STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	**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
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and a complaint survey started on 04/14/24 and concluded 04/18/24. Durring the complaint investigation the facility was found to be noncomplaint with the regulatory requirements. Based on the results of the recertification survey an extended survey was also completed.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility policy, and staff interview, the facility failed to promote care in a manner that maintained or enhanced residents' dignity for 1 of 14 sampled residents (Resident #14) and 1 supplemental resident (Resident #6) who required assistance with dressing. Failure to ensure the residents wore clean clothing and were fully dressed the resident following cares does not promote mental well-being or dignity. Findings included: Review of the facility policy titled "Resident Dignity" occurred on 04/17/24. This policy, dated	F 557	F557 – Respect/Dignity: 1. Verbal re-education to nursing staff on duty on 04/16/2024 provided by DNS on resident dignity specific to grooming/clean clothes. 2. Any residents needing assist with grooming and dressing have the potential to be affected by this deficient practice. 3. All nursing staff were re-educated on GSS Dignity Policy and Procedure including groomings, appropriate dress as per resident choice, and clean clothing by DNS on 04/26/2024 or before the next	5/15/24

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

Electronically Signed | 05/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 557	Continued From page 1 November 2023, stated, ". . . PURPOSE To maintain the dignity of all residents . . . To promote, encourage, support and enhance the residents' self-esteem . . ." - Review of Resident #14's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated 03/14/24, identified dependent on assistance with dressing. Observations showed: * 04/14/24 at 11:40 a.m. Resident #14 wore pants soiled with food debris when staff brought the resident to the dining room for lunch. * 04/15/24 at 8:37 a.m. Resident #14 in the wheelchair in her room wearing pants soiled with food debris. The resident's roommate was in the bed with food debris noted on the bed beside her. - Review of Resident #6's medical record occurred on 04/14/24. The MDS, dated 02/27/24, identified dependent on assistance with dressing. Observation on 04/14/24 at 11:55 a.m. showed Resident #6 wore a shirt and pants soiled with food debris. During an interview on 04/16/24 at 3:45 p.m., an administrative nurse (#1) stated staff are expected to change residents' clothing if soiled and pull pants back up following a check and change.	F 557	scheduled shift. 4. DNS or designee will complete resident observation audits for grooming and appropriate clean clothing. Audits will be completed 3x/week for 4 weeks, then 1x/week for 4 weeks, then 1x/month for 3 months. Audit results will be submitted to monthly QAPI Committee for review and recommendation. 5. Compliance date: May 15th, 2024.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 580	Continued From page 2 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 580	Continued From page 3 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 4 sampled residents (Resident #17) with weight loss. Failure to notify the physician of these changes may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Review of the facility policy titled "Weight and Height - R/S, LTC [rehab/skilled, long term care]" occurred on 04/17/24. This policy, dated 09/18/23, stated, ". . . To ensure that resident maintains acceptable parameters of nutritional status regarding weight . . . To report changes in a resident's clinical condition (significant weight change) immediately to physician . . . 8. . . . Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days, and 10 percent in 180 days. 9. The licensed nurse should immediately notify the medical provider regarding any significant weight change . . ." Review of Resident #17's medical record occurred on all days of survey. Diagnoses included dementia and diabetes. Review of the	F 580	F580 – Notification of Changes 1. MD was notified of resident #17's weight loss on 04/19/2024, no new orders. The resident will remain on the nutritional risk committee list with weekly weights. 2. All residents have the potential to be affected by the deficient practice of not notifying the provider of the change of condition. 3. All licensed nurses were re-educated by DNS on 04/26/2024 on GSS Weight and Height Policy and Procedure, specific to monitoring for weight changes and timely notification to the provider. All licensed nurses were re-educated on GSS Notification of Change of Policy and Procedure, specific to weight loss and nutritional status, by DNS or designee on 05/08/2024 or before the next scheduled shift. System change implemented: DFN will print off weight reports weekly, review for changes, and consult the dietician as indicated. 4. DFN, ADON or designee will audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 580	Continued From page 4 significant change Minimum Data Set (MDS), dated 03/06/24, identified weight loss and supervision/set-up assistance for eating. The progress notes identified the following: * 01/16/24 at 9:46 a.m., "Nutritional Status - Dietitian Assessment . . . Nutrition Admit Note: . . . Wt [weight]-176.5# [pounds] . . . MNA [mini nutrirional assessment] score was a 12 which puts her w/in [within] normal nutritional status. Plan to continue to monitor & [and] allow time for her to adjust to the facility. . . ." * 02/20/24 at 10:41 a.m., "Care Conference Note . . . Resident meal and fluid intakes are poor. Resident does need encouragement with food and fluids. Resident current weight is 169.5lb [pounds]." * 03/19/24 10:02 a.m., "Care Conference Note . . . Resident is currently 167 pounds. meal intake is 50% [percent] or more of meals. Resident shows a weight loss, since admission. . . ." * 03/26/24 at 11:08 a.m., "Nutritional Status - Dietitian Assessment . . . Current wt-168# . . . Weight is down 17# since 1/23/24 (9.2%). . . . MNA score was a 10 which has declined & puts her at risk for malnutrition. . . ." * 04/15/24 at 12:16 p.m., "Nutritional Status - Dietitian Assessment . . . Wt-163# . . . . Weight is down 18# in 90 days (9.9%); & 22# in 180 days (11.9%). . . . MNA score was a 9 which has declined. Plan to continue to monitor her nutritional status & will be following up as needed." The medical record lacked documentation of provider notification of Resident #17's significant weight loss.	F 580	documentation for notification of provider for significant weight loss 1x/week for 4 weeks, then 1x/month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. Completion date: May 15th, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 580	Continued From page 5 During an interview on 04/16/24 at 4:30 p.m., an administrative nurse (#1) confirmed facility staff failed to notify the provider of the significant weight loss for Resident #17.	F 580		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 14 sampled residents (Resident #20, #29 and #35) and one supplemental resident (Resident #44). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Failure to code discharge status may affect appropriate discharge planning and follow-up if needed. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI Manual, revised October 2023, Section A, page A-42 stated, ". . . A 2105 Discharge Status . . . Steps for Assessment 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. .	F 641	F641 – Accuracy of Assessment 1. On 04/17/2024, RAC-CT certified DNS re-educated the MDS Coordinator on accurate MDS coding and completion. MDS's with coding errors for Resident #20, #29, #35, & #44 were corrected and transmitted on 04/18/2024 and accepted. 2. Any resident has the potential to be affected by this deficient practice. 3. MDS Coordinator and Director of Food and Nutrition will be re-educated by GSS Senior Clinical Reimbursement Analyst on accurate MDS coding for Section A, K, M, & N through the MDS RAI Manual by 5.10.24. 4. DNS or designee will audit 5 completed MDS's prior to transmission for accuracy of coding in section A, K, M, & N. Any incorrect coding identified will be immediately addressed. Audits will be completed 1x/month for 3 months. Audit results will be submitted to QAPI Committee for review and	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 641	Continued From page 6 . . Select the two-digit code that corresponds to the resident's discharge status. . . . Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility . . ." Review of Resident #44's medical record occurred on 04/17/24. A physician's order dated, 03/28/24, stated, "Discharge to [facility name] Assisted Living . . ." A progress note, dated, 03/28/2024 9:56 [a.m.] "Discharge-Home, Assisted Living . . ." Resident #44's Discharge MDS dated 03/28/24 identified facility staff coded item A2105 discharge status: 04 Short-Term General Hospital. The MDS is incorrectly coded for a discharge to a hospital. During an interview on 04/17/24 at 11:55 a.m., a staff member (#11) confirmed staff failed to correctly code Resident #44's discharge MDS. SECTION K: WEIGHT LOSS The Long-Term Care Facility RAI User's Manual, revised October 2023, Section K: Swallowing/Nutritional Status, pages K-3 through K-6, stated, ". . . K0200B: Weight: 1. Base weight on the most recent measure in the last 30 days. . . . K0300: Weight Loss . . . Steps for Assessment: This item compares the resident's weight in the current observation period with their weight at two snapshots in time: . . . At a point closest to 30-days preceding the current weight. . . . At a point closest to 180-days preceding the current	F 641	recommendations. 5. Completion date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 641	Continued From page 7	F 641		

