STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on November 18-20, 2025. During the investigation, the facility was found noncompliant with regulatory requirements. Based on the results of the investigation survey, an extended survey was also completed on November 20, 2025.	F0000		12/26/2025
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on information received from the facility reported incident (FRI), record review, and staff interviews, the facility failed to thoroughly investigate and document an alleged violation of neglect for 1 of 1 sampled resident (Resident #1) who fell from a bath chair. Failure to thoroughly investigate an incident of potential neglect may result in future neglect and or harm to other residents. Findings include:	F0610	Facility investigative team reviewed and updated resident #1 fall with injury investigative file on 11/23/25. Any resident has the potential to be affected. All resident incidents will be reviewed which occurred in the last 30 days to ensure the investigation was complete. All Licensed nurses educated on responsibilities of initiating the initial investigation. Facility investigative team (which includes Administrator, DNS, Social Worker) will complete training on the investigation process on 12/24/25. IDT team will review investigative information to ensure the information is complete. Regional GSS staff or designee will conduct audits on all new incidents for complete investigations 100% weekly for four weeks, 50% of new incidents per month for the next two months, then random selection of five per quarter for the next three quarters Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: December 26th, 2025.	12/26/2025

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

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

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F0610 SS = D	Continued from page 1 Review of the FRI, submitted to the state survey agency (SSA) on 11/12/25, identified Resident #1 fell from the bath chair and sustained a left femoral neck (hip) fracture on 11/11/25. A physician's progress note, dated 11/11/25, stated, ". . . fell when she had gotten out of the shower earlier today. Initially started having left hip pain. . . . Impression and plan multiple falls . . .Fracture of femoral neck, left . . . admitting . . .” During an interview on 11/18/25 at 11:12 a.m., the certified nurse aide (CNA) (#4) stated during Resident #1’s bath on 11/11/25, she did not have the resident secured in the bath chair with the safety strap, and, “When I had finished her bath and was going to get her dried off and dressed she [Resident #1] reached for the door on the tub and fell out of the tub chair. I called for help on my walkie and [CNA (#6)] came to help me. She got the hoyer [mechanical lift] and we transferred her [Resident #1] from the floor back to the bath chair. Then the nurse came in and checked [Resident #1] and did vitals and left the room. After that I called for help to transfer [Resident #1] from the tub chair to her wheelchair.” When asked how the resident was transferred from the bath chair to the wheelchair the CNA (#4) stated, "With the sit-to-stand lift." During an interview on 11/18/25 at 12:10 p.m., the CNA (#6) stated, "[CNA (#4)] called for help on walkie. I went in right away and [Resident #1] was wet, crawling on all fours and trying to get back into the tub. I asked her [Resident #1] if she was ok and she said, 'Get me off the floor I'm cold.' We waited for help to come and after no one came to help us we called again and no one came. We waited for help for 10-15 minutes and then we used the hoyer lift to get [Resident #1] off the floor into the bath chair. I asked her if she had any pain and she said 'No.' [CNA (#4)] put a lap belt on her and I left to get the nurse." During an interview on 11/18/25 at 12:25 p.m., a nurse (#5) stated, "At 1:20 p.m. I saw the tub room light on and I went in there to do a skin check. [Resident #1] was in the bath chair without the belt on and I noticed a hoyer lift sheet underneath her. I pointed to it and shrugged my shoulders and then [CNA (#4)] said, 'Did they tell you she fell.' [Resident #1] said she had no pain and moved her legs and arms without any concerns and then I left the tub room." Review of nursing progress notes identified the following:	F0610		

