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 05/25/2023

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 05/22/23 and concluded 05/25/23. The concerns identified by the complainant was partially substantiated.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		6/29/23

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

Electronically Signed | 06/12/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices, record review, facility policy, and staff interview, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form and Notice of Medicare Non-coverage (NOMNC) form two days in advance of discharge for 2 of 3 supplemental residents (Resident A and B) discharged from Medicare Part A services. Failure to provide Medicare Part A letters/notices within the required time frame has the potential to limit the residents' right to an expedited review of service termination (NOMNC) and/or to exercise their rights to Medicare Part A services (SNFABN).	F 582	F582 – Medicaid/Medicare Coverage/Liability Notice 1. Appropriate Medicare forms will be completed and filed for resident A by 6/13/23. Resident B no longer resides in the facility. Reviews will be completed on all residents who had Medicare A services end since June 1st, 2022. Appropriate documentation will be completed to ensure we compliance with the Medicare denial process. 2. Any resident receiving Medicare A services currently and future residents	

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F 582	Continued From page 2 Findings include: Review of the facility policy titled "SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNFABN)" occurred on 05/24/23. This policy, dated 02/13/23, stated, ". . . to inform the beneficiary of potential non-coverage . . . The skilled nursing facility (SNF) will issue the Skilled nursing Facility Advance Notice of Non-Coverage (SNFABN). . . to appropriately inform Medicare beneficiaries of potential financial liability and allow . . . the opportunity to request a Medicare demand bill. . ." Review of the facility policy titled "Notice of Medicare Non-Coverage (NOMNC)" occurred on 05/24/23. This policy, dated 02/14/23, stated, ". . . affords the beneficiary the right to an expedited determination review. . . to dispute the provider's decision to end covered care. All beneficiary's whose covered services are being terminated must receive a Notice of Medicare Non-Coverage before their services end. . ." Review of the Medical record showed facility staff failed to provide a written notification form NOMNC to the residents' representative before Resident A's services ended on 01/21/23 and failed to provide written SNFABN and NOMNC forms to the residents' representative before Resident B's services ended on 04/06/23. During interviews on 05/23/23 at 05:12 p.m., and on 05/24/2023 at 10:03 a.m., administrative staff members (#3 and #6) agreed the facility failed to provide Medicare notices to Resident A and B's representatives regarding the end of their	F 582	admitted on a skilled stay could be affected. 3. On 6/7/23 MDS coordinator was educated on the appropriate Medicare Denial process. The same education will be provided to the Medicare team on 6/14/23. During weekly Medicare meetings, the team will discuss all Medicare A residents. If it is determined a resident will be coming off Medicare A services, the MDS coordinator or designee will contact the appropriate individual and give appropriate (48 hour) notice that Medicare services will be ending. Appropriate documentation will be placed on the Medicare forms that the information was discussed. A copy of the forms will be made and placed in the resident EMR. The original documents will be sent to the resident contact to be signed and returned to the facility. The facility will update the record to reflect the documents were returned to the facility. 4. MDS Coordinator or designee will audit the appropriate use of the SNF Advance Beneficiary Notice of Non-Coverage and Notice of Medicare Non-coverage one time a week for one month (if available), weekly for one month, bi-weekly for one month. The Quality Assurance Committee will review and monitor appropriate use of the SNF Advance Beneficiary Notice of Non-Coverage and Notice of Medicare Non-coverage Audits during monthly quality meetings. The Quality Assurance	

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F 582	Continued From page 3 Medicare Part A benefits.	F 582	Committee will ensure compliance. 5. Completion Date: June 29th, 2023	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		6/29/23

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, information provided by the complainant, and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment on 2 of 2 units (100 Unit and 200 Unit). Failure to maintain a safe, clean, and sanitary environment does not provide a comfortable/homelike environment and places residents at risk for injury. Findings include: The complainant indicated the facility failed to clean carpets, repair and paint walls throughout the facility. Observations of resident rooms and the environment on all days of the survey showed the following: *100 Unit: 103-1 and 2: minor scrapes on wall behind headboards. 105-1 and 2: chipped paint/wall damage behind headboards. 106-1 and 2: chipped paint/wall damage behind headboards and the room smells of urine. 107 to 111 beds 1 and 2: chipped paint/wall damage behind headboards. 112-1 and 2: chipped paint/wall damage behind headboards and the room smells of urine.	F 584	F584 □ Safe Environment 1. Rooms/repairs noted in the CMS-2567 will be fixed by facility staff or contracted to be repaired by an outside vendor. A facility audit will be conducted in all areas to ensure compliance with F584. 2. All residents have the potential to be affected. 3. All staff will be re-educated by the Director of Environmental Services on the proper procedure for reporting work orders. All environmental staff will be educated on the proper procedures, work order process, preventive maintenance & cleaning/deep cleaning per facility policy by 6/14/23. Facility staff will complete carpet cleaning, noted minor wall/heater repairs, fan cleaning/repairs and odor issues. A formal contract(s) will be obtained by 6/29/23 for major painting and wall repair. 4. Environmental Director or designee will do Environment audits three times a week for one month, weekly for two months, bi-weekly for one month, monthly	

