STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	**300 MAIN ST S , VELVA, North Dakota, 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
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding facility reported incident and complaints was completed on April 8, 2026. During the report and complaint investigation the facility was found out of compliance with regulatory requirements.	F0000		04/24/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility reported incident (FRI) investigation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remain free from abuse for 1 of 5 sampled residents (Resident #2) who was subjected to physical abuse by another resident. Failure to ensure the facility had processes in place to meet the needs of residents resulted in a bruise to Resident #2's face and placed all residents at risk for physical harm, pain, mental anguish, and emotional distress. Findings include: Review of the facility policy titled "Abuse and	F0600	F600 – Free from Abuse & Neglect On March 20th, resident #2 was slapped by resident #1. Staff member immediately separated residents. Resident #1 was assessed for injuries and there weren't any injuries noted immediately. Staff monitored residents to ensure safety. Proper notifications were completed. It was noted on 3/21/26 that resident #1 had a small round bruise under right eye that lined up with her glasses frame, resident #2 denied pain. Facility investigated the incident between Resident #1 and Resident #2. Any resident has the potential to be affected. Facility reviewed residents with behaviors to ensure safety needs are being met and ensured resident care plans were updated with appropriate interventions. All-staff were educated on the facility abuse policy with a focus on resident behaviors to ensure all residents are safe on May 6th. IDT team will review investigative information to ensure the information is complete. Facility Director of Nursing or designee will conduct audits on all resident incident/behaviors weekly for four weeks, 50% of behaviors/incidents per month for the next two months, then random selection of five per quarter for the next three quarters Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: May 8th, 2026	05/08/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S , VELVA, North Dakota, 58790

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F0600 SS = D	Continued from page 1 Neglect" occurred on 04/08/26. This policy, dated 04/07/25, stated, ". . . The resident/client has the right to be free from abuse, neglect . . . Residents/clients must not be subjected to abuse by anyone, including, but not limited to . . . other resident/clients." Review of the facility's initial FRI investigation, dated 03/20/26, stated, ". . . Male resident became upset with female resident's vocalizations. Male resident told female resident to shut up and female resident told male resident to shut up. Male resident then slapped female resident on the cheek. Staff members immediately intervened and separated the residents. Staff are monitoring residents to ensure safety. Female resident doesn't remember the incident and does not appear to be impacted by the incident. A witness interview, dated 03/26/26, stated, "[Medication aide] was passing medications at the time when she heard [Resident #1] tell the resident to 'shut up' and then [Resident #2] told him to shut up. [Resident #1] slapped her on the cheek." Review of Resident #1's medical record occurred on 04/08/26. Diagnoses included unspecified dementia, anxiety, and depressive disorder. The care plan stated, ". . . The resident has impaired cognitive function impaired thought process R/T [related to] confusion E/B [evidenced by] poor recall, mixing up days and nights. Confusion, and poor recall. . . . Interventions: resident understands consistent, simple, direct sentences. Provide resident with necessary cues- stop and return if agitated. Cue, reorient and supervise as needed. Redirect reassure as needed." Review of Resident #1 nursing progress notes identified the following: * 03/20/26 at 8:08 p.m. "on passing the other resident he told her to shut up and slapped her on her rt [right] cheek we pulled him away and put him in a safe place. * 03/21/26 at 3:55 p.m. "call placed to [name of guardian] made aware that resident had slapped another resident last pm." * 03/23/2026 at 4:32 p.m. "Resident to resident physical contact made - Date and time of event: 03/20/26 6:45 PM - Fractural account of what happened: Resident was yelling and calling out help me, Resident told resident to shut up, Resident then told resident to shut up. Resident B struck resident	F0600		05/08/2026

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F0600 SS = D	Continued from page 2 across her face on the right slide. CNAs saw what was happening and separated both residents and removed them to a safe place. Resident's condition after event: Resident quickly returned to baseline . . .Immediate intervention & education: Separated residents, educated them that this was inappropriate behavior. . . " Review of Resident #2 medical record occurred on 04/08/26. Diagnoses included Alzheimer's disease and anxiety. Review of Resident #2's nursing progress notes identified the following: 03/20/26 at 8:10 p.m., "resident was yelling help as per usual behavior the other resident told her to shut up and slapped her on her rt [right] cheek on passing her [sic] both resident [sic] were parted and taken to safe places" 03/21/26 at 3:15 p.m., "Resident to resident physical contact made- Date and Time of Event: 03/20/2026 6:45 p.m. - Factual account of what happened: small round bruise, size of a dime noted under right eye, bruise lines up with bottom of her glasses, denies pain. . . ." During an interview on 04/08/26 at 12:20 p.m., an administrative staff member (#1) stated this incident occurred only once and Resident #2's bruise resolved without issue. During an interview on the afternoon of 04/08/26, Resident #1 denied any concerns or issues with other residents, he denied being hit by anyone, and denied hitting any other residents. The facility failed to protect Resident #2 from physical abuse.	F0600		05/08/2026