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F0610 SS = D	Continued from page 2 * 11/11/25 at 4:11 p.m., ". . . resident had a fall from the bath chair at 1305 [1:05 p.m.], resident was able to move all extremities per her usual with skin check, when [daughter's name] comes to facility at 1400 [2:00 p.m.], she sits with resident to help her play bingo, resident then states 'she is having lots of pain,' grabbing at her left hip . . . resident was taken to her room to lay down, call was placed to [doctor's name] at 1445 [2:45 p.m.], made aware of fall and pain, orders received and observed to send resident to the hospital forx-rays (sic) . . . ambulance here at 1530 [3:30 p.m.] . . ." * 11/17/25 at 4:53 p.m. ". . . Resident arrived today via [by] Nursing home van . . ." Review of the facility Investigation dated, 11/17/25, occurred on 11/18/25 and stated, ". . . INVESTIGATION SUMMARY: The resident [Resident #1's] care planned as assist of 1 with bathing and assist of 1 with pivot transfers. On 11/11/2025, at approximately 1300 [1:00 p.m.], CNA . . . finished the resident's bath, pivot transferred into the bath chair. Prior to securing the lap belt to the bath chair, the resident grabbed onto the open door to the whirlpool and fell forward. CONCLUSION: At the conclusion of the investigation, the facility determined there was no willful intent to neglect as the resident . . . spontaneous movement of grabbing the open tub door prior to securing the bath chair belt, resulted in the fall. . . ." Upon request, the facility provided staff interviews related to the incident. The interviews identified the following: * "On 11/13/2025, DNS [director of nursing services] interviewed [CNA (#4)] on what had transpired the day of the fall. [CNA (#4)] stated that she transferred the resident [Resident #1] in the bath chair, collected v/s [vital signs], and put the resident in the whirlpool. When [CNA (#4)] was finished, she tated (sic) she opened the whirlpool tub door, and [CNA (#4)] expressed that the resident [Resident #1] was reaching and attempting to grab onto things and that [CNA (#4)] was guiding her hands back to the bath chair bars to hold on to. [CNA (#4)] stated that when she was moving the resident out of the whirlpool tub, is when the resident [Resident #1] started reaching for the open tub door and was attempting to grab onto it. [CNA (#4)] stated that she was reaching too far and ended up on the floor. . . ."	F0610		

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F0610 SS = D	Continued from page 3 * "On 11/13/2025, DNS interviewed [(CNA (#6)] in regards to the incident on 11/11/2025. . . . [(CNA (#6)] stated that the resident [Resident #1] was on the floor and that the resident stated, 'get me off the floor." [CNA (#6)] stated she went and got a sling and a hoyer and her and [CNA (#4)] assisted the resident off the floor. . . . DNS immediately educated [(CNA (#6)] on fall management and to never move the resident without a nurse assessing the resident first. * "On 11/13/2025, DNS spoke with [nurse (#5)] in regards to the incident. DNS asked for a run through of what happened. . . . [Nurse (#5)] asked what happened and [CNA (#4)] told her that the resident had fallen out of the bath chair and that they [CNA (#4) and CNA (#6)] picked her up using the sling and hoyer. . . ." The facility's investigation failed to include specific details discovered during staff interviews that would raise concerns of staff negligence resulting in Resident #1's fall and subsequent fracture.	F0610		
F0684 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 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 record review, review of facility policy, review of the facility reported incident (FRI) and investigation, and staff interviews, the staff failed to provide treatment and care in accordance with professional standards of practice to maintain residents' highest level of functioning for 1 of 1 sampled resident (Resident #1) who experienced a fall from the bath chair. Failure to ensure a licensed nurse performed a full-body assessment after a fall may have resulted in further injury and/or pain to the resident. Findings include Review of the facility policy titled "Fall Prevention and Management" occurred on 11/18/25. This policy, dated 10/14/25, stated, ". . . For Fallen Resident . .	F0684	Resident #1 was assessed by a nurse for protentional injury prior to transfer to hospital on 11/11/25 and care plan was updated with residents readmission on 11/17/25. DNS immediately re-educated to CNA and CMA on resident fall to not move until evaluated by licensed nurse. Any resident who has a fall has the potential to be affected by this practice. On 12/24/25 Administrator will provide education to all staff on GSS Fall Prevention and Management Policy and Procedure specific to a nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. Licensed nurses will use the updated fall checklist. Director of Nursing Services or designee will conduct audits on fall checklist 100% weekly for four weeks, 50% of new incidents per month for the next two months, then random selection of five per quarter for the next three quarters. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: December 26th, 2025.	12/26/2025

