STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smp Health - St Raphael	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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46477 Based on record review and resident and staff interviews, the facility failed to follow the grievance process for 2 of 2 sampled residents (Resident #99 and #133) with concerns regarding treatment from staff during cares. Failure to act upon resident grievances is a violation of resident's rights and may result in resident dissatisfaction. Findings include: The facility failed to provide a policy. - During an interview on 08/05/24 at 1:25 p.m., Resident #133 stated on the night of admission, he/she pushed the call light multiple times. A certified nurse aide (CNA) (#5) came to the doorway and yelled, What the [explicit comment] do you want? This happened again the same night. The resident stated he/she did not want to deal with this CNA again, so he/she took himself/herself to the bathroom for the remainder of the night. When asked if the resident reported the incident to staff, Resident #133 replied, yes. - During an interview on 08/05/24 at 2:36 p.m., Resident #99 stated three weeks ago during the night shift, an unknown CNA came to the doorway and yelled, What do you want? The resident stated he/she felt disrespected. When asked if the resident reported the incident to staff, Resident #99 replied, yes. - During an interview on the afternoon of 08/08/24, administrative staff members (#1 and #2) stated all resident incidents are covered during the management stand up meetings and these incidents were delegated to the unit manager to further review. The staff members reported the staff involved received verbal coaching but failed to follow up with the residents. The facility failed to make a prompt effort to resolve Resident #99 and #133's grievances and keep both residents apprised of progress toward a resolution.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39211 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 residents (Resident #22 and #149) observed for insulin preparation and administrations. Failure to prime insulin pens correctly may result in residents receiving an inaccurate dose. Findings include: Review of the facility policy titled Insulin Pen occurred on 08/08/24. This policy, revised July 2023, stated, . Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. screw the pen needle onto the insulin pen. Twist open and remove the outer cover from the pen needle. H. Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. - Observation on 08/07/24 at 8:08 a.m. showed a nurse (#7) prepared Resident #22's insulin pen for administration. The nurse failed to remove the cover of the needle before priming the insulin pen. - Observation on 08/07/24 at 4:44 p.m. showed a nurse (#8) prepared Resident #149's insulin pen for administration. The nurse failed to remove the cover of the needle before priming the insulin pen. During an interview the morning of 08/08/24, an administrative staff member (#1) stated she expected staff to remove the cover of the needles when priming insulin pens. 46477 2. Based on observation, record review, policy review, and staff interview, the facility failed to transcribe a treatment order accurately for 1 of 1 sampled resident (Resident #133) observed during a dressing change. Failure to accurately transcribe orders may result in residents receiving the wrong treatment and potentially cause adverse effects. Findings include: Review of the facility policy titled Standing Orders occurred on 08/08/24. This policy, dated July 2021, stated, . 1. standing orders must be on PCC [Point click care] MAR [Medication Administration Record] to be implemented. 4. When implementing an order from the standing orders, the nurse will enter it into . MAR . TAR [Treatment Administration Record] accordingly. Observation on 08/06/24 at 10:20 a.m. showed a medication aide (#11) removed a soiled Interdry (antimicrobial dressing) from under Resident #133's abdominal folds and replaced with a clean Interdry after bathing. Review of Resident #133's medical record occurred on 08/07/24. The recorded failed to identify an order for Interdry and instructions for administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/08/24 at 11:00 a.m., an administrative staff member (#1) confirmed the record lack the required information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46477 Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications in 1 of 2 medication carts (Union Square) observed. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled Medication Cart occurred on 08/08/24. This policy, revised 2023, stated, . Medication cart will be locked when not within complete site of the nurse and/or med aid [medication aide] left unattended . Observation on 08/06/24 at 3:47 p.m. showed a staff nurse (#3) left the medication cart unlocked and unattended for 55 minutes. The medication cart remained by the nurses station unlocked and out of the nurses' view with staff members and residents present. During an interview on 08/08/24 at 10:55 a.m., an administrative nurse (#1) confirmed she expected staff to lock the medication cart when out of eyesight.

