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 04/24/2025

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, facility reported incident survey, and complaint survey started on April 14, 2025 and ended on April 16, 2025. During the complaint investigation, the facility was found in compliance with regulatory requirements. During the facility reported incident survey, the facility was found noncompliant with regulatory requirements.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		5/15/25

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

Electronically Signed | 05/13/2025

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 04/24/2025

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 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and resident and staff interview, the facility failed to provide care in a manner that maintained, enhanced, and respected resident's dignity and individuality for 1 of 9 sampled residents (Resident #7) who voiced concerns regarding sleep and toileting cares. Failure to honor Resident #7's choice for napping, bedtime, and toileting does not enhance the resident's quality of life and may result in decreased self-esteem, quality of life, and increased pain. Findings include: Review of the facility policy titled "Resident Dignity" occurred on 04/24/25. This policy, dated December 2024, stated, ". . . PURPOSE . . . To maintain the dignity of all residents . . . To promote, encourage, support and enhance the residents' self-esteem . . . To promote a sense of self-worth . . . promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 550	F550 – Resident Rights 1. Verbal re-education to all staff on duty on 4/24/24 provided by administrator and DNS on resident rights specific to call light response times. 2. All residents have the potential to be affected by this deficient practice. 3. All staff were re-educated on GSS Resident Rights Policy and Procedure including call light answering and response times on Wednesday, May 14th. New facility process: Facility Leadership rounding implemented to assist in answering call lights and visits with residents to ensure their needs are met. 4. DNS or designee will complete call light response times audit to ensure appropriate wait times and residents needs being met. Audits will be completed 3x/week for 4 weeks, then 1x/week for	

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 04/24/2025

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 550	Continued From page 2 full recognition of his or her individuality. . . ." Review of Resident #7's medical record occurred on all days of survey. The current care plan stated, ". . . I have . . . incontinence . . . TOILET USE: Resident is not toileted -Is checked and changed every 3 hours and PRN [as needed] . . . Resident requires x2 [2 staff] assist with check and change. . . . TRANSFER-Transfer Between Surfaces: Resident needs x2 assist with hoyer [mechanical lift]. . . . I have chronic pain/discomfort R/T [related to] osteoarthritis right knee and limited mobility. . . ." During an interview on 04/21/25 at 12:33 p.m., Resident #7 stated she would like to go to bed at 8:00 p.m. and must wait until 10:00 p.m. The resident stated staff tell her, "Well we're busy, you have to wait." Observations on 04/21/25 identified the following: *12:53 p.m., a certified nurse aide (CNA) (#3) assisted Resident #7's roommate. Resident #7 stated to the CNA (#3), "I'd like to lay down too." *1:04 p.m., the CNA (#3) finished assisting the roommate. Resident #7 stated, "How about me?" The CNA stated, "I'll come back, I have a couple of things to do," and left the room. *1:30 p.m., Resident #7's call light on. *1:37 p.m., Resident #7's call light remained on. *1:41 p.m., a medication aide (MA) (#5) entered Resident #7's room and stated, "Let me go finish my med pass." The MA turned off the call light and exited room. *1:42 p.m., Resident #7 turned the call light back on. *1:44 p.m., A staff member (#6) entered resident's room and asked, "What do you need?"	F 550	4 weeks, 1x/month for 1 months then 1x/quarter for 3 quarters. Audit results will be submitted to the QAPI committee for review and recommendation. 5. Compliance date: May 15th, 2025	