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F0684 SS = D	Continued from page 4 . Procedure 1. Do not move resident. . . . Stay with the resident and summon the licensed nurse . . . A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. Do not attempt to move the resident if . . . hip fracture is suspected. . . ." Review of the FRI, submitted to the state survey agency (SSA) on 11/12/25, identified Resident #1 fell from the bath chair and sustained a left femoral neck (hip) fracture on 11/11/25. Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, ". . . I have an ADL [activities of daily living] self-care performance deficit R/T [related to] . . . Dementia, Impaired balance, Limited mobility and weakness. . . . TRANSFER: Transfer - Between Surfaces: pivot x2 [assist of two] with gait belt. . . ." A physician's progress note, dated 11/11/25, stated, ". . . fell when she had gotten out of the shower earlier today. Initially started having left hip pain. . . . Impression and plan multiple falls . . . Fracture of femoral neck, left . . . admitting . . ." During an interview on 11/18/25 at 11:12 a.m., a certified nurse aide (CNA) (#4) stated, during Resident #1's bath on 11/11/25 she did not have the resident secured in the bath chair with the safety strap, and "When I had finished her bath and was going to get her dried off and dressed she [Resident #1] reached for the door on the tub and fell out of the tub chair. I called for help on my walkie and [CNA (#6)] came to help me. She got the hoyer [mechanical lift] and we transferred her [Resident #1] from the floor back to the bath chair. Then the nurse came in and checked [Resident #1] and did vitals and left the room. After that I called for help to transfer [Resident #1] from the tub chair to her wheelchair." When asked how the resident was transferred from the bath chair to the wheelchair the CNA (#4) stated, "With the sit-to-stand lift." During an interview on 11/18/25 at 12:10 p.m., a CNA (#6) stated, [CNA (#4)] called for help on the walkie. I went in right away and [Resident #1] was wet, crawling on all fours and trying to get back into the tub. I asked her if she was ok and she said, 'Get me off the floor I'm cold.' We waited for help to come and after no one came to help us we called again, and no one came. We waited for help for 10-15 minutes and then we used the hoyer lift to get [Resident #1] off the floor into the bath chair. I asked her if she had any	F0684		

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F0684 SS = D	Continued from page 5 pain and she said 'No.' [CNA (#4)] put the lap belt on her and I left to get the nurse." During an interview on 11/18/25 at 12:25 p.m., a nurse (#5) stated, "At 1:20 p.m. I saw the tub room light on, and I went in there to do a skin check. [Resident #1] was in the bath chair without the belt on and I noticed a hoyer lift sheet underneath her, I pointed to it and shrugged my shoulders and then [CNA (#4)] said, 'Did they tell you she fell.' [Resident #1] said she had no pain and moved her legs and arms without any concerns and then I left the tub room." Facility staff failed to complete a nursing assessment to evaluate potential injury or determine an appropriate transfer method prior to assisting the resident from the floor. Following bathing, staff utilized a sit-to-stand lift that was neither included in the resident's care plan nor assessed as a safe transfer option for Resident #1. These lapses may have contributed to additional injury and pain for the resident.	F0684		
F0689 SS = SQC-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, review of the facility reported incident (FRI) and investigation, and staff interviews, the staff failed to provide appropriate supervision and use of assistive devices for 2 of 2 sampled residents (Resident #1 and #2) who required staff assistance while bathing. Failure to utilize the bath chair safety strap during bathing resulted in a fall with a fracture for Resident #1 and placed all residents at risk of accidents, falls, and/or injuries. During the on-site FRI investigation, the survey team determined noncompliance with regulatory requirements	F0689	On 11/18/25 resident #2 sustained no injury. Resident #1 was readmitted to the facility on 11/17/25 and care plan updated. On 11/18/25, DNS re-educated nursing staff directly involved with Resident #1 incident on 11/11/25 in the proper use of safety belt when using the whirlpool bath chair. On 11/18 all nursing staff were educated and competency certification was completed via OnShift message and in person training completed to the proper use of the safety belt when caring for a resident in the bath chair which included a training video. All CNA bath aides received in person training/competency verification prior to there next scheduled shift. All nursing staff will receive training/competency verification prior to using the whirl pool tub. Any residents who use the whirlpool tube with the bath chair have the possibility to be affected. On 12/24/25 Administrator completed education to all staff on proper use of the bathchair safety belt when using the whirlpool bathchair. Facility updated bath aide orientation to include manufacture's video on bathchair use. Director of Nursing Services or designee will observe whirlpool bathchair/seatbelt compliance for one bath per day for five days, two baths per week for week, one bath per week two weeks, three baths per month for two months, three baths per quarter for three quarters. Any deficient practice identified will be addressed	12/26/2025

