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 06/11/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 06/08/26 and concluded 06/11/26. During the complaint investigation, the facility was found in compliance with regulatory requirements.	F0000		07/10/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the facility reported incident (FRI), review of facility policy, and resident and staff interview, the facility failed to ensure residents remained free from abuse for 1 of 1 supplemental resident (Resident #27) who displayed physical behaviors towards another resident. Failure to protect Resident #31 from physical abuse may have resulted in pain or injury and placed all residents at risk for physical harm, pain, mental anguish, and emotional distress. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include:	F0600	"Past Noncompliance - no plan of correction required"	07/10/2026

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

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

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F0600 SS = D	Continued from page 1 Review of the facility policy titled "Abuse and Neglect" occurred on 06/11/26. This policy, dated 04/07/25, stated, ". . . The resident/client has the right to be free from abuse . . . Residents/clients must not be subjected to abuse by anyone, including . . . other residents/clients . . . Procedure: . . . If it is an allegation of resident/client to resident/client abuse, the residents/clients will be separated immediately and both ensured a safe environment. . . ." The surveyor determined a deficient practice existed on 06/07/26 when Resident #27 slapped Resident #31's face. The facility immediately implemented corrective action and completed it on 06/08/26. -Review of Resident #31's medical record occurred on 06/11/26. Diagnoses included dementia and anxiety. The current care plan stated, "The resident has impaired cognitive function or impaired thought processes R/T [related to] Dementia E/B [evidenced by] Confusion, wandering, talking to dolls, stuffed cats and bear, as if real. . . .Cue, reorient and supervise as needed. . . ." -Review of Resident #27's medical record occurred on 06/11/26. Diagnoses included early onset Alzheimer's disease. A Brief Interview for Mental Status (BIMS), completed on 04/10/26, identified a score of 9, indicating moderately impaired cognition. Resident #27's current care plan stated, ". . . The resident has a behavior symptom R/T dementia E/B being rude towards staff, pulling roommates privacy curtain while staff are doing cares. Inappropriate touching, altercations with other residents . . . Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. . . . Resident may at times strike out during altercations. If reasonable, discuss resident's behavior. Explain/reinforce to resident why behavior is inappropriate and/or unacceptable. . . . Minimize potential of resident behavior problems by modifying environmental factors and daily routine redirecting resident to avoid potential conflict. . . ." The initial FRI report stated at approximately 11 a.m. on 06/07/26, "Resident [#27] was annoyed that resident [#31] had put her own eye glasses on her therapy cat. Words were exchanged between the two residents and then resident [#27] apparently slapped [Resident #31] on the right check [sic]. There was no injury noted on resident [#31]. Nurse interviewed the	F0600		07/10/2026

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F0600 SS = D	Continued from page 2 resident involved and neither [Resident #27] or [Resident #31] could recall the encounter. . . . Residents were separated immediately. Staff will monitor the two residents involved. Monitor resident [#31] for any injury. Proper notifications were completed." The final investigation stated, ". . . In reviewing camera footage from the event, resident [#27] had reached for the eyes [sic] glasses that resident [#31] had put on the therapy cat. [Resident #31] pulled the eye glasses away when [Resident #27] reached for them. There was a short verbal encounter. Resident [#27] with her left hand made open hand contact with the right check [sic] of [Resident #31]. The residents were immediately separated. There was no visible injury or negative psychosocial outcome from this event. Either resident didn't remember the incident occurring when the charge nurse visited with the residents after the encounter occurred. . . . Facility will monitor residents to ensure the safety of all residents. . . ." During an interview on 06/11/2026 at 1:26 p.m., when asked, Resident #27 stated she does not remember slapping anyone on Sunday (June 7, 2026), but her son told her she was involved in something with another lady a few days ago. The resident stated her memory was so bad, she didn't remember things and asked if she was in trouble. During an interview on 06/11/2026 at 1:31 p.m., an administrative nurse (#2) stated on Sunday (June 7, 2026), staff called and informed her and the Administrator of an incident. The staff reported the incident to the staff on the next shift and informed them to keep the residents separated. After the incident, staff monitored the residents, kept them part, and made sure they felt safe. The administrative nurse stated she asked both residents about the incident, neither remembered it, and Resident #31 showed no fear. The administrative nurse stated the facility recently held an all-staff meeting in April and provided abuse and neglect education, conducted scenarios with questions/answers, and had a power point presentation. The facility printed the information for the staff who were unable to attend in person. During an interview on 06/11/2026 at 1:46 p.m., when asked, Resident #31 stated her first name, then responded with nonsensical statements to further questions. Finally, when asked if anyone slapped her recently, she replied "no." During an interview on 06/11/2026 at 1:55 PM, an	F0600		07/10/2026