weight. . . . From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 180 days ago. . . . If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss. . . . Coding Instructions . . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of . . . 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. . . ."

- Review of Resident #35's medical record occurred on all days of survey. An admission MDS, dated 11/07/23, identified the resident's weight as 190 pounds. A quarterly MDS, dated 01/26/24, identified the resident's weight as 140 pounds, a weight loss of 25% in 180 days.

The quarterly MDS failed to identify Resident #35's weight loss.

During an interview on 04/17/24 at 12:00 p.m., a dietary manager (#12) confirmed she coded Resident #35's Quarterly MDS incorrectly for weight loss.

SECTION M: SKIN CONDITIONS

The Long-Term Care Facility RAI User's Manual, revised October 2023, pages M-8 stated, "M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage . . . Determine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 641	Continued From page 8	F 641		

"Present on Admission" For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement. 1. Review the medical record for the history of the ulcer/injury. 2. Review for location and stage at the time of admission/entry or reentry. Pages M-12 through M-13 stated, ". . . M0300B: Stage 2 Pressure Ulcers . . . Steps for Assessment . . . Identify the number of these pressure ulcers that were present on admission/entry . . . Coding Instructions for M0300B . . . M0300B1 . . . Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2 . . . M0300B2 . . . Enter the number of these Stage 2 pressure ulcers that were first noted at the time of admission/entry . . . Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry. . . ."

Review of Resident #20's medical record occurred on all days of survey. Diagnoses included pressure ulcer to right and left buttock, stage two.

The annual MDS, dated 11/26/23, identified "2" for number of stage two pressure ulcers present and "2" for number of stage two pressure ulcers present on admission.

The quarterly MDS, dated 02/25/24, identified "2" for number of stage two pressure ulcers present and "0" for number of stage two pressure ulcers present on admission.

During an interview on 04/16/24 at 10:58 a.m., an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 641	Continued From page 9	F 641		

administrative nurse (#1) confirmed Resident #20's bilateral stage two pressure ulcers to the buttocks were present on admission.

During an interview on 04/17/24 at 11:55 a.m., an administrative nurse (#9) confirmed staff failed to code Resident #20's quarterly MDS correctly regarding pressure ulcers present on admission.

SECTION N: MEDICATIONS

The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-1, and N-6 to N-8 stated, "Section N Medications . . . N0415: High-Risk Drug Classes: Use and Indication . . . Coding Instructions . . . N0415E1. Anticoagulant (e.g., [for example] warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period . . . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., . . . clopidogrel) was taken by the resident at any time during the 7-day observation period. . . ."

Review of Resident #29's medical record occurred on all days of survey. A physician's order, dated 11/08/21, stated, "Clopidogrel Bisulfate Tablet . . . Give 75 mg [milligrams] by mouth one time a day for antiplatelet/AFib [atrial fibrillation]. . ." The quarterly MDS, dated 02/02/24, identified the use of an anticoagulant medication and failed to identify the use of an antiplatelet medication.

