STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smp Health - Maryhill	110 Hillcrest Dr Enderlin, ND 58027

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to ensure safety for 2 of 4 sampled residents (Resident #2 and #9) observed during transfers and ambulation. Failure to utilize gait belts and the required staff assistance placed the residents at risk for accidents and/or injury. Findings include: Review of the facility policy titled Safe Resident Handling/Transfers occurred on 09/25/25. This policy, dated May 2025, stated, . It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience . Review of the facility policy titled Standards of Care Policy occurred on 09/25/25. This policy, dated August 2025, stated, . Gait belt will be used when resident needs assistance with walking and transferring. - Review of Resident #2's medical record occurred on all days of survey. The care plan stated, . MOBILITY: I use a w/c [wheelchair] for mobility. [NAME] PRN [as needed] when able with staff assist. TRANSFER: I need assist of two [staff] with gait belt and pivot for transfers . I have impaired Cognitive Function . A quarterly Minimum Data Set (MDS), dated [DATE], identified severely impaired cognition. Observation on 09/23/25 at 4:02 p.m. showed a certified nurse aide (CNA) (#6) assisted Resident #2 to the edge of the bed, applied a gait belt, and assisted to stand in front of a front wheel walker (FWW). The resident lightly held onto the walker handles, leaned back into the CNA's hand and away from the walker, and began to walk towards the bathroom. The resident vocally expressed fear of falling. The CNA (#6) stated, She [Resident #2] is a walk-to-dine but we will need to use the wheelchair. She didn't do very well [transfer/ambulate]. After toileting, the CNA (#6) assisted the resident to stand with the gait belt and directed him/her to hold onto the walker handles. The CNA utilized the gait belt and pivoted the resident to the wheelchair. Review of Resident #2's ADL care sheet, dated 09/22/25, identified the resident required two staff assistance with a gait belt with pivot transfers. The care sheet failed to identify walk-to-dine. The CNA (#6) failed to follow Resident #2's plan of care for two staff assistance with transfers and utilize a wheelchair for mobility to the bathroom ensuring the resident's safety. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/25 at 10:25 a.m., an administrative staff member (#1) confirmed Resident #2 required two staff for transfers. - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia and repeated falls. The care plan stated, . I am an assist of one and a pivot transfer. I am unable to walk due to decreased strength and mobility . I am at risk for falls r/t [related to] Gait/balance problems and hx [history] of falls. A quarterly MDS, dated [DATE], indicated maximum assistance required with toilet transfer and chair/bed - to - chair transfer. Review of Resident #9's ADL care sheet, dated 09/22/25, showed the resident required one staff assistance and a gait belt for transfers. Observation on 09/22/25 at 1:14 p.m. showed a CNA (#4) placed both hands on Resident #9's buttocks/hips to turn the resident's body when transferring from a wheelchair to the toilet, from the toilet back into the wheelchair, and from the wheelchair into a recliner. The resident was hunched over during the transfers. Observation on 09/23/25 4:46 p.m. showed a CNA (#3) placed both hands on Resident #9's buttocks/hips to turn the resident's body when transferring from a wheelchair to the toilet and from the toilet back into the wheelchair. The CNA (#3) stated, He [Resident #9] is not one we use the gait belt on. How he does [transfers] depends upon how tired he is. Both CNAs (#3) and (#4) failed to utilize a gait belt when transferring Resident #9. During an interview on 09/25/25 at 12:00 p.m., an administrative staff member (#1) stated, she expected staff to follow the ADL care sheet and use a gait belt for Resident #9's transfers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 4 sampled residents (Resident #2, #27, and #28) observed during cares. Failure to practice infection control standards during personal cares has the potential to spread infection throughout the facility.Findings include: Review of the facility policy titled Infection Prevention and Control Program occurred on 09/25/25. This policy, revised May 2025, stated, . Institutional factors may also facilitate transmission of infections among residents. Direct/indirect contact with equipment used to provide care. Improper hand hygiene. Improper glove use. Hand hygiene continues to be the primary means of preventing the transmission of infection. Glove Hygiene . Remove and discard gloves . after every procedure that involves potential exposure to blood or body fluids. Perform hand hygiene immediately after removal of gloves . Resident dressings and supplies should be properly stored to maintain their integrity . - Observation on 09/23/25 at 11:10 a.m. showed a certified nurse aide (CNA) (#4) entered Resident #28's room, performed hand hygiene, applied gloves, removed the resident's clothing and a soiled brief, and completed perineal cares. With the same gloves, the CNA (#4) applied a clean brief, washed and dried the resident's legs and feet, applied clean socks and pants, assisted the resident into a wheelchair, removed a shirt, washed the resident's back, and applied a clean shirt. The CNA (#4) then removed the soiled gloves and performed hand hygiene. The CNA (#4) failed to remove their soiled gloves, perform hand hygiene, and apply new gloves between clean and dirty tasks. - Review of Resident #27's medical record occurred on all days of survey and identified the resident on enhanced barrier precautions related to wounds. Observation on 09/23/25 at 1:50 p.m. showed a nurse (#5) applied personal protective equipment (PPE) inside Resident #27's room, obtained wound supplies from a basket in the room, and placed the supplies onto an overbed table visibly soiled with dried liquid/food. While the resident laid on the bed, the nurse sprayed wound cleanser onto a weeping abdominal wound, dried the wound with gauze, and without removing their soiled gloves, opened clean dressing supplies, used the scissors to cut one of the dressings to fit the wound, placed it into the wound, and covered the area with a foam dressing. The nurse then removed the soiled gloves, performed hand hygiene, applied new gloves. After applying another wound dressing, the nurse removed the soiled gloves, performed hand hygiene, applied clean gloves, and placed the bottle of wound cleanser and the scissors back into the wound supply basket without sanitizing them. The nurse placed the overbed table beside the resident without sanitizing the surface, removed their PPE, performed hand hygiene, and exited the room. The nurse (#5) failed to place the wound supplies onto a clean surface, remove their soiled gloves, perform hand hygiene, and apply clean gloves after cleansing a wound and before applying a clean dressing, sanitize the wound cleanser bottle and scissors before placing them back into the basket, and sanitize the overbed table. - Observation on 09/23/25 at 4:02 p.m. showed a certified nurse aid (CNA) (#6) performed hand hygiene, applied gloves, assisted Resident #2 to the bathroom, removed a soiled brief, performed perineal cares, applied a clean brief, pulled up the resident's pants, and transferred the resident into a wheelchair. Without removing their soiled gloves, the CNA combed the resident's hair, adjusted their (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clothing, and moved the wheelchair from the bathroom to the room doorway. The CNA removed their soiled gloves, performed hand hygiene, and exited the room. The CNA (#6) failed to remove their soiled gloves and perform hand hygiene after perineal care and before to moving onto other tasks and failed to disinfect the wheelchair handles after touching them with soiled gloves. During an interview on 09/25/25 at 10:25 a.m., an administrative staff member (#1) stated she expected staff to place the wound supplies onto a clean surface, remove soiled gloves after cleaning wounds and before applying clean dressings, sanitize the wound cleanser and scissors before placing them back into the wound supply basket, sanitize the overbed table after wound cares, and remove gloves/perform hand hygiene after perineal care and before moving on to other tasks.