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	04/17/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observations, record review, facility policy, and staff interview, the facility failed to promote care in a manner that maintained or enhanced residents' dignity for 1 of 14 sampled residents (Resident #14) and 1 supplemental resident (Resident #6) who required assistance with dressing. Failure to ensure the residents wore clean clothing and were fully dressed the resident following cares does not promote mental well-being or dignity. Findings