During an interview on 04/17/24 at 12:16 p.m., an administrative nurse (#9) confirmed staff failed to code Resident #29's MDS correctly regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 641	Continued From page 10 anticoagulant/antiplatelet medication use.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 5 of 14 sampled residents (Resident #17, #27, #29, #35, and	F 657	F657 – Care Plans 1. On 04/18/2024, DNS re-educated the clinical interdisciplinary team (IDT) on updating care plans timely with residents change in condition and/or treatment	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 657	Continued From page 11 #41). Failure to revise the care plan limited the staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled, "Care Plan . . .LTC [long term care]" occurred on 04/17/24. This policy, revised, 11/01/23, stated, ". . . . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. . . . This plan of care will be modified to reflect the care currently required/provided for the resident. . . . Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. . . ." - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2, atrial fibrillation, and chronic congestive heart failure. Current physician's orders identified a diuretic and insulin. A progress note, dated 03/26/24 at 11:08 a.m., stated, ". . . At risk for malnutrition . . . Has had a weight loss . . . . Weight is down 17# [pounds] since 1/23/24 (9.2%). . . ." Resident #17's current care plan lacked problems and interventions related to risk for malnutrition, actual weight loss, use of a diuretic, diabetes, and insulin use. - Review of Resident #27's medical record occurred on all days of survey. Diagnoses included osteomyelitis right ankle, sepsis, and pneumonia. The current care plan stated, ". . .	F 657	plan. Resident #17 care plan updated on 4/18/24 to include or update focus / goal / interventions for malnutrition risk / weight loss, Type II DM, Diuertics, and antidepressant, and insulin. Resident # 27 care plan updated on 5/7/24 to include or update focus / goal / interventions for change of antibiotics and cam boot with weight-bearing activities. Resident #29 care plan updated on 4/18/ to include or update focus / goal / interventions for discontinuation of oxygen . Resident #35 care plan updated on 4/18/24 to include or update focus / goal / interventions to include diuretic and hypoglycemic medications. Resident #41 care plan updated on 4/18/24 to include or update focus / goal / interventions to include nutrition risk / weight loss and use of diuretics. Resident #41 discharged on 4/22/24. 2. All resident have the potential to be affected. 3. All nursing staff were re-educated by DNS on GSS Care Plan Policy and Procedure, specific to timely updates plans on 04/26/2024 or prior to next scheduled shift. System change implemented: Clinical IDT will review care plans during clinical morning meeting, with CNA input as indicated. 4. Social Worker or designee will audit 5 Care Plans for updates with change in treatment plan/resident preferences 1x/week for 4 weeks, then 1x/month for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 657	Continued From page 12 The resident is on medications with FDA [federal drug administration] Boxed Warnings or warnings of adverse consequences R/T [related to] use of IV [intravenous] Vancomycin [antibiotic]. . . ." Physician's orders showed IV Vancomycin discontinued on 01/09/24, and Doxycycline (oral antibiotic) 500 mg (milligrams) twice a day ordered on 01/09/24. On 04/08/24, the Doxycycline was renewed to continue through 05/01/24. On 04/01/24, a physician's order stated, ". . .100% weight bearing to right ankle, when wearing the cam boot [Controlled Ankle Motion boot - an orthopedic device prescribed for the treatment and stabilization of severe sprains, fractures, tendon, or ligament tears in the ankle of foot] . . ." Resident #27's current care plan lacked updated information addressing the discontinuation of Vancomycin and addition of Doxycycline, and the care associated with the resident's cam boot. - Review of Resident #29's medical record occurred on all days of survey. A nursing progress note dated 01/29/24 at 3:29 p.m., stated, ". . . Writer received written orders to d/c [discontinue] oxygen continuously . . ." The current care plan stated, " . . . Oxygen therapy: I am on 2L [liters] of O2 [oxygen] via NC [nasal cannula] continuously. . . ." The facility failed to update Resident #29's care plan related to oxygen use. - Review of Resident #35's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2, chronic congestive heart failure, and lymphedema.	F 657	months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5. Completion date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 657	Continued From page 13 Current physician's orders identified a diuretic and oral hypoglycemics (medications used to treat diabetes). Review of Resident #35's progress notes showed the following: * 11/20/23 at 2:11 p.m., ". . . Nutrition Risk Note: . . . is triggering due to . . . poor meal intakes & low MNA [mini-nutritional assessment] score of 11. Wt [weight] -186# [pounds]. . . Intakes are averaging 59% at meals. . . ." * 01/17/24 at 3:09 p.m., ". . . Nutrition Risk: . . . is triggering due to poor meal intakes. Wt-140.5# . . ." (a 25% weight loss in 2 months) The current care plan failed to identify nutrition risk, actual weight loss, use of a diuretic, diabetes, and use of oral hypoglycemic medications. - Review of Resident #41's medical record occurred on all days of survey. Diagnosis included chronic congestive heart failure, atherosclerotic heart disease, and trochanteric fracture of right femur. Physician's orders showed Furosemide 40 mg and Spironolactone 25 mg (diuretics) every morning for heart failure. Oxycontin 10 mg twice a day, discontinued 