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 04/24/2025

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 550	Continued From page 3 The staff member turned the call light off, exited the room and spoke with a CNA (#3) in the hall. The CNA #3 stated, "It's going to be a while." *1:47 p.m., Resident #7 turned the call light back on. *1:48 p.m., approximately 55 minutes from the first time Resident #7 requested to lay down, two CNAs (#3 and #4) brought the mechanical lift into Resident #7's room. CNA (#4) asked the resident, "Are you ready to lay down?" The resident stated, "I was ready an hour ago, there's a mess in here and everything. Where have you been?" A CNA (#3) stated, "Busy helping people." The resident responded, "What am I, Swiss cheese? They have to go find you to help me. You did all this for my roommate and then walked out. I'm supposed to be checked at 1 [1:00 p.m.], it's almost 2 [2:00 p.m.], you do this to me all the time. It hurts to sit here like this. I've been sitting here too long; I haven't been changed since 10:00 this morning." The two CNAs (#3 and #4) transferred the resident into bed, removed the wet brief, and performed perineal care. During an interview on 04/24/25 at 11:20 a.m., an administrative staff member (#2) stated she expected staff to answer call lights within 10 minutes and provide care as soon as possible.	F 550		
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	F 641	F641 – Accuracy of Assessments	5/15/25

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 04/24/2025

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 4 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 4 of 13 sampled residents (Residents #3, #13, #28, and #189). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, pages I-5 and I-8, stated, ". . . Active Diagnoses in the Last 7 Days - Check all that apply . . . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . . . medical treatments . . . during the 7-day look-back period . . ." Review of Resident #189's medical record occurred on all days of survey. Medications included Buspirone (an anti-anxiety) and Sertraline (an antidepressant). The admission MDS dated 04/10/25, showed the facility failed to include the diagnoses of anxiety and depression. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page M-2 stated, ". . . M01001 . . . Check A if resident has a Stage 1 or	F 641	1. On 04/24/25, RAC-CT certified DNS re-educated the remote MDS Coordinator on accurate MDS coding and completion. MDS's with coding errors for resident #28 were modified/corrected 4/24/25, transmitted on 04/26/25 and accepted on 5/6/25. MDS's with coding errors for Residents #189, # 3 & #13 were modified/corrected on May 9th, transmitted on May 9th and accepted on May 12th. 2. All residents have the potential to be affected by this deficient practice. 3. Remote MDS coordinator & DNS were re-educated by GSS Senior Clinical Reimbursement Analyst on accurate MDS coding for Section I, M, & N through the MDS RAI Manual on Wednesday, May 14th. New facility process: MDS coordinator will review 100% of validation reports and address any error messages as indicated. 4. DNS or designee will audit 5 completed MDS's prior to transmission for accuracy of coding in section I, M, & N. Any incorrect coding identified will be immediately addressed. Audits will be completed 1x/week for 4 weeks, 1x/month for 2 months then 1x/quarter for 3 quarters. Audit results will be submitted to the QAPI Committee for review and recommendations. 5. Completion date: May 15th, 2025	

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 04/24/2025

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 5	F 641		

greater pressure ulcer/injury, a scar over bony prominence . . ."

Review of Resident #13's medical record occurred on all days of survey. Diagnoses identified Stage 1 and Stage 2 pressure ulcers on the buttocks. The quarterly MDS, dated 04/09/25, showed the facility failed to code the presence of pressure ulcers.

SECTION N: MEDICATIONS

The Long-Term Care Facility RAI User's Manual, revised October 2024, pages N-1 to N-3 and N-7 stated, ". . . N0300: Injections . . . Record the number of days that any type of injection (e.g., subcutaneous, intramuscular, or intradermal) was received . . . N0350: Insulin . . . A. Insulin injections - Record the number of days that insulin injections were received . . . B. Orders for insulin - Record the number of days the physician . . . changed the resident's insulin orders . . . N0415A1. Antipsychotic: Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period . . ."

- Review of Resident #3's medical record occurred on all days of survey. The physician's orders identified Abilify (an antipsychotic medication). The quarterly MDS, dated 04/03/25, showed the facility failed to code the antipsychotic.