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F0600 SS = D	Continued from page 3 administrative staff member (#3) stated staff followed the policy as they intervened in the altercation immediately, kept the two residents separated, reported the incident immediately, and assessed Resident #27. Based on the following information, non-compliance at F0600 is considered past non-compliance. The facility implemented corrective actions for the residents affected by the deficient practice as follows: *Staff immediately intervened, separated the residents, and assessed for injury. *Notified the Administrator and the Director of Nursing and reported the incident to the State. *Informed staff on upcoming shifts to ensure staff continue to monitor the residents. *Reviewed the camera footage and interviewed the residents. *Notified families and providers. *Reviewed and updated the residents' care plans.	F0600		07/10/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an	F0641	F641 – Accuracy of Assessment On 06/11/2026, DNS and Administrator re-educated the MDS Coordinator on accurate MDS coding and completion. MDS's with coding errors for Resident #3, #24, & #33 were corrected and transmitted on 07/1/2026 and accepted. Any resident has the potential to be affected by this deficient practice. Reviewed all residents who have devices to ensure correct coding in section M &P. MDS Coordinator was re-educated by GSS Senior Clinical Reimbursement Analyst on accurate MDS coding for Section M & P through the MDS RAI Manual on 7/1/26. IDT Team weekly will review sections M&P coding prior to MDS Coordinator transmitting the MDS assessments. DNS or designee will audit five completed MDS's prior to transmission for accuracy of coding in section M & P weekly for four weeks and then monthly for three months. Any incorrect coding identified will be immediately addressed. Audit	07/10/2026

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F0641 SS = D	Continued from page 4 individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and resident and staff interviews, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 12 sampled residents (Residents #3, #24, and #33). 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: -Observation on all days of survey showed a pressure reducing mattress on Resident #3's bed. Review of Resident #3's medical record occurred on all days of survey. The quarterly MDS, dated 04/17/26, failed to identify a pressure reducing device for the bed. During an interview on 06/11/26 at 9:16 a.m., an administrative nurse (#1) confirmed staff coded the quarterly MDS incorrectly, and resident does have a pressure reducing device for the bed. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI User's Manual, revised October 2025, pages P-2 and P-5, stated, ". . . P0100. Physical Restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body . . . A. Bed rail . . . Code 0, not used: if	F0641	Continued from page 4 results will be submitted to QAPI Committee for review and recommendations. Completion date: July 10th, 2026.	07/10/2026

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F0641 SS = D	Continued from page 5 the item was not used during the 7-day look-back period or it was used but did not meet the definition. . . ." - Review of Resident #24's medical record occurred on all days of survey. The quarterly MDS, dated 04/01/26, identified bed rail used daily. Observation throughout the survey showed bilateral positioning bed rails on Resident #24's bed. The "Physical Device and/or Restraint Evaluation and Review," dated 3/31/26, determined the resident used assist bars for independent bed mobility and were not restraints. During an interview on 06/09/26 at 4:57 p.m., an administrative nurse (#1) confirmed staff coded Resident's #24's quarterly MDS incorrectly for physical restraints. -Review of Resident #33's medical record occurred on all days of survey. The quarterly MDS, dated 04/30/26, identified bed rails used daily. Observation on 06/09/26 at 4:24 p.m. showed bilateral assist bars on Resident #33's bed. The "Physical Device and/or Restraint Evaluation and Review," dated 04/29/26, determined the assist/grab bar(s) were not restraints. During an interview on 06/09/26 at 4:25 p.m., Resident #33 confirmed using the assist/grab bars to reposition or get out of bed. Resident #33 denied the bars restrained movement.	F0641		07/10/2026
F0657 SS = D	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.	F0657	F657 – Care Plans On 06/11/2026, DNS re-educated the clinical interdisciplinary team (IDT) on updating care plans timely with residents change in condition and/or treatment plan. Resident #2 care plan updated on 7/1/20206 to reflect problems and interventions related to anicoagulant use. Resident #34 care plan updated on 7/1/2026 to reflect trauma history and trauma related symptoms. IDT Team was re-educated by DNS on GSS Care Plan Policy and Procedure, specific to timely updates plans on 7/1/2026. Process change implemented: Clinical IDT will	07/10/2026

