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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Souris Valley Care Center	300 Main St S Velva, ND 58790

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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: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:* 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. * 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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 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 includeReview of the facility policy titled Fall Prevention and Management occurred on 11/18/25. This policy, dated 10/14/25, stated, . For Fallen Resident . 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 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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 includeReview 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. - 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 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 [DATE], 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