03/06/24 and Oxycodone (narcotic pain medications) 5 mg every 8 hours as needed, discontinued 03/12/24. The current care plan stated, ". . . I am on medications with FDA Black Boxed Warnings R/T [related to] use of Oxycontin [and] Oxycodone . . . The resident has acute/chronic pain/discomfort R/T arthritis & Right hip fracture E/B [evidenced by] able to vocalize pain. Takes scheduled	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 657	Continued From page 14 Tylenol and Oxycontin. Has Oxycodone as needed. . . ." A review of Resident #41's progress notes, dated, 03/26/2024, showed, ". . . Nutrition Risk Note: [resident name] is triggering due to weight loss, . . . Wt-110# . . . Weight is down 18# in 30 days (14.1%). . . ." The current care plan failed to identify nutrition risk and weight loss, use of diuretics, and discontinuation of oxycodone and oxycontin. During an interview on 04/16/24 at 4:40 p.m., an administrative nurse (#1) confirmed she expected care plans to be updated with the resident's current orders, medication changes, and when new problems are identified.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 1 of 1 resident (Resident #29) observed during administration of intermediate acting insulin. Failure to administer intermediate-acting insulin within fifteen minutes of a meal may result in a hypoglycemic (low blood sugar) reaction.	F 658	F658 – Professional Standards 1. Nurses working on 04/18/2024 was re-educated by DNS on providing nourishment to residents receiving short and intermediate-acting insulin within 15 minutes of administration. The nurse working at time of incident 04/14/2024 was re-educated by DNS on next scheduled shift (04/22/2024) on providing nourishment to resident receiving short	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 658	Continued From page 15 Findings include: Prescribing information for Humalog Mix 75/25 insulin (an intermediate acting insulin), found at https://www.humalog.com/mixes, occurred on 04/17/24, and stated, ". . . Inject HUMALOG Mix75/25 subcutaneously within 15 minutes before a meal. . . ." Review of Resident #29's medical record occurred on all days of survey. A current physician's order stated, "HumaLOG Mix 75/25 KwikPen Subcutaneous Suspension Pen-injector (75-25) 100 UNIT/ML [unit/mL] . . . Inject 18 unit subcutaneously one time a day . . . with supper." Observations on 04/14/24 showed the following: * 5:19 p.m., a nurse (#3) prepared and administered 18 units of Humalog 75/25 to Resident #29. * 5:44 p.m., Resident #29 seated at the dining room table waiting for the supper meal to be served. (25 minutes later) The facility failed to follow prescribing instructions for timing of Resident #29's Humalog 75/25 insulin. During an interview on 04/16/24 at 3:30 p.m., an administrative nurse (#1) confirmed she expected staff to administer intermediate insulin within 15 minutes of a meal.	F 658	and intermediate-acting insulin within 15 minutes of administration. 2. All residents who receive insulin have the potential to be affected. 3. All licensed nurses were re-educated by DNS on GSS Insulin Administration Policy and Procedure, specific to providing nourishment within 15 minutes of administering short and intermediate acting insulin on 04/26/2024 or prior to next scheduled shift. 4. DNS or designee will conduct observation audits on 3 residents, verifying nourishment is provided within 15 minutes of short and intermediate-acting insulin administration. Audits will be completed 3X/week for 4 weeks, then 1X/week for 4 weeks, then 1X/month for 1 month. Any deficient practice identified will be immediately addressed. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5. Completion date: May 15th, 2024.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 684	Continued From page 16 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policy, the facility failed to ensure staff provided care and services for 1 of 1 sampled resident (Resident #27) with orders for a CAM Boot (Controlled Ankle Motion boot - an orthopedic device prescribed for the treatment and stabilization of severe sprains, fractures, tendon, or ligament tears in the ankle of foot). Failure to document application and removal of an orthopedic device, and to follow physician's orders for elevating legs/heels, may result in pain and/or worsening of resident's condition. Findings include: Review of the facility policy titled "Care Plan - LTC [Long Term Care], Therapy & Rehab" occurred on 04/17/24. This policy, dated 11/01/23, stated, ". . . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being . . . The care plan will emphasize the care of the whole person ensuring that the resident will receive appropriate care and services. . . ." Review of Resident #27's medical record occurred on all days of survey and included a diagnosis of nondisplaced trimalleolar (lower leg	F 684	F684 – Quality of Care 1. Resident #27 care plan reviewed and updated on 05/07/2024 to include CAM boot to right foot for weight bearing activities with documentation. 2. All residents with special devices have the potential to be affected by this deficient practice. 3. All nursing staff re-educated on following provider orders and plan of care specific to CAM boot application with documentation by DNS on 04/26/2024 or prior to next scheduled shift. All staff re-educated on Quality of Care by Administrator on 05/08/2024. 4. MDS Coordinator or designee will conduct observation audits on all residents with orders/plan of care for pressure relieving device/treatment i.e. CAM boots, heel protectors, floating heels to verify proper use. Audits will be conducted 1x/day for 5 days, then 1x/week for 3 weeks, then 1x/month for 2 months. 5. Compliance Date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 684	Continued From page 17	F 684		

