

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
K 000	A certification survey conducted on February 15, 2022, found Souris Valley Care Center in compliance with the requirements of 483.73 Long Term Care Emergency Preparedness. INITIAL COMMENTS	K 000			
K 211 SS=E	This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction that was protected by a wet and dry automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The nursing facility was separated from an attached apartment building by an occupancy separation wall having a two-hour fire resistance rating. Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 211		3/16/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/28/2022

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 211	Continued From page 1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this code. 8.3.3.1. Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 7.2.1.15.2 The facility failed to inspect and test all fire rated door assemblies throughout the facility. Review of documentation and interview with staff determined not all fire rated door assemblies had been inspected in the past year. Failure to inspect and test fire rated door assemblies increases the risk of injury or death due to fire. The deficiency affected numerous fire rated door assemblies throughout the facility.	K 211	K221 Means of Egress – General: 1. All fire rated door assemblies will be inspected throughout the facility. 2. All fire rated doors have the potential to be affected. 3. Maintenance employees were educated on inspecting fire rated doors on February 15th, 2022. All the facility fire rated doors were inspected on Wednesday, March 2nd. 4. Facility Director or Designee will audit to ensure that the fire rated door assemblies were inspected. We will randomly select 8 doors on a quarterly basis to ensure annual compliance. The Quality Assurance Committee will review and monitor audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date: Tuesday, March 16th		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324		3/10/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022	
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 324	Continued From page 2 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: 1- The facility failed to install cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. A readily accessible means for manual activation shall be located between 1067 mm and 1219 mm (42 in. and 48 in.) above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. 19.3.2.5.1, 9.2.3, NFPA 96 10.5.1. Observation determined the manual actuation device for the fire-extinguishing system serving the Kitchen exhaust hood was mounted at a height of more than forty-eight (48) inches above			K 324	K324 Cooking Facilities: 1. The manual actuation device for the fire extinguishing system for the kitchen exhaust hood will be lowered to no more than forty-eight (48) inches above the floor. Kitchen hood fire extinguishing system needs to be inspected on a semi-annual. 2. All improperly installed manual actuation devices and proper inspections of kitchen hood fire extinguishing system have the potential to be affected. 3. Maintenance employees were educated on the appropriate installation of the actuation device and kitchen hood fire extinguishing system on February 28th,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 3 the floor. The manual pull was 56 inches above the floor. Failure to inspect, maintain, and install the wet chemical extinguishing system in accordance with NFPA 96 increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) wet chemical extinguishing system in the facility. 2- Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months. 19.3.2.5.1, 9.2.3, NFPA 96 11.2.1. The facility failed to test and service the fire-extinguishing system serving the Kitchen exhaust hood in accordance with NFPA 96. Record review determined the fire-extinguishing system serving the Kitchen exhaust hood was last inspected and serviced on 12/29/2021 by an outside company. No other record was available to indicate a service of the Kitchen exhaust hood was completed in the past year. Failure to inspect and service the fire-extinguishing system for the Kitchen exhaust	K 324	2022. Manual actuation device will be moved by Thursday, March 10th. On 2/28/22 we contact the Vendor to complete kitchen hood fire suppression inspection prior to the six-month required time frame. 4. We will submit the required information into the TELS system to ensure bi-annual inspection compliance. The Quality Assurance Committee will review and monitor audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Compliance Date: Thursday, March 10th		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 324	Continued From page 4 hood at required intervals increases the risk of injury or death due to fire.	K 324			
K 712 SS=F	This deficiency affected one (1) of two (2) required inspections of the Kitchen exhaust hood fire-extinguishing system in the past year. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to conduct fire drills as required. Fire drill records review determined no fire drills were conducted on the following shifts: 1- First shift during the first quarter in the past year. 2- Third shift during the second quarter in 2021. 3- First, second, and third shift during the third quarter of 2021. 4- Second and third shifts during the fourth quarter of 2021. Failure to conduct fire drills as required increases	K 712	K712 Fire Drills: 1. Facility will conduct fire drills on a monthly basis as required, one drill per shift per quarter. 2. All portions of the facility have the potential to be impacted by not completing required fire drills. 3. Maintenance employees were educated on the need to conduct monthly fire drills as required on February 28th, 2022. Fire drill was completed on 2/28/22 and drills will be completed monthly as required. 4. We will submit the required information into the TELS system to	3/10/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 712	Continued From page 5 the risk of death or injury due to fire. The deficiency affected seven (7) of twelve (12) drills in the past year.	K 712	ensure monthly fire drill compliance. Facilities Director or designee will audit the completion of monthly fire drills on quarterly basis. The Quality Assurance Committee will review and monitor audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Compliance Date: Thursday, March 10th	3/16/22	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	Continued From page 6 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to test the emergency power generator in accordance with NFPA 110, Standard for Emergency Power and Standby Systems. Record review determined the diesel emergency power generator was not exercised under load for 4 continuous hours in the past 36 months. Failure to test the emergency power generator in accordance with NFPA 110 increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) emergency power generator in the facility. The emergency power generator serves the entire facility.	K 918	K918 Electrical Systems – Essential Electrical Systems: 1. Facility will exercise the diesel emergency generator under load for four (4) continuous hours as required. 2. All portions of the facility have the potential to be impacted by not completing the required load test on the diesel generator. 3. Maintenance employees were educated on the need to complete the required load test on the diesel generator on February 28th, 2022. The required load test on the diesel generator was completed on Tuesday, March 16th. 4. We will submit the required information into the TELS system to ensure annual generator load testing compliance. Facilities Director or designee will audit the completion of the required diesel generator load test annually. The Quality Assurance Committee will review and monitor audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Compliance Date: Tuesday, March		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2022
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN ST S VELVA, ND 58790		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 918	Continued From page 7	K 918	16th		