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F 584	Continued From page 5 113-1 and 2: chipped paint/wall damage behind headboards. *200 Unit 205-1: a hole in the wall along the right side of the bed approximately 8 inches vertical by 1 inch horizontal. 205-2: a box fan with a broken grate and dust build up on the grate and fan blades. 206-1: area of paint scrapped off the wall above the head of the bed 207-2: multiple long scratches/gouges on the wall behind the headboard, nail or screw holes in the wall; paint outline visible; metal end cap of heater off and leaning against wall. 208-2: gouges into the wall at the head of the bed with sheet rock exposed and fragments located on the floor. 209-2: an oscillating fan with dust build up on the grates and fan blades, staining on the carpet in middle of the floor. 211-2: a blue box fan with dust build up on the grate and fan blades. 212-1: area of paint scrapped off the wall above the head of the bed. 212-2: gouges in the wall at the head of the bed with sheet rock exposed. 214-1: area of paint scrapped off the wall near the head of the bed. Review of a facility maintenance repair work binder, dated 04/15/23-05/23/23, showed requests on 05/14/23 and 05/18/23 to shampoo the carpet in room 207. Another request on 05/14/23 stated, "urine on the floor in front of bed 1". The requests had not been signed off as completed.	F 584	for 3 months. The Quality Assurance Committee will review and monitor Environmental Audit during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date: June 29th, 2023	

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F 584	Continued From page 6 During an interview on 05/24/23 at 8:14 a.m., a staff member (#8) stated housekeeping staff were not responsible to clean resident fans nor were fans on a cleaning schedule. During an interview on the afternoon of 05/24/23, an administrative staff member (#7) stated he expected staff to deal with requests to clean carpet of urine or feces as soon as possible and not allow multiple days to pass prior to completion.	F 584		
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: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY ON 02/10/22. Based on record review, review of professional reference, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 4 sampled resident (Resident #25) reviewed for blood glucose levels. Failure to notify the physician of blood glucose levels that are out of range may result in untreated hypoglycemia (low blood glucose level). Findings include: The facility failed to provide a policy regarding following physician's orders.	F 658	F658 – Professional Standards 1. Provider was notified of occurrences when he was in the facility for rounds on 05/24/2023. Licensed nurses for resident #25 will be re-educated by 06/13/2023 to ensure understanding/competency of reporting hypoglycemic episodes and parameters. 2. All diabetic residents have the potential to be affected . 3. All licensed nurses will be re-educated by 06/13/2023 on the proper procedure of notifying the physician when sugars are outside of established	6/29/23

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F 658	Continued From page 7 Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 64, stated, ". . . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of Resident #25's medical record occurred on all days of survey. Diagnoses include Type 2 diabetes mellitus. The physician's orders included, Toujeo [insulin] inject 55 units one time a day, Ozempic [antihyperglycemic] inject 2 mg [milligrams] every Wednesday, Novolog [short acting insulin] inject 10 units in morning, hold if blood glucose is less than 120, and Novolog 8 units at lunch and supper, hold if blood glucose is less than 120. Check Blood Sugars four times daily. "Notify MD [Doctor of Medicine] of blood sugar less than 70 or greater than or equal to 400." Review of Resident #25's blood glucose levels from January 20, 2023 to March 7, 2023 showed facility staff failed to notify the physician of blood sugars less than 70 mg/dl [milligrams per deciliter] on five occasions. During an interview on 05/24/23 at 11:04 a.m., an administrative nurse (#3) confirmed staff failed to notify the physician of Resident #25's blood sugar results per physician's order.	F 658	parameters. 4. DNS or designee will do a blood Glucose audit three times a week for one month, weekly for one month, bi-monthly for four months. The Quality Assurance Committee will review and monitor Blood Glucose Audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date: June 29th, 2023.	
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.	F 758		6/29/23

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F 758	Continued From page 8 §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; §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	F 758		