sections that form the ankle joint) fracture of right lower leg. Physician's orders showed 100% weight bearing to right ankle when wearing the CAM boot and to keep right foot elevated every shift. The current care plan showed, ". . . The resident has actual impairment to skin integrity R/T [related to] surgical incision/surgical wound E/B [evidenced by] recent surgery on right ankle fracture. . . . Elevate heels off bed. . . ."

Review of Resident #27's treatment administration record (TAR) and certified nurse aide (CNA) documentation, dated 04/01/24 through 04/17/24, failed to show who is responsible for application and removal of the CAM Boot or documentation to elevate the right foot. Review of the CNA Kardex showed "Repositioning/Skin Care: Elevate heels off bed."

Observations throughout the survey showed Resident #27 wore a CAM boot to his right foot. Further observations showed:
* 04/14/24 at 2:30 p.m. Seated in the wheelchair without his right foot elevated.
* 04/15/24 at 9:45 a.m. Two CNAs (#4 and #7) transferred the resident into bed and failed to elevate the resident's heels.
* 04/15/24 at 3:05 p.m. In bed without his heels elevated.
*04/15/24 at 4:25 p.m. A nurse (#3) performed wound care. Upon completion, the nurse failed to elevate the resident's heels off the bed.
* 04/16/24 at 9:40 a.m. Seated in the wheelchair without his right foot elevated.
* 04/16/24 at 1:15 p.m. In bed, without his heels elevated.
* 04/17/24 at 9:00 a.m. Seated in the wheelchair without his right foot elevated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 684	Continued From page 18 During an interview on 04/17/24 at 12:15 p.m., an administrative staff member (#1) stated she expected nursing staff to determine who will be responsible for following the order and add it to the TAR or CNA Kardex, and she expected staff to follow the plan of care or order. The facility failed to provide care according to physician's orders, develop and follow the plan of care, and to direct the staff responsible to document the removal/application of the orthopedic device (CAM boot).	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate and sufficient supervision and/or assistive devices for 1 of 5 sampled residents (Resident #35) who required staff assistance and a gait belt with transfers. Failure to provide adequate assistance and/or use the assistive devices appropriately during transfers placed the residents at risk for accidents, falls, and/or injuries. During the standard survey, the team determined	F 689	F689 – Accidents and Hazards 1. Resident #35 sit-stand-walk UDA and care plan were reviewed, verified accurate for residents current needs and determined current care plan interventions of 2 person assist with gait belt for transfers was appropriate on 04/16/2024. Immediately upon discovery / notification by surveyor of IJ, re-education was provided to HIM / CNA staff member involved on 04/14/2024 at 1630 on providing care as per care plan, specific	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 689	Continued From page 19 an Immediate Jeopardy (IJ) situation existed on 04/16/24 at 5:15 p.m. The IJ resulted from staff failure to provide sufficient supervision and use the assistive device (gait belt) in a manner to avoid a fall and/or potential injury. * 04/16/24 at 5:29 p.m., The survey team contacted the State Survey Agency (SSA) to report the findings and discuss potential immediate jeopardy (IJ). * 04/16/24 at 6:30 p.m., The survey team notified the administrator and the director of nursing (DON), of the IJ situation, provided them with the IJ template, and requested they develop a plan for removal of the immediate jeopardy. * 04/16/24 at 6:35 p.m., The SSA notified the CMS (Centers for Medicaid & Medicare Services) location of the IJ situation. * 04/16/24 at 8:40 p.m., The facility provided (via email) an IJ removal plan. * 04/17/24 at 8:30 a.m., The SSA reviewed and accepted the IJ removal plan. The removal plan contained the following: * Inservice and education on appropriate actions/interventions per care plan specific to toileting and transfers to meet residents needs and prevent injury, with the staff member directly involved in the deficient practice, all nursing staff on duty, and on-coming staff. * Review of Resident's transfer requirements as outlined in their individual care plans. * Review of facility policies and resources for questions/concerns.	F 689	to resident transfer and toileting to meet residents needs and prevent injury. Additional training on ADLs and Transfers was assigned to HIM / CNA staff member on 04/18/2024 All nursing staff on duty were immediately re-educated by DNS or designee on providing care as per care plan specific to toileting and transfers to meet residents needs and prevent injury. All other nursing department staff were re-educated prior to next scheduled shift by DNS or designee. DNS or designee completed observation audits of staff transfers and toileting 2X / day for 5 days. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendation. QA committee determined for resident safety that the public bathrooms be locked so that resident safety remains a high priority. 2. Any resident who needs assistance with transfers and toileting care has the potential to be affected. 3. On 04/26/2024, DNS re-educated nursing staff on Prevention of accidents and hazards and promoting resident safety. All staff re-educated on Prevention of accidents and hazards and promoting resident safety by administrator on 05/08/2024. System change implemented: Clinical IDT will review care plans during clinical morning meeting, with CNA input as indicated. 4. MDS Coordinator will conduct observation audits on 5 residents verifying care is provided as per care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 689	Continued From page 20 * 04/17/24 at 10:12 a.m., the survey team verified the implementation of the removal plan. The deficient practice remained at a "D" scope and severity following the removal of the IJ. Findings include: Review of the facility policy titled "Fall Prevention and Management - Rehab/Skilled [R/S], Therapy & [and] Rehab" occurred on 04/17/24. This policy, dated 04/02/24, stated, ". . . To promote resident well-being by developing and implementing a fall prevention and management program . . . Proactive Approach before a Fall occurs . . . 2. Complete the Falls Tool UDA [user defined assessment] for fall screening and identifying fall risk factors. 3. Care Plan the appropriate interventions . . . 4. Communicate fall risks and interventions to prevent a fall before it occurs . . ." Review of the facility policy titled "Care Plan - R/S, LTC [Long Term Care], Therapy & Rehab" occurred on 04/17/24. This policy, dated 11/01/23, stated, ". . . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being . . . The care plan will emphasize the care of the whole person ensuring that the resident will receive appropriate care and services. . . ." Review of Resident #35's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 01/26/24, identified Resident #35 had severely impaired cognition. The current care plan stated, ". . . I am	F 689	plan. Audits will be completed x1/week for 4 weeks, then 1x/month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. 5. Compliance Date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 689	Continued From page 21 at risk for falls r/t [related to] balance difficulty, weakness and unsteadiness. I do have a hx [history] of falls r/t dementia and poor safety awareness, weakness and ambulatory dysfunction. . . . I will not sustain serious injury through the review date. . . . TOILET USE: I need extensive assist of two with transfers . . . TRANSFERS: Transfers with assist of two with gait belt . . . I will at times try to transfer myself in the restroom . . ." Review of nursing progress notes identified the following: * 04/13/24 at 4:43 p.m., ". . . Staff called nurse to resident room and stated that he is in the bathroom on the floor and bleeding from his head and blood on the floor and his hands and arms. Nurse assessed and resident cleansed and noted laceration to right side of forehead and skin tears to right elbow and top of hand. Resident was self transferring and lost balance and fell and then pulled call light. Pressure applied to laceration and vital signs obtained. Call placed to family and provider on call . . . and rec'd [received] verbal order to send to ER [emergency room] via ambulance." * 04/13/24 at 5:00 p.m., ". . . Call placed to . . . hospital switchboard and requested to be connected to provider on call . . . Updated that resident had unwitnessed fall with injury and has a laceration to right side of forehead and skin tears to right elbow and top of hand. She stated to send resident to ER for evaluation of head laceration and because this is the 3rd fall resident has had since 4/11/24 and 2nd within 24 hours." * 04/14/24 12:20 a.m., ". . . Resident returned to facility following ER visit d/t [due to] fall with head	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 689	Continued From page 22	F 689		

laceration. Resident returns with 6 sutures to lacerated area on right side of forehead. . . ."

