STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smp Health - Ave Maria	501 19th St NE Jamestown, ND 58401

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. 27221 Based on record review, review of facility policy, review of the facility's investigation reports, and staff interviews, the facility failed to ensure residents have the right to remain free from mental and/or physical abuse for 1 of 1 sampled resident (Resident #2) who had a rag placed in her mouth by staff to silence her. Failure to provide the services necessary to avoid mental anguish and emotional distress, resulted in an unsafe environment for Resident #2 and may result in fear, anxiety, and/or psychosocial harm. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately after hearing the concerns reported by staff. Findings include: Review of the facility policy titled Abuse occurred on 06/11/24. This policy, reviewed January 2024, stated: * Abuse is defined as . intimidation, or punishment with resulting physical harm, pain, or mental anguish, or deprivation of . services that are necessary to attain or maintain physical, mental, or psychosocial well-being. * Physical abuse is defined as . controlling behavior through corporal punishment. * Mental abuse is defined as . harassment, and threats of punishment . Review of Resident #2's medical record occurred on 06/11/24. Diagnoses included dementia with agitation and anxiety disorder. The current care plan identified, . As per therapy assessments she [Resident #2] shows severe cognitive impairment, minimal awareness, confusion and disorientation, easily distracted, shows difficulty focusing attention, requires simple commands and remains minimally directable. She has some non-sensical speech along with tangential speech during conversations in which she shows disorganized thinking processes. She has the tendency to moan/groan, speak in a nonsensical manner, make humming sounds, and she seems to do these sounds in a repetitive manner and she will make these sounds in a varying degree of volume. This could reflect internal distress, racing thoughts and/or confusion and her behaviors may be her attempt at processing her thoughts or what is going on around her. (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	During an interview on 06/11/24 at 4:20 p.m., four managerial staff members (#6, #7, #8 and #9) provided copies of the facility's Initial Facility Reported Incident Report and Final Investigation, stating, We immediately began investigating the incident and suspended the CNA (#5) pending the results of our investigation. Review of the facility's initial report, dated 06/07/24, identified, . Staff reported to Nurse Manager that CNA [certified nurse aide] has been observed being rough while providing cares to residents. Yelling, disrespecting and belittling residents. Staff reported CNA admitting to placing towel in resident's mouth to keep her quiet and this was also witnessed by another CNA. Review of the facility's final investigation, dated 06/10/24, included the following staffs' written testimonies, dated 06/07/24: * CNA (#2) wrote, . She [CNA (#5)] admitted to putting a rag in [Resident #2's] mouth so she'd be quiet . * CNA (#3) wrote, . She [CNA (#5)] has put a towel in her [Resident #2's] mouth to make her be quiet and she will put [Resident #2] in her wheelchair with it in her mouth still. During interviews on 06/11/24 at 3:33 p.m. and 5:43 p.m., a CNA (#3) stated, [Resident #2] is completely dependent. She is one to yell continuously, not yell loud. She'd [CNA (#5)] say, 'Shut up, be quiet,' only in her [Resident #2's] room, not in the hallway. One day, she grabbed a washcloth and put it in her mouth. I took it back out. It wasn't in there long. When I took the towel out, she rolled her eyes at me. During an interview on 06/12/24 at 12:54 p.m., a CNA (#2) stated, [Resident #2] always makes sounds. She can't help it. I was changing [Resident #2] with [CNA (#5)] last week. [CNA (#5)] admitted , 'If she [Resident #2] doesn't shut up, I put a rag in her mouth.' I was speechless. It was so shocking. I couldn't believe it. I told her, 'I tell her [Resident #2] the babies are sleeping, and she quits.' She ignored me. I talked to [CNA (#3)] later on and she just said she actually seen her do it, which is awful. As per facility policy, facility staff failed to: * Provide the services necessary to avoid mental anguish and emotional distress, * Utilize appropriate interventions when caring for residents exhibiting behaviors, * Identify abusive actions (i.e.: placing a washcloth in a resident's mouth to prevent them from speaking), Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions for the residents affected by the deficient practice and put measures in place to ensure the deficient practice does not reoccur by: * Immediately contacting the CNA (#5) accused of abuse to discuss the concerns reported by staff, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	* Placing the CNA (#5) on suspension until further notice, pending the results of the investigation, * Interviewing all of the staff members (#1, #2, #3, and #4) that reported concerns, * Reporting the concerns to the North Dakota Department of Health and Human Services, * Reporting the concerns to local Police Department, * Re-educating all staff members of the facility's reporting expectations on 06/07/24, * Re-educating all staff members of the facility's Abuse Policy starting on 06/11/24, * Completing audits pertaining to abuse/neglect. This surveyor determined a deficient practice existed on 06/07/24. The facility implemented corrective action and all staff education by 06/11/24.