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F0657 SS = D	Continued from page 6 (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 resident and staff interviews, the facility failed to review and revise care plans to reflect the residents' current status for 2 of 12 sampled residents (Resident #2 and #34). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care Plan" occurred on 06/10/26. This policy, revised 12/01/25, stated, ". . . This plan of care will be modified to reflect the care currently required/provided for the resident . . ." Review of the facility policy titled "Trauma Informed Care" occurred on 06/10/26. This policy, revised 12/31/25, stated, ". . . PROCEDURE. . . Individualize Care Plan interventions to avoid re-traumatization . . ." -Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic embolism and thrombosis of deep veins of right lower extremity. Current physician's orders included Apixaban (an anticoagulant). Progress notes identified a hospitalization in April of 2026 for an upper GI (gastrointestinal) bleed. The facility failed to revise and update Resident #2's care plan to reflect problems and interventions related to anticoagulant use.	F0657	Continued from page 6 review care plans during clinical morning meeting, with appropriate staff input as warranted. DNS or designee will audit five Care Plans for updates with change in treatment plan/resident preferences weekly for four weeks, then monthly for three months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendations. Completion date: July 10th, 2026.	07/10/2026

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F0657 SS = D	Continued from page 7 During an interview on 06/10/26 at 1:26 p.m., an administrative nurse (#2) confirmed the facility failed to update Resident #2's care plan. -Review of Resident #34's medical records occurred on all days of survey. Diagnoses included depression and generalized anxiety. Current physician's orders included an antidepressant medication daily for generalized anxiety and depression. A trauma assessment, dated 03/17/26, identified Resident #34 experienced trauma from the death of her son. The assessment indicated the resident experienced nightmares, avoided situations that reminded her of the event(s), constantly on guard, watchful or easily startled, felt numb or detached from people, activities, or surroundings, and felt guilty or unable to stop blaming herself for the event(s). The assessment further identified heart palpitations, headaches, shortness of breath, changes in sleep patterns, sleep disturbances, pain, difficulty with movement, and changes in appetite when relieving a traumatic experience. The assessment identified "playing games on phone" as an intervention that is a helpful coping strategy. The current care plan lacked a problem, goals, or interventions related to Resident #34's trauma history and trauma-related symptoms. During an interview on 06/08/26 at 12:39 p.m., Resident #34 became tearful and visibly upset while discussing her son who had passed away and stated the facility was aware of her son's death.	F0657		07/10/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757	F757 – Drug Regimen Is Free from Unnecessary Drugs Resident #2 and #32 had an AIMS assessment completeted on 6/11/26 by nurse manager. Any resident receiving antipsychotropic medications has the potential to be affected by this practice. Reviewed all residents receiving antipsychotropic medications to ensure AIMS had been completed.	07/10/2026

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F0757 SS = D	Continued from page 8 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure adequate monitoring for 2 of 5 residents (Resident #2 and #32) reviewed for psychotropic medications. Failure to complete a baseline assessment before starting an antipsychotic and periodically while on the medication may result in undetected side effects and adverse consequences related to the antipsychotic medication. Findings include: Review of the facility policy titled “Psychotropic Medications” occurred on 06/10/26. This policy, revised 12/09/25, stated, “. . . If the physician prescribes an antipsychotic for the resident . . . If a resident is admitted on psychotropic medications or returns from hospitalization on new psychotropic medications . . . a registered nurse must complete the Abnormal Involuntary Movement Scale [AIMS]. . . Throughout the administration of psychotropic medication, the following must be completed. . . the Abnormal Involuntary Movement Scale [AIMS]. . . every six months. . .” -Review of Resident #2's medical record occurred on all days of survey and identified an admission date of 12/02/25. Physician's orders included Quetiapine (an antipsychotic) started prior to admission. The record lacked a baseline assessment or an AIMS for the use of the antipsychotic medication. -Review of Resident #32's medical record occurred on all days of survey. Physician's orders included	F0757	Continued from page 8 All licensed RN nurses were re-educated by DNS by 7/8/2026 in reference to the Psychotropic Medication Policy and Procedure specific to completing an AIMS assessment prior to administrating a new antipsychotic medication. Weekly during Clinical Meeting we will ensure that AIMS is completed for new admissions, readmission and for any resident with new orders for antipsychotropic medciations. DNS or designee will complete AIMS assessment audit on any new orders for antipsychotics weekly for four weeks and monthly for three months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. Compliance Date: July 10th, 2026.	07/10/2026