Observations showed the following:
* 04/14/24 at 12:13 p.m., Resident #35 seated in a wheelchair in the dining room eating lunch. The resident had sutures to the right side of the forehead and a tegaderm [transparent adhesive bandage] to the right forearm.
* 04/14/24 at 4:30 p.m., Resident #35 sat in a wheelchair by the dining room and stated he needed to use the bathroom to staff member (#2). The staff member (#2) opened the door to the public bathroom in the hallway for the resident, and asked "Are you good?" Resident #35 responded "Yes." The staff member (#2) walked away. Resident #39, also cognitively impaired, pushed Resident #35 in the wheelchair into the bathroom and closed the door. The surveyor notified the nurse (#3). The nurse (#3) entered the bathroom, stopped Resident #35 from self-transferring to the toilet, placed a gait belt on Resident #35 and assisted the resident to the toilet. Resident #35 used the toilet. The nurse (#3) assisted the resident to stand and pivot back into the wheelchair with a gait belt.
* 04/15/24 at 4:35 p.m., Resident #35 sat on the bed and transferred himself from the bed to the wheelchair. No staff were present in the room.
* 04/16/24 at 9:35 a.m., Two certified nurse aides (CNAs) (#4 and #5) assisted Resident #35 to transfer from the wheelchair to the toilet. The resident transferred himself to the toilet before they could apply the gait belt. Once the resident was seated on the toilet the CNA (#4) applied a gait belt to the resident. Resident #35 used the toilet and the CNAs (#4 and #5) lifted under Resident #35's arms to assist him to stand,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 689	Continued From page 23 completed perineal cares and both CNAs held the resident under his arms and by the waistband of his pants, to pivot transfer to the wheelchair. During an interview on 04/16/24 at 3:20 p.m., an administrative nurse (#1) confirmed she expected staff to follow the care plan for transfers to ensure resident safety, and to use gait belts appropriately. Facility staff failed to follow the care plan to provide sufficient supervision and assistance with transferring and toileting, and use a gait belt with a resident who was identified as a fall risk, who had a recent fall with injury, and had the potential to for further falls.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 692	Continued From page 24 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status or 1 of 4 sampled residents (Resident #35) with weight loss. Failure to reassess/monitor weight variances may delay needed treatment for weight loss and alter the resident's ability to maintain sufficient nutritional status. Findings include: Review of the facility policy titled "Weight and Height - R/S, LTC [rehab/skilled, long term care]" occurred on 04/17/24. This policy, dated 09/18/23, stated, ". . . To ensure that resident maintains acceptable parameters of nutritional status regarding weight . . . To report changes in a resident's clinical condition (significant weight change) immediately to physician . . . To accurately measure weight . . . All residents are weighed at a minimum of weekly for the first four weeks following admission . . . 7. If weight varies by more than three percent, reweigh resident and document. Report weight to licensed nurse. 8. The licensed nurse should notify the director of food and nutrition (DFN) within 24 hours regarding significant weight change. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days, and 10 percent in 180 days. . . ." Review of Resident #35's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, chronic heart	F 692	F692 – Nutrition and Weight 1. Resident #35 was weighed on 05/07/2024. The provider was notified of weight changes on (05/09/2024). The resident will remain on the nutritional risk committee list with weekly weights. 2. Every resident has the potential to be affected by this deficient practice. 3. All licensed nurses were re-educated by DNS on 04/26/2024 on GSS Weight and Height Policy and Procedure, specific to monitoring for weight changes and timely notification to the provider. The facility will continue to have monthly Nutritional Risk Committee meetings, reviewing all residents at risk, including weight changes. System change implemented: DFN will print off weight reports weekly, review for changes and consult dietician as indicated. 4. DFN, ADON, or designee will audit documentation for documentation of weights as per care plan and action taken if indicated 1x/week for 4 weeks, then 1x/month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 692	Continued From page 25 failure, lymphedema, and diabetes. Physician's orders identified: * 11/01/23, Weekly weight on bath day. * 11/01/23, Metolazone [a diuretic medication] 10 milligrams in the morning. The medical record identified staff failed to weigh Resident #35 weekly from 11/13/23 until 12/04/23. During this three week period, the weights showed a 52 pound weight loss (from 186 lbs. to 134 lbs.), which represents a 27% weight loss. The medical record failed to identify the significant weight loss and/or its possible causes. During an interview on 04/17/24 at 10:12 a.m., the dietary manager (#12) and dietician (#13) agreed the facility failed to identify Resident #35's significant weight loss and address any causes. The dietary manager (#12) stated she recalled a conversation with nursing, and that the team felt the first two weights were inaccurate; however, they failed to re-weigh Resident #35 and document the conversation. Facility staff failed to perform weights and re-weighs as ordered/per facility policy, identify the significant weight loss, and assess any related causes for Resident #35.	F 692	5. Compliance Date: May 15th, 2024.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of	F 697		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 697	Continued From page 26 practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interviews, the facility failed to provide care and services to control pain for 1 of 1 sampled resident (Resident #31) reviewed for pain management. Failure to administer as needed (prn) pain medications and inform the physician of increased use of prn pain medication resulted in Resident #31 experiencing anxiety and mental anguish and may have contributed to the resident experiencing increased and/or unresolved pain. Findings include: Review of the facility policy titled "Pain Management" occurred on 04/17/24. This policy, dated February 2024, stated, ". . . PURPOSE To provide residents assistance in pain management. To promote well-being by ensuring that residents are as comfortable as possible. . . . Individualized approaches will be developed to address the resident's pain management in a holistic manner. . . ." Review of Resident #31's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated 01/26/24, identified intact cognition and frequent pain rated "10" on a 0-10 scale. A second MDS, dated 02/26/24, identified pain affected her sleep occasionally and interfered with therapy activities and day to day activities frequently.	F 697	F697 – Pain 1. ADON notified provider of resident # 31 frequency of PRN medication usage on May 9, 2024. Nurse involved no longer employed at facility effective in the month of March. 2. Residents receiving PRN pain or antianxiety medications have the potential to be affected. 3. All licensed nurses re-educated by DNS or designee on Pain Management: monitoring pain, administering PRN pain mediaction as per order, if no results from non-medication interventions, notification to provider if no relief from ordered medication on 04/26/2024 or before next scheduled shift. System change implemented: DNS or designee will review PCC PRN medication report monthly to monitor the frequency of use, notifying the consultant pharmacist and provider when indicated. 4. MDS nurse or designee will interview / observe 5 residents with PRN pain medications to verify if pain is being controlled. Audits will be completed 3X / week for 2 weeks, then 1 time / week for 6 weeks, then 1 X / month for 1 month. Any deficient practice identified will be addressed immediately. All audit results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 697	Continued From page 27 Resident #31's care plan stated, ". . . I have chronic pain/discomfort . . . E/B [evidenced by] limited mobility and verbalization of pain. . . . I will not have an interruption in normal activities due to pain . . ." Physician's orders included: * 01/19/24, "Acetaminophen Oral Tablet (Acetaminophen) [tylenol] Give 1000 mg [milligrams] by mouth three times a day related to BILATERAL PRIMARY OSTEOARTHRITIS OF KNEE . . . BILATERAL PRIMARY OSTEOARTHRITIS OF HIP." * 01/19/24, "Ultram 50 mg (TraMADOL HCL) [narcotic analgesic] *Controlled Drug* Give 50 mg by mouth as needed for pain Take up to three times daily as needed if pain unrelieved by tylenol." * 01/29/24, "LORazepam [antianxiety medication] Oral Tablet 0.5 MG Give 0.5 mg by mouth as needed for anxiety/agitation related to ANXIETY DISORDER . . . Take up to one time daily." During an interview on 04/14/24 at 12:54 p.m., Resident #31 stated, "I have had issues getting my pain and anxiety medications which has created a lot of anxiety for me not knowing if I would get them [pain and antianxiety medications] or not. A nurse refused to give me my tramadol and Ativan [lorazepam] when I requested them." Review of Resident #31's progress notes and medication administration record (MAR) identified the following: *01/22/24 at 9:16 p.m. ". . . Resident . . . Stated she wanted her Ultram, Tylenol and Ativan so she can sleep. Did not give them. She stated she	F 697	will be submitted to the monthly QAPI Committee for review and recommendation. 