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F0689 SS = SQC-J	Continued from page 6 existed on 11/11/25 when facility staff failed to utilize the bath chair safety strap resulting in a fall/fracture. *On 11/18/25 at 2:03 p.m. the survey team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed on 11/11/25. *On 11/18/25 at 3:00 p.m., The survey team notified the administrator and the director of nursing (DON) of the IJ situation, provided the IJ template and requested a plan for removal of the immediate jeopardy. *On 11/18/25 at 5:35 p.m., The facility provided an IJ removal plan. *On 11/19/25 at 8:20 a.m., The SSA reviewed and accepted the IJ removal plan. The removal plan contained the following: *Signage posted in the bath area as a reminder to staff to use the safety belt at all times when using the bath chair. *Education was provided through video, on-shift messaging, and in-person training on the proper use of the safety belt while caring for a resident in the bath chair to prevent injury, with the staff members directly involved with the deficient practice, all nursing staff on duty, and on-coming staff. *On 11/20/25 at 2:00 p.m., The survey team verified the implementation of the removal plan. The deficient practice remained at a “G” scope and severity following the removal of the IJ. Findings include Review of the facility policy titled "Bathing" occurred on 11/18/25. This policy, dated 08/29/25, stated, ". . . PURPOSE . . . To promote safety for the resident in the bath . . . The use of safety measures and equipment are designed to reduce the risk of injury to residents during a bathing experience. . . . PROCEDURE Tub (whirlpool) . . . Bathing . . . Use appropriate safety measures and equipment to prevent accidents. Safety belts are used for bathing units . . . and bathing lifts. . . ." Review of the FRI, submitted to the SSA on 11/12/25, identified Resident #1 fell from the bath chair and sustained a left femoral neck (hip) fracture on 11/11/25.	F0689	Continued from page 6 immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Compliance Date: December 26th, 2025.	

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F0689 SS = SQC-J	Continued from page 7 - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, ". . . . Impaired balance, Limited mobility and weakness. . . . BATHING: Resident requires x1 [assist of one] staff assist . . . TRANSFER: Transfer - Between Surfaces: pivot x2 [assist of two] with gait belt. . . ." A physician's progress note, dated 11/11/25, stated, ". . . fell when she had gotten out of the shower earlier today. Initially started having left hip pain. . . . Impression and plan multiple falls . . . Fracture of femoral neck, left . . . admitting . . .” During an interview on 11/18/25 at 11:12 a.m., a certified nurse aide (CNA) (#4) stated during Resident #1’s bath on 11/11/25, she did not have the resident secured in the bath chair with the safety strap, and “When I had finished her bath and was going to get her dried off and dressed she [Resident #1] reached for the door on the tub and fell out of the tub chair. When asked how the resident was transferred from the bath chair to the wheelchair the CNA (#4) stated, "With the sit-to-stand lift." During an interview on 11/18/25 at 12:10 p.m., a CNA (#6) stated, "[CNA (#4)] called for help on the walkie. I went in right away and [Resident #1] was wet, crawling on all fours and trying to get back into the tub. I asked her if she was ok and she said 'Get me off the floor I'm cold.' We waited for help to come and after no one came to help us we called again and no one came. We waited for help for 10-15 minutes and then we used the hoyer lift to get [Resident #1] off the floor into the bath chair. I asked her if she had any pain and she said 'No.' [CNA (#4)] put the lap belt on her and I left to get the nurse." During an interview on 11/18/25 at 12:25 p.m., a staff nurse (#5) stated, "At 1:20 p.m., I saw the tub room light on and I went in there to do a skin check. [Resident #1] was in the bath chair without the belt on." This interview conflicts with the CNA (#4's) statement that she applied the belt before leaving to get a nurse. Review of nursing progress notes identified the following: * 11/11/25 at 4:11 p.m., ". . . resident had a fall from the bath chair at 1305 [1:05 p.m.], resident was able to move all extremities . . ." * 11/11/25 at 6:43 p.m. ". . . [daughter's name] phones	F0689		

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F0689 SS = SQC-J	Continued from page 8 stating 'resident left hip is broken . . ." * 11/17/25 at 4:53 p.m. ". . . Resident arrived today via [by] Nursing home van . . . Resident did have a fall and fx [fracture] (sic) her left hip. . . ." - Review of Resident #2's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 08/29/25, identified dependent on staff for assistance with bathing and substantial/maximum assistance with transferring in and out of the shower/tub. Observation on 11/18/25 at 1:38 p.m. showed Resident #2 seated in the whirlpool tub filled with water, bath chair safety strap behind the bath chair and not secured. When asked about the bath chair safety strap not being secured, the CNA (#3) stated, "He [Resident #2] was sliding down in the chair so I took it off. I just remembered I had not put it back on." Facility staff failed to utilize the safety belt with whirlpool bathing for Residents #1 and #2 and failed to perform a nursing assessment prior to Resident #1 being moved/assisted off the floor following the fall. During an interview on 11/18/25 at 2:00 p.m., an administrative staff member (#1) stated she expected staff to secure the safety belt for all residents in the bath chair and staff should never remove the safety belt during a bath for any reason .	F0689		