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F0757 SS = D	Continued from page 9 Risperidone (an antipsychotic) initiated on 05/28/26. The record lacked a baseline assessment or an AIMS for the use of the antipsychotic medication. During an interview on 06/10/26 at 1:26 p.m., an administrative staff member (#2) stated the facility failed to complete AIMS assessments for Resident #2 and #32 on antipsychotics.	F0757		07/10/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, review of professional standards, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 sampled resident (Resident #32) with a significant medication error. Failure to administer medication and monitor lab results according to physician's orders may inhibit the effectiveness of the medications and cause subtherapeutic levels. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 838-851, stated, ". . . Obtain the appropriate medication. Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record] or computer printout. Rationale: This is a safety check to ensure that the right medication is given. If these are not identical, recheck the prescriber's written order in the client's chart. . . . Prepare the medication. While preparing the medication, recheck each prepared drug and container with the MAR again. Rationale: This second safety check reduces the chance of error . . . Perform appropriate assessments (e.g. . . laboratory results) specific to the medication . . ." Review of the facility policy titled "Medication Errors" occurred on 06/11/26. This policy, revised 03/02/26, stated, ". . . Medication Error. . . administration of medications . . . which are not in accordance with the prescriber's order. . . Amount .	F0760	F760 – Residents are Free of Significant Med Errors Resident #32 is end of life and family is refusing lab draw. Provider is aware of family's wishes. Any resident that has a medication or lab order change has the potential to be affected. DNS evaluated facility lab process and educated nursing staff on tracking of ordered labs to assure they are drawn and reported to provider timely. All Residents were reviewed to ensure that all labs have been completed as ordered. DNS or dersignee will educate appropriate nursing staff on the process for passing medications that includes comparing the physician's order with the amount on hand and administering the correct dose ordered. Lab orders will be reviewed during our weekday clinical meetings to ensure labs are drawn and provider is notified of results. Education will be completed by 7/8/26. DNS or designee will audit orders for lab draws, drawn timely and reported to provider weekly for four weeks then monthly for three months. Any deficient practice identified will be addressed immediately. All audit results will be submitted to the monthly QAPI Committee for review and recommendation. Compliance Date: July 10th, 2026	07/10/2026

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 06/11/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0760 SS = D	Continued from page 10 . . When the resident receives an amount of medication that is greater than or less than the amount ordered by the prescriber. . ." Review of Resident #32's record occurred on all days of survey. Diagnoses included hypothyroidism (underactive thyroid gland). A provider's order, dated 01/08/26, identified levothyroxine (thyroid medication) 137 microgram (mcg) by mouth once daily, and lab work in two months to check the resident's thyroid-stimulating hormone (TSH). Review of Resident #32's nurses' notes identified the following: *02/22/26 at 4:23 p.m., ". . . went to give resident her am Levothyroxine . . . noted that the dose was incorrect on the medication card in the med cart . . . the dose was changed on 01/08/26, dose was not given this am, unsure how long the incorrect dose was given as the medication cards are dated 01/21/26 and 02/05/26 . . . Resident's condition . . . no change noted. . . Dose Given: 125 mcg" *02/23/26 at 5:19 p.m., "Communication/Visit with Physician . . . orders received and observed per [physician] to continue levothyroxzine [sic] at 137 mcg po once daily, cancel tsh for 03/04/26, and move to mid [middle of] april [sic] 2026 instead." The medical record lacked documentation of a TSH level in mid-April, as ordered. During an interview on 06/11/26 at 12:44 p.m., an administrative staff member (#2) confirmed the facility failed to collect a TSH level for Resident #32 in mid-April as ordered after the med error was corrected. Resident #32 received 45 doses of levothyroxine at the wrong dose before facility staff realized the error and failed to obtain a TSH level as ordered by the provider.	F0760		07/10/2026