5. Compliance Date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 697	Continued From page 28 did not know why she cant [sic] get them three times a day like in the last place. Explained this is new facility and we don't have an order for it that often. . . ." The MAR identified Resident #31 did not receive any PRN doses of Tramadol or Ativan on this day. * 01/23/24 at 12:44 p.m. ". . . fax sent to Dr. [doctor] . . . re: [regarding] resident is very upset that her Tramadol is not scheduled at 0900 [9:00 a.m.], 1500 [3:00 p.m.], and at bedtime, Tramadol was scheduled at these times at her last place of residence, resident states "she needs it scheduled because of her back and knee pain," can we schedule it as resident wishes? . . ." * 01/23/24 at 3:58 p.m. ". . . fax received from Dr. . . . stating "NO Keep it prn" referring to the Tramadol . . ." * 01/26/24 at 11:31 p.m. ". . . Resident was calm and cooperative. Requesting Tramadol told her could not give she already received it 3 times today. Stated that I needed to go research and bring her the Tramadol. Restated I could not give her any because she already received it 3 times today. . . ." The MAR identified Resident #31 only received two doses of Tramadol on this day, and did not receive Ativan until 11:10 p.m., almost two hours after she requested it. The facility failed to administer prn pain and antianxiety medications as ordered and when Resident #31 requested. Review of a physician's progress note, dated 02/21/24 for Resident #31 stated, ". . . She [Resident #31] states for years, she was on lorazepam 2-3 times daily as needed for anxiety .	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 697	Continued From page 29 . . She also notes that the tramadol she has previously taken 2-3 times per day and that is not being given as often since her admission to the nursing home. She is wondering if those can be adjusted. . . . She makes it a point that she is 94 years old and has been on the anxiolytics and tramadol for a number of years without problems and I do not see at this point any reason why we cannot be more liberal with the anxiolytics and the tramadol. She already has the tramadol ordered 3 times daily as needed if pain is unrelieved by Tylenol and I think that is adequate for now to continue with that order. The lorazepam however, will be increased to twice daily. . . ." Monthly pharmacy review progress notes for Resident #31 included the following: * 02/28/24 ". . . Pain: freq [frequent] moderate - severe. PRN Meds: tramadol 76 (+58) [indicating the resident requested and received tramadol 58 more times in February then she did in January]. Lorazepam now scheduled, . . . assess need to schedule a dose of tramadol to help control pain. . . ." * 03/28/24 ". . . Pain: frequent moderate-severe pain mostly relieved with PRN tramadol. PRN Meds: tramadol 75 [prn doses] . . . for pain control, may consider scheduling for better pain control next month. . . ." The facility failed to inform the physician of Resident #31's increased use of prn pain medication and suggestions for scheduled doses as indicated by the pharmacy reviews. During an interview on 04/16/24 at 11:50 a.m., an administrative nurse (#1) stated she was not	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 697	Continued From page 30 aware of Resident #31's concerns with not receiving her prn pain and antianxiety medications. The also reported she did not notify the physician of the pharmacy monthly reviews since it was not noted specifically as a recommendation. During an interview on 04/16/24 at 1:29 p.m., an administrative nurse (#1) agreed Resident #31 could have received Tramadol and Ativan on 01/22/24 when she had requested it and on 01/26/24 she could have received prn tramadol when she requested it. The administrative nurse stated she expects staff to administer medications as ordered and as requested by the resident.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 758	Continued From page 31 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/25/23 Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 1 of 2 sampled resident (Resident #24) who received an as needed (PRN) psychotropic. Failure to limit PRN	F 758	F758 – PRN Psychotropics 1. DNS notified the provider verbally of 14-day reviews on Resident #24. The order was for 14-day reviews and was put in on 04/17/2024. On 05/01/2024, the provider was notified of 14-day usage with orders to continue PRN Ativan. 2. Any resident receiving PRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 758	Continued From page 32 psychotropic use to 14 days unless reevaluated by a practitioner placed the resident at risk of receiving unnecessary medications and experiencing adverse drug effects. Findings include: Review of the facility policy titled "Psychotropic Medications" occurred on 04/17/24. This policy, dated December 2023, stated, ". . . PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN. . . . ." Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated 10/02/23, included Lorazepam (antianxiety) 0.5 milligrams every 4 hours as needed for anxiety/agitation. The facility failed to obtain an order to extend the psychotropic medication beyond the original 14 days and failed to include the rationale/specific circumstances for its extended use and a stop date established by the prescriber. During an interview on 04/16/24 at 10:48 a.m., an administrative nurse (#1) confirmed the facility failed to obtain a new order for the extended use of Resident #24's Ativan.	F 758	psychotropic medications has the potential to be affected by this deficient practice. 3. All licensed nurses re-educated on GSS Psychotropic Medication Policy and Procedure specific to PRN 14 day stop order requirements by DNS or designee on 04/26/2024. System change implemented: Clinical interdisciplinary team will review PCC Dashboard psychotropic medication at clinical meeting each business day to ensure stop order is present for all PRN psychotropic orders and will follow up as indicated. 4. MDS Coordinator will conduct documentation audit to verify compliance with 14 day stop requirements. Audits will be conducted 1 X / week for 4 weeks, then 1 X / month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. Compliance Date: May 15th, 2024.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 33 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 34 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 6 sampled residents (Resident#17, #35 and #195) observed with enhanced barrier precautions (EBP). Failure to practice infection control standards related to linen handling, hand hygiene, and glove use, and ensure staff use the proper personal protective equipment (PPE) has the potential to spread infection throughout the facility.	F 880	F880 – Infection Control 1. Laundry staff were re-educated of appropriate hand hygiene and glove use on 04/16/2024. Nursing staff were re-educated on EBP, hand hygiene, glove use, and linen handling on 04/26/2024. 2. Any resident has the potential to be affected by this deficient practice. 3. DNS re-educated nursing staff on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 35 Findings include: Review of the facility policy titled "Standard and Transmission-Based Precautions, All Service Lines - Enterprise" occurred on 04/17/24. This policy, revised 04/02/24, stated, ". . . Purpose . . . To prevent the spread of infection . . . Enhanced Barrier Precautions . . . Enhanced barrier precautions expand the use of PPE [Personal Protective Equipment] beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] . . . Enhanced barrier precautions are needed for residents with chronic wounds (pressure ulcers . . .) . . . and Residents with Indwelling Medical devices (. . . indwelling urinary catheters . . .) . . ." Review of the facility policy titled "Laundry, Resource Packet - Collecting Soiled Clothes and Linens" occurred on 04/17/24. This undated policy stated, ". . . Soiled laundry will be collected to prevent the spread of potential infectious disease. All soiled linens, soiled with bodily material, will be treated as if it is potentially infectious. . . . Clothes and linens should be placed directly into plastic bags. . . ." Review of the facility policy titled "Hand Hygiene - Enterprise" occurred on 04/17/24. This policy, dated 03/29/22, stated, ". . . All employees in patient care areas . . . will adhere to the 4 Moments of Hand Hygiene . . . 2. Before Clean Task 3. After Bodily Fluid/Glove removal . . . Gloves are a protective barrier for the HCW	F 880	EBP, hand hygiene, glove use, and linen handling on 04/26/2024. All staff re-educated on infection control practices, specific to hand hygiene and glove use, EBP, and handling linen by administrator on 05/08/2024. 4. Infection Preventionist will conduct observation audits of 5 staff members verifying proper hand hygiene, glove use, handling of linen, and EBP practices. Audits will be completed 1x/week for 4 weeks, then 1x/month for 2 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. Compliance Date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 36	F 880		

[health care worker] according to standard precautions. 1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal. . . . Change gloves when moving from a dirty to clean or sterile activity performing hand hygiene in between changing gloves. . . ."

- Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . I require Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device:-Foley Catheter . . . Don gown and gloves when performing high contact care activities including: dressing . . ."

Observation on 04/15/24 at 12:00 p.m. showed a sign on Resident #17's door stating, "Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing . . . Changing Linens. . . ." A laundry aide (#8) wore a glove on the right hand, applied alcohol based hand rub (ABHR) to the gloved hand, entered Resident #17's room with clean laundry, and exited the room. Without removing the glove and performing hand hygiene, the laundry aide retrieved a set of clothes from the laundry cart, applied ABHR to the same glove on the right hand, and took the laundry into a different resident room.

The laundry aide (#8) failed to follow facility policy for hand hygiene and glove use.

Observation on 04/16/24 at 8:10 a.m. showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 37	F 880		

Resident #17 seated in a wheelchair by the bed and the resident's personal blanket on the floor. A certified nurse aide (CNA) (#7) wore a gown and no gloves and assisted the resident to don a shirt. The CNA performed hand hygiene and donned gloves. The CNA removed soiled linens from the bed and placed them directly on the floor. Without performing hand hygiene or donning clean gloves, the CNA (#7) applied clean linen to the bed, picked up Resident #17's the blanket off of the floor, folded it and placed it on top of clean linen at the foot of the bed.

The CNA (#7) failed to wear appropriate PPE while performing high contact care activities, change gloves and perform hand hygiene per facility policy, failed to place the soiled linen in a plastic bag prior to placing it on the floor, and placed a soiled blanket back on Resident #17's bed.

-Review of Resident #35's medical record occurred on all days. A Wound/Skin Assessment completed on 03/26/24 identified ". . . Left Heel Unstageable Pressure Ulcer . . ."

Observation on 04/14/24 at 11:48 a.m. showed a sign on Resident #35's door stating, "Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . . . Transferring . . . Providing Hygiene . . . Changing briefs or assisting with toileting . . ."

Observation on 04/16/24 at 9:35 a.m. showed two CNAs (#4 and #5) assisted resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 38	F 880		

transfer from the wheelchair to the toilet in the public bathroom. Both CNAs wore gloves but failed to don gowns. The CNA (#5) removed the resident's soiled brief and placed a new brief. The CNA (#5) cleaned urine off the floor, removed her gloves, and without performing hand hygiene donned new gloves. The CNAs assisted the resident from the toilet to the wheelchair after CNA (#4) performed perineal cares.

The CNAs (#4 and #5) failed to don appropriate PPE while they toileted Resident #35 and the CNA (#5) failed to follow facility policy for hand hygiene and glove use.

- Review of Resident #195's medical record occurred on all days of survey. A Wound/Skin Assessment completed on 04/12/24 identified "Stage II PU [pressure ulcer] noted on coccyx. Physician notified. . . ."

The current care plan stated, ". . . I have an actual impairment to skin integrity R/T fragile skin, immobility, and incontinence E/B [evidenced by] Stage II pressure ulcer. . . ."

Observation on 04/13/24 at 4:30 p.m. showed a sign on Resident #195's door stating, "Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . . .Transferring . . .Providing Hygiene . . . Changing briefs . . . " A nurse (#14) and CNA (#11) performed hand hygiene, donned gloves, and entered the resident's room to provide cares and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 880	Continued From page 39 transfer the resident. Staff failed to don a gown. During an interview on 04/16/24 at 3:20 p.m., an administrative nurse (#1) stated she expected staff to handle linens and use gloves/perform hand hygiene per policy. During an interview on 04/17/24 at 12:15 p.m., an administrative nurse (#1) stated she expected staff to follow enhanced barrier precautions by donning correct PPE required for the cares being delivered.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F 883		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 883	Continued From page 40 immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccination for 1 of 5 sampled residents (Resident #17)	F 883	F883 – Immunizations 1. ADON sent education and consent form for PCV-20 vaccination to resident #17's POA on 05/09/2024. 2. Any resident has the potential to be affected. (We have to do our PCV 20s.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 883	Continued From page 41 reviewed for immunization status. Failure to offer pneumococcal vaccine to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contract pneumonia and spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19 [coronavirus], Other . . . LTC [long term care] . . ." occurred on 04/17/24. This policy dated, 09/21/23, stated, ". . . To provide residents and clients the opportunity to receive immunizations as they fit into their healthcare goals. . . . Upon admission, each client, resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines . . . Review current vaccinations. . . . Provide and document education on the benefits and potential side effects of the vaccinations for which the client/resident is eligible. . . ." Review of Resident #17's medical record occurred on all days of survey. The resident was admitted in January of 2024. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or their legal representative. The facility failed to follow their policy for pneumococcal vaccine administration.	F 883	3. All licensed nurses re-educated by DNS or designee on GSS Immunization policy and procedure specific to pneumococcal vaccination education to all residents at time of admission on 04/26/2024 or prior to next scheduled shift. System change implemented: Immunization education, including pneumococcals, added to the admission packet to ensure immunization education and offering is completed for all residents at the time of admission. 4. Infection Preventionist will conduct documentation audit for 100% of admissions for administration or refusal of immunizations. Audits will be completed 1x/month for 3 months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. 5. Compliance Date: May 15th, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	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
F 883	Continued From page 42 During an interview on 04/16/24 at 3:20 p.m., an administrative nurse (#1) verified the facility failed to assess Resident #17's pneumococcal immunization status and document history, offer and/or refusal of the pneumococcal vaccine.	F 883		