- Review of Resident #28's medical record occurred on all day of survey. A physician's order, dated 06/24/24, identified Ozempic (an injectable non-insulin hypoglycemic medication)

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 04/24/2025

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 subcutaneously weekly. The significant change MDS, dated 11/19/24, showed facility the facility failed to code the Ozempic injection. A quarterly MDS, dated 02/13/25, showed the facility coded one insulin injection and one insulin order during the look back period, even though the resident received no insulin. During interviews on 04/24/25, an administrative nurse (#2) confirmed staff coded Resident's #3, #13, #28, and #189's MDSs incorrectly.	F 641		
F 689 SS=E	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 the facility reported incident (FRI), review of the facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and proper use of assistive devices to prevent accidents for 1 of 2 sampled residents (Resident #13) and 4 supplemental residents (Residents #7, #12, #23, and #30) observed during full body mechanical lift (Hoyer) transfers. Failure to ensure staff use a mechanical lift properly placed residents at risk of serious injury from falls. Findings include:	F 689	F689 – Free of Accidents & Hazards 1. Verbal re-education to nursing staff on duty on 4/24/25 provided by DNS on Safe Resident Handling Process specific to completing to the time out to verify the sling is secure when transferring with a total lift. 2. Any resident who needs assistance with transfers with a total lift has the potential to be affected by this deficient practice. 3. DNS or designee re-educated staff on prevention of accident and hazards and promoting resident safety on Wednesday,	5/15/25

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 04/24/2025

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 7 Review of the facility policy titled "Safe Resident Handling Program (SRHP)" occurred on 04/24/25. This policy, dated 12/23/24, stated, ". . . The Safe Resident Handling Program (SRHP) is a loss prevention program that has proven to reduce negative outcomes related to resident injuries . . . Will perform a TIME OUT safety stop while the resident is in a sling or harness and still over the surface of the bed or chair to ensure that all straps are secure before moving away from the surface. This is to be completed once the straps are taut, but before the resident leaves a surface. . . . Whan a resident's weight is supported by a solid surface, such as a bed, the loops on the slings are loose and can come off the lift. After raising the resident's weight up and off the support service [sic] and before moving the resident from the support surface, STOP, take a "time out", and check/tug on each and every sling connection to be sure it is secure. . . ." Review of the FRI occurred on 04/21/25. The final report, dated 02/21/25, stated, ". . . Resident was being transferred with a Hoyer lift with an assist of two staff when harness came off of hook and resident slipped out of the Hoyer sling with head resting on leg of it. Resident was assessed by nurse and no injuries were found. . . . The right upper sling hook came off during transfer and resident slid out of sling to the floor, lying on her right side with her head resting on the leg of the total lift. A 'timeout' double check for proper sling hook placement was not performed prior to transfer. . . ." - Review of Resident #7's medical record	F 689	May 14th. New facility process: Staff will conduct time out to ensure that sling loops are secured prior the resident transferring. All lifts have a reminder label to conduct time out prior to transferring the resident with the total lift. 4. DNS or designee will conduct observation audits of two CNA's who are completing total lift transfers. Audits will be completed 2x/week for 4 weeks, 1x/week for 4 weeks, 1x/month for 1 month then 1x/month for 3 quarters. All audit results will be submitted to the QAPI Committee for review and recommendations. 5. Compliance date: May 15th, 2025	

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 04/24/2025

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 8	F 689		

occurred on all days of survey. The current care plan stated, ". . . TRANSFER - Transfer Between Surfaces: Resident needs x2 [two staff] assist with hoyer and X [extra]-Large mesh sling."

Observation on 04/21/25 at 1:48 p.m. showed two CNAs (#3 and #4) transferred Resident #7 from the wheelchair to the bed using a full body mechanical lift. After connecting the lift sling straps to the hooks on the lift, CNA (#3) raised the lift while CNA (#4) moved to the opposite side of the bed. The CNAs failed to perform a timeout to check the loops of the sling were securely connected to the lift before moving the resident from above the bed.

- Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . TRANSFER - Transfer Between Surfaces: x2 staff assist with large high back sling and hoyer."

Observation on 04/21/25 at 2:30 p.m. showed two CNAs (#9 and #11) transferred Resident #12 from the bed to the wheelchair using a full body mechanical lift. After connecting the lift sling straps to the hooks on the lift, CNA (#9) raised the lift while CNA (#11) moved to the opposite side of the bed. The CNAs failed to perform a timeout to check the loops of the sling were securely connected to the lift before moving the resident from above the bed.

