The other resident swung and hit this resident in the torso. This resident reciprocated and hit the other resident on top of the head.* 04/30/26 at 6:40 p.m., . Resident was walking in the hallway behind another resident. Resident grabbed the shirt collar of the other resident and pulled, choking the other resident.* 05/01/26 at 10:02 p.m., . 5/1/26 1820 [6:20 p.m.] . [Resident initials] was monitoring resident as she was being intrusive. She turned her attention to another resident, when she looked up [Resident #1] had ahold of the male resident. He grabbed her and pushed her against the wall. [Resident #1] slid down the wall landing on her buttocks with her back resting on the couch.* 05/10/26 at 5:29 p.m., . Resident was done with supper and was leaving the dining room. Came up behind another resident who was eating and punched him in the back of the head and called him a 'damn fool'. Resident . remained very angry. Resident that was punched had no injuries . During interviews on 07/07/26 at 12:45 p.m. and 4:30 p.m., two administrative staff members (#1 and #2) reported they talk about behaviors every morning with social services and the unit managers. They described Resident #1 as trying to annoy the other residents, but not intentionally hurt them. They indicated she can be nice one minute and acting out the next and doesn't target any one person. The facility failed to effectively manage Resident #1's behaviors which resulted in repeated episodes of resident-to-resident abuse.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, review of facility policy, and staff interview, the facility failed to report incidents of abuse to the State Survey Agency (SSA) within the required time frames for 1 of 4 sampled residents (Resident #1) reviewed for resident-to-resident altercations. Failure to ensure potential abuse incidents of abuse are reported immediately to the SA, and no later than 2 hours after the allegation is made, may result in continued abuse, fear, anxiety, and psychosocial harm. Findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation and Misappropriation of Resident Property occurred on 07/07/26. This policy, dated January 2026, stated, . Reporting of all alleged violations to the . state agency . and to all other agencies . within specific time frames . Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, dementia with agitation, depression, severe psychotic disorder with delusions, and wandering. The current care plan stated, . I have behaviors s/t [secondary to] dementia. I have a history of elopement attempts, agitation, restlessness, physical aggression, verbal aggression, and barricading. I wander and may enter my peers' room. I sometimes take items and refuse to let them go . Resident #1's progress notes identified the following:* 01/15/26 at 3:46 p.m., . Resident came up to another resident and placed her hands on his arm and was trying to move him or just hang on to him. The other resident then turned and pushed her away from him. She lost her footing and started to twist a little with her left knee/leg. In doing this she fell to the floor with partial assistance from a dietary staff that tried to keep her from falling and kept resident from hitting the floor as hard. She c/o [complained of] her left knee hurting but when asked again she said nothing hurt.* 01/26/26 at 9:40 p.m., . Resident was in the activity room . Another resident started wheeling into her. Staff in the room . stopped the other resident from running into her and as she was being pulled back, she pulled her left leg up and kicked this resident in the right leg.* 01/31/26 at 3:44 p.m., Resident wandering the dining room. Resident walked up to peer, scowled and flicked her in the forehead. Interaction was unprovoked as other resident was sitting quietly at the table. PRN [as needed] hydrocodone given to rule out pain . treat pain as able . * 03/13/26 at 5:44 p.m., . Another resident was standing by her. This resident hit the other resident in the face. * 04/03/26 at 6:53 p.m., . Resident was sitting at a table in the dining room close to another resident. She was seen reaching out and touching one of the toys the other resident had. The other resident swung and hit the resident on the right side of her head. Resident appears to be teary by this and upset.* 04/10/26 at 6:27 p.m., . Resident had walked up to a table and started to pull out a chair to sit down. Another resident at the table grabbed the chair away from her and pushed it in under the table. Resident started pointing a finger and 'scold' the other resident. The other resident picked up a paperback book and hit this resident in the hand, told her to 'Go Away' . No injuries noted. * 04/19/26 at 8:10 p.m., . Resident walked up to another table next to another resident. The other resident swung and hit this resident in the torso. This resident reciprocated and hit the other resident on top of the head.* 04/30/26 at 6:40 p.m., . Resident was walking in the hallway behind another resident. Resident grabbed the shirt collar of the other resident and pulled, choking the other resident.* 05/01/26 at 10:02 p.m., . 5/1/26 1820 [6:20 p.m.] . [Resident initials] was monitoring resident as she was being intrusive. She turned her attention to another resident, when she looked up [Resident #1] had ahold of the male resident. He grabbed her and pushed her against the wall. [Resident #1] slid down the wall landing on her buttocks with her back resting on the couch.* 05/10/26 at 5:29 p.m., . Resident (continued on next page)		

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