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	05/20/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, review of the facility reported incident (FRI), and resident/staff interview, the facility failed to protect 2 of 2 sampled resident's (Resident #6 and #7) right to be free from physical abuse from each other. Failure to ensure residents remained free from physical abuse resulted in a physical altercation involving hair pulling, hitting, and biting which necessitated bloodborne pathogen testing. Findings include: The surveyor determined a deficient practice existed on 04/20/26. The facility implemented and completed corrective actions on 04/22/26. Review of the facility policy titled Abuse occurred on 05/20/26. This policy, revised January 2026, stated, Abuse is defined as a willful infliction of injury . intimidation . with resulting physical harm, pain, or mental anguish . Physical Abuse is defined as hitting, slapping, pinching, kicking, etc. Review of the initial FRI, dated 04/20/26, stated, . [Resident #6] and [Resident #7] were roommates at the time of this incident today. At approximately 4:50 pm, [Resident #7] (who has dementia) went over to his roommate's side of the room and started to take some of his roommate's popcorn. The two residents had an unwitnessed altercation that involved [Resident #7] being bite [sic] by [Resident #6] and [Resident #7] pulling out some of [Resident #6's] hair. Review of Resident #6's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated [DATE], identified intact cognition. The current care plan stated, . He [Resident #6] can become irritable towards others when he feels that they are . taking something from him . Due to the incident with his roommate on 4/20/26, the IDT [Interdisciplinary Team] has determined that he will remain in a private room at this time d/t [due to] his specific preferences and his beliefs. A behavior progress note, dated 04/20/26, stated, . Author was called down to room stating that resident and his roommate were in a physical altercation. [Resident #6] reports that his roommate [Resident #7] went to his side of the room and grabbed his bag of popcorn that was sitting on his nightstand. [Resident #6] stated that he told his roommate to leave it alone and called him a thief. His roommate then started to hit him on the top of . his head and pulled his hair. He had a large clump of hair on his left arm. He [Resident #6] stated he then bit his roommate [Resident #7] which caused a small opening in the skin. Staff went to answer the light that was on in their room and immediately separated the two gentlemen . Residents' roommate [Resident #7] was immediately moved to a private room. Police were called and report was done. Due to the bodily fluids from both gentlemen (saliva from [Resident #6] and blood from the roommate [Resident #7]) our exposure plan was implemented and both gentlemen were drawn for HIV [human immunodeficiency virus], HEP [Hepatitis] B, HEP C. Review of Resident #7's medical record occurred on all days of survey. The MDS, dated [DATE], identified moderately impaired cognition. The care plan stated, . [Resident #7] . has had a history of expressing frustrations verbally by raising voice or cussing in these moments at staff . Due to incident on 4/20/26, IDT has determined that resident will be in a private room. During an interview on 05/19/26 at 11:25 a.m., Resident #7 voiced no concerns regarding the other residents. During an interview on 05/19/26 at 11:40 a.m., Resident #6 voiced no concerns regarding his safety and stated, I'm a devout Christian. I've had two previous roommates that swore. Of course, it's not (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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(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	against the law. My last roommate, [Resident #7], attacked me. He tried to steal my candy corn. He pulled out some of my hair, hit me five times on the top of my head, and tried to hit me in the face. I blocked him and bit his hand. I have not seen him since it happened. Interviews with seven additional residents (Resident #3, #4, #5, #8, #9, #10, and #11) occurred on 05/19/26. All voiced no concerns with other residents and felt safe. During an interview on 5/20/26 at 12:30 pm, three administrative staff members (#1, #2, and #3) confirmed there have been no further negative interactions between the two residents since the incident that occurred on 04/20/26. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions for residents who may be affected by the deficient practice as follows:* 04/20/26, moved Resident #7 to a private room on another wing of the facility to separate the residents and protect all residents. * 04/20/26, assessed Resident #6 and #7 for injuries and obtained fluid samples to test for bloodborne pathogens. * 04/20/26, reported the incident to the local authorities and State Agency.* 04/20/26, investigated the incident that occurred between Resident #6 and #7.* Updated Resident #6 and #7's care plans.* 04/21/26 and 04/22/26, re-educated staff on the facility's abuse policy, including how to report abuse if/when they witness negative interactions between residents.* Completion and on-going quality assurance and behavior tracking.