- Review of Resident #23's medical record occurred on all days of survey. The current care plan stated, ". . . Transfer Between Surfaces: x2 assist with Hoyer lift w/ [with] medium sling . . ."

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 04/24/2025

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 9 Observation on 04/21/25 at 1:26 p.m. showed two CNAs (#3 and #11) transferred Resident #23 from the wheelchair to the bed using a full body mechanical lift. After connecting the lift sling straps to the hooks on the lift, CNA (#11) raised the lift while CNA (#3) moved to the opposite side of the bed. The CNAs failed to perform a timeout to check the loops of the sling were securely connected to the lift before moving the resident from above the wheelchair. - Review of Resident #30's medical record occurred on all days of survey. The current care plan stated, ". . . Transfer between surface: hoyer using large high back sling X2 staff assist . . ." Observation on 04/21/25 at 12:53 p.m. showed two CNAs (#3 and #5) transferred Resident #30 from the wheelchair to the bed using a full body mechanical lift. After connecting the lift sling straps to the hooks on the lift, CNA (#5) raised the lift while CNA (#3) moved to the opposite side of the bed. The CNAs failed to perform a timeout to check the loops of the sling were securely connected to the lift before moving the resident from above the wheelchair. The staff failed to perform a timeout during full body mechanical lift transfers per education provided after a facility reported incident on 02/14/25. During an interview on 04/24/25 at 11:15 a.m., an administrative nurse (#2) stated she expected staff to perform a time out with every mechanical lift transfer.	F 689		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/15/25

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 04/24/2025

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 10 §483.80 Infection Control The facility must establish and maintain an 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 §483.71 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;	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 04/24/2025

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 11 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 1 of 1 sampled resident (Resident #18) with Multi-Resistant Staph Aureus (MRSA) (a type of contagious infection resistant to antibiotics) in a wound. Failure to follow infection control practices related to location of a dressing change and enhanced	F 880	F880 – Infection Prevention and Control 1. On 4/21/25 education was immediately completed with the nurse who completed the wound care to resident #18 in the nurse's station/medication room in relation to proper Enhanced Barrier Precautions PPE use and not completing wound treatment in the nurse's	

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 04/24/2025

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 12 barrier precautions (EBP) has the potential to spread infection throughout the facility. During the on-site recertification survey, the team determined an Immediate Jeopardy (IJ) situation existed on 04/21/25 at 3:55 p.m. The IJ was identified when a staff nurse performed a dressing change in the medication room and failed to wear Personal Protective Equipment (PPE) (a gown). This finding placed all residents, staff, and visitors at risk for infection and/or spread of infection. *04/22/25 at 10:00 a.m., the survey team notified the administrator and director of nursing (DON) of the IJ situation, provided the IJ template, and requested a plan for removal of the IJ. *04/22/25 at 1:45 p.m., the survey team reviewed and accepted the facility's removal plan for the IJ. The removal plan contained the following: *Facility issued a directive that the nurse's station (medication room) must not be used for wound care. *The nurse's station (medication room) was deep cleaned. *All residents with wounds will have their wound treatments completed in the resident's room with proper PPE. *1:1 education provided to the staff nurse who performed the wound care regarding appropriate location to perform wound care, the standards of EBP, and the correct use of PPE. *Educated all staff on proper use of PPE and guidelines of EBP. This training was conducted via On Shift (all employee text message) and in person to staff on duty or prior to next scheduled shift.	F 880	station/medication room. On 4/22/25 education was completed to all staff via on-shift message and in-person training completed on the proper use of EBP PPE and all nurses (RN & LPN) education not providing wound care treatments in the nurse's station/medication room. All other staff will get in person training prior to the next scheduled shift. The nurse station was deep cleaned on 4/22/25. DNS or designee completed observation audits of staff in reference to appropriate wound care 1x/day for 10 days. Any deficient practice identified will be addressed immediately. Audit results will be submitted to QAPI Committee for review and recommendation. 2. All residents have the potential to be affected by this deficient practice. 3. DNS or designee will be re-educated on GSS policy Standard, Enhanced Barrier and Transmission Based Precautions to all staff on proper use of PPE, completing wound treatments in an appropriate location and caring for residents with an MDRO on Wednesday, May 14th. New facility process: We will not be providing wound treatments in the nurse station/medication room. Staff will use PPE appropriately as per policy. 4. DNS or designee will conduct observation audits on 2 nurses providing wound care to verify location and proper	