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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. 39211 Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standards of infection control for 8 of 25 sampled residents (Resident #9, #28, #70, #79, #92, #96, #260, and #360) observed during cares. Failure to follow infection control practices during resident cares related to hand hygiene, glove use, and enhanced barrier precautions (EBP), has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene occurred on 08/08/24. This policy, revised September 2023, stated, . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of care. The use of gloves does not replace hand hygiene. Practice hand hygiene before donning and after doffing gloves. Review of the facility policy titled Skin and Wound Management Program occurred on 08/08/24. This policy, revised June 2024, stated, . Cleaning a Wound and Applying a Dressing . Carefully remove the soiled dressings. Place soiled dressings in the appropriate waste receptacle. Remove your gloves and dispose of them in an appropriate waste receptacle. Perform hand hygiene. Put on gloves . Apply any topical medications, foams, gels, and/or gauze to the wound . Gently place a layer of dry, . or other prescribed cover dressing . Apply tape . Remove and discard gloves. Perform hand hygiene. Review of the facility policy titled Enhanced Barrier Precautions occurred on 08/08/24. This policy, revised June 2024, stated, . Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities. Standing orders will be implemented for enhanced barrier precautions for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and /or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, .) even if the resident is not known to be infected or colonized with a MDRO. make gowns and gloves available immediately in or outside of the resident's room. In general, gowns and gloves would not be required for resident care activities other than those listed below, . Device care or use: . feeding tube . Wound care: any skin opening requiring a dressing . 40489 HAND HYGIENE/GLOVE USE - Observation on 08/06/24 at 3:08 p.m. showed the CNA (#12) assisted Resident #9 who is on enhanced barrier precautions with transferring to the wheelchair from the bed. When completed CNA (#12) removed her gown, gloves and grabbed the resident's blanket and placed on resident's lap. The CNA (#12) pushed Resident #9 out of the room and failed to perform hand hygiene. - Observation on 08/06/24 at 1:12 p.m. showed two CNAs (#4 and #10) assisted Resident #70 with incontinent cares. The CNA (#4) removed her gloves and without performing hand hygiene exited the resident's room with the Hoyer lift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	WOUND CARE - Observation on 08/06/24 at 3:24 p.m. showed the nurse (#3) removed the soiled dressing from Resident 260's foot, removed the soiled gloves, and without performing hand hygiene donned new gloves, applied a clean dressing to the wound, and wrapped the resident's foot with a protective dressing. - Observation on 08/06/24 at 3:24 p.m. showed the nurse (#13) removed the soiled dressing from Resident #360's right knee, cleansed the area with soap and water, and without removing the soiled gloves and performing hand hygiene, applied a clean dressing and a compression sleeve to the wound. - Observation on 08/07/24 at 1:55 p.m. showed the nurse (#7) removed Resident #92's wound dressing. Without removing the soiled gloves and performing hand hygiene, inserted a foam dressing into the wound, secured the outer dressing with tape, and then removed her gloves. During an interview on 08/08/24 at 10:55 a.m., an administrative nurse (#1) confirmed she expected staff to follow policy and procedures for hand hygiene and dressing changes. 46477 ENHANCED BARRIER PRECAUTIONS: - Review of Resident #28's medical record occurred on all days of survey. Physician's orders included a dressing change to a surgical wound twice daily. The care plan stated, Enhanced Barrier Precautions (EBP) related to Chronic Wounds (unhealed surgical wound) . Personal Protective Equipment (PPE) use during wound care . Observation on 08/06/24 at 10:27 a.m., showed a nurse (#14) removed a soiled dressing from Resident #28's wound, cleansed the wound, and applied a clean dressing. The nurse (#14) failed to apply a gown before providing wound care. - Observation on 08/07/24 at 1:30 p.m. showed a nurse (#9) applied gloves and entered Resident #79's room with medications. A sign on the resident door indicated EBP. The nurse administered the medications and water flushes through the resident's feeding tube. The nurse (#9) failed to wear the appropriate enhanced barrier precautions PPE. - Review of Resident #96's medical record occurred on all days of survey. Physician's orders included wound care to a right ankle pressure ulcer daily. The care plan stated, Enhanced Barrier Precautions (EBP) related to Chronic Wounds (pressure ulcer) and Indwelling Medical Device urinary catheter . Enhanced Barrier Precautions (EBP) should be used for the duration of the affected residents [sic] stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Observation on 08/06/24 at 9:33 a.m., showed a nurse (#14) performed a dressing change to Resident #96's wound. The nurse failed to wear the appropriate enhanced barrier precautions PPE. 46963