

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER Souris Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of the facility reported incident (FRI) investigation, record review, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remain free from abuse for 1 of 5 sampled residents (Resident #2) who was subjected to physical abuse by another resident. Failure to ensure the facility had processes in place to meet the needs of residents resulted in a bruise to Resident #2's face and placed all residents at risk for physical harm, pain, mental anguish, and emotional distress. Findings include: Review of the facility policy titled Abuse and Neglect occurred on 04/08/26. This policy, dated 04/07/25, stated, . The resident/client has the right to be free from abuse, neglect . Residents/clients must not be subjected to abuse by anyone, including, but not limited to . other resident/clients. Review of the facility's initial FRI investigation, dated 03/20/26, stated, . Male resident became upset with female resident's vocalizations. Male resident told female resident to shut up and female resident told male resident to shut up. Male resident then slapped female resident on the cheek. Staff members immediately intervened and separated the residents. Staff are monitoring residents to ensure safety. Female resident doesn't remember the incident and does not appear to be impacted by the incident. A witness interview, dated 03/26/26, stated, [Medication aide] was passing medications at the time when she heard [Resident #1] tell the resident to 'shut up' and then [Resident #2] told him to shut up. [Resident #1] slapped her on the cheek. Review of Resident #1's medical record occurred on 04/08/26. Diagnoses included unspecified dementia, anxiety, and depressive disorder. The care plan stated, . The resident has impaired cognitive function impaired thought process R/T [related to] confusion E/B [evidenced by] poor recall, mixing up days and nights. Confusion, and poor recall. Interventions: resident understands consistent, simple, direct sentences. Provide resident with necessary cues- stop and return if agitated. Cue, reorient and supervise as needed. Redirect reassure as needed. Review of Resident #1 nursing progress notes identified the following: * 03/20/26 at 8:08 p.m. on passing the other resident he told her to shut up and slapped her on her rt [right] cheek we pulled him away and put him in a safe place. * 03/21/26 at 3:55 p.m. call placed to [name of guardian] made aware that resident had slapped another resident last pm. * 03/23/2026 at 4:32 p.m. Resident to resident physical contact made - Date and time of event: 03/20/26 6:45 PM - Fractural account of what happened: Resident was yelling and calling out help me, Resident told resident to shut up, Resident then told resident to shut up. Resident B struck resident across her face on the right side. CNAs saw what was happening and separated both residents and removed them to a safe place. Resident's condition after event: Resident quickly returned to baseline . Immediate intervention & education: Separated residents, educated them that this was inappropriate behavior. Review of Resident #2 medical record occurred on 04/08/26. Diagnoses included Alzheimer's disease and anxiety. Review of Resident #2's nursing progress notes identified the following: 03/20/26 at 8:10 p.m., resident was yelling help as per usual behavior the other resident told her to shut up and slapped her on her rt [right] cheek on passing her [sic] both resident [sic] were parted and taken to safe places 03/21/26 at 3:15 p.m., Resident to resident physical contact made- Date and Time of Event: 03/20/2026 6:45 p.m. - Factual account of what happened: small round bruise, size of a dime noted under right eye, bruise lines up with bottom (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of her glasses, denies pain. During an interview on 04/08/26 at 12:20 p.m., an administrative staff member (#1) stated this incident occurred only once and Resident #2's bruise resolved without issue. During an interview on the afternoon of 04/08/26, Resident #1 denied any concerns or issues with other residents, he denied being hit by anyone, and denied hitting any other residents. The facility failed to protect Resident #2 from physical abuse.		