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 04/24/2025

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 13 *04/22/25 at 2:20 p.m., the survey team verified the implementation of the removal plan and the IJ removal. The deficient practice remained at an "D" scope and severity following the removal of the immediate jeopardy. Findings include: Review of the facility policy titled "Multidrug-Resistant Organisms, MRSA . . ." occurred on 04/24/25. This policy, dated April 2024, stated, ". . . Residents colonized with a CDC [Centers for Disease Control] targeted MDRO [Multi Drug Resistant Organism] and select epidemiologically important MDROs at the facilities discretion are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. . . . Summary of PPE Use . . . Enhanced Barrier Precautions . . . Applies to: All residents with any of the following: Wounds . . . Infection or colonization with a novel or targeted MDRO . . . PPE used for these situations: During high-contact resident care activities: Wound care: any skin opening requiring a dressing . . . Required PPE: Gloves and gown prior to the high-contact care activity . . . Face protection may also be needed if performing activity with risk of splash or spray . . ." Review of the facility policy titled "Enhanced Barrier and Transmission-Based Precautions" occurred on 04/24/25. This policy, dated April 2025, stated, ". . . Enhanced barrier precautions expand the use of 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	F 880	PPD use. Audits will be completed 2x/week for 4 weeks, 1x/week for 4 weeks, 1x/month for 1 month then 1x/month for 3 quarters. All audit results will be submitted to the QAPI Committee for review and recommendations. 5. Compliance date: May 15th, 2025	

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 04/24/2025

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 14 care activities that provide opportunities for transfer for multi drug-resistant organisms (MDROs) to staff hands and clothing. . . . Enhanced barrier precautions are used for residents who are infected or colonized with a CDC-targeted MDRO . . ." Review of the facility policy titled "Personal Protective Equipment PPE . . ." occurred on 04/24/25. This policy, dated January 2025, stated, ". . . Wear a gown for direct resident/patient contact if the resident/patient is on Enhanced Barrier Precautions. . . to protect clothing from potential contamination. . . ." Review of the facility policy titled "Wound Dressing Change" occurred on 04/24/25. This policy, dated November 2024, stated, ". . . Follow EBP (wash hands before entering and exiting the room, wear gloves and gown). . . ." Review of Resident #18's medical record occurred on all days of survey. Diagnoses identified chronic osteomyelitis (a bone infection) to the left ankle and foot, MRSA, and group B streptococcus (a type of bacterial infection). Physician's orders included Betadine (an antiseptic solution cleanser used to prevent the growth of and kill bacteria), wet to dry dressings to the wound on the left great toe, and Doxycycline (an antibiotic medication) daily for 14 days for MRSA. The current care plan stated ". . . I require Enhanced Barrier Precautions (EBP) R/T [related to] open wounds, MRSA, & Strep B . . . wound to left toe . . ." Observation on 04/21/25 at 3:55 p.m. showed a nurse (#12), with gloved hands, performed a	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 04/24/2025

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 15 dressing change to Resident #18's MRSA infected left great toe in the medication room. The resident's left foot rested on a disposable pad on the floor, and the soiled dressing, removed from the resident's foot by the nurse, also on the pad. Observation showed a spray bottle of wound cleanser nearby. At 4:05 p.m., Resident #18 exited the medication room and the nurse (#12) stated the dressing change should have been completed in the resident's room and not the medication room as the resident is on EBP. The staff nurse (#12) failed to complete the dressing change in the resident's room and failed to wear the appropriate PPE prior to completing the dressing change. During an interview on 04/22/25 at 10:00 a.m., an administrative nurse (#2) confirmed the medication room is considered a clean space. At 2:20 p.m., an administrative staff member stated he/she expected facility staff to perform procedures in the resident's room and wear appropriate PPE.	F 880		