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F 758	Continued From page 9 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: 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 1 sampled resident (Resident #36) who received an as needed (PRN) psychotropic. Failure to limit PRN psychotropic use to 14 days unless reevaluated by a practitioner placed the resident as risk of receiving unnecessary medications and experiencing adverse drug effects. Findings include: Review of the facility policy titled "Psychotropic Medications" occurred on 05/23/23. This policy, reviewed/revised 12/09/22, 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 order. 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 the medication. . . ."	F 758	F758 – Free from Unnecessary Psychotropic Meds/PRN Use 1. On 05/23/2023 DNS removed Ativan Order per the discontinuation order on 01/18/2023 2. Any resident with PRN psychotropic medications or any resident with the potential need for PRN psychotropic medications. 3. All licensed nurses will be re-educated by 06/13/2023 on the proper procedure of PRN psychotropic medications and notify the physician within fourteen days. Re-education on Psychotropic Medication Policy will be done by 06/29/2023. 4. DNS or designee will do a PRN psychotropic Medication Audit three times a week for one month, weekly for one month, bi-weekly for one month & monthly for three months. The Quality Assurance Committee will review and monitor PRN psychotropic Medication Audits during monthly quality meetings. The Quality Assurance Committee will	

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F 758	Continued From page 10 Review of Resident #36's medical record occurred on all days of survey. The physician's orders included a current order for Ativan (antianxiety) 1 milligram every six hours PRN, dated 11/16/22. The facility failed to obtain an order to extend the psychotropic medication beyond the original 14 days and failed to include the rational/specific circumstances for its extended use and a stop date established by the prescriber. During an interview on 05/23/23 at 5:30 p.m., an administrative nurse (#3) confirmed the facility failed to obtain a new order for the extended use of the Ativan. The nurse (#3) also stated she discovered an order to discontinue the PRN Ativan dated 01/18/23 and confirmed the facility failed to complete the physicians order to discontinue the Ativan on 01/18/23 for Resident #36.	F 758	ensure compliance. 5. Completion Date: June 29th, 2023.	
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 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,	F 880		6/29/23

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F 880	Continued From page 11 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, 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.	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 05/25/2023

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 §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 3 sampled residents (Residents #5) observed during cares. Failure to practice infection control standards related to urine disposal has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Catheter: Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen" occurred on 05/25/23. This policy, revised 02/10/23, stated, ". . . Procedure . . . When emptying the catheter bag, place a moisture resistant barrier beneath the measuring container and avoid placing the container on the floor. . . . Do not allow tip of tubing to touch sides of the measuring container or any surface. . . . When done, clean drainage port tip with alcohol wipe and replace in the holder. . . . Wash and dry measuring container according to location procedure. . . ."	F 880	F880 – Infection Prevention and Control 1. Verbal education was provided to nursing staff on 05/24/2023 regarding appropriate process on catheter cares. 2. All residents who have catheters have the potential to be affected. 3. All nursing staff will be re-educated by 06/13/2023 on the proper procedure for administering catheter care. Re-education on Catheter Care Policy will be done by 06/29/2023. The annual skills fair is coming up in July for all nursing staff to test out catheter care competencies. Catheter Policy and skill competencies were added for in-house new hires and the Travel Orientation Binder on 05/24/2023. 4. DNS or designee will do a Catheter Audit three times a week for one month, weekly for two months, bi-weekly for one	

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F 880	Continued From page 13 Review of Resident #5's medical record occurred on all days of survey. The current diagnoses included Methicillin Resistant Staphylococcus Auraus (MRSA) as the cause of other diseases. Observation on 05/23/23 at 8:48 a.m. showed a certified nurse aide (CNA) (#1) obtained a measuring container from the bathroom, placed it directly on the floor, and emptied the contents of Resident #5's urine collection bag into the container. Without cleaning the drainage port tip with an alcohol wipe, the CNA (#1) placed the port tip back into the holder. The CNA entered the shared bathroom, discarded the urine into the toilet, rinsed the container with water from the bathroom sink, and emptied it into the toilet. During an interview on 05/24/23 at 11:25 a.m., two administrative nurses (#3 and #4) stated they expected staff to place a barrier under the collection container, wipe the drainage port before and after emptying the contents of the urine collection bag, and use a clean container to obtain water from the sink.	F 880	month, monthly for three months. The Quality Assurance Committee will review and monitor Catheter Care Audits during monthly quality meetings. The Quality Assurance Committee will ensure compliance. 5. Completion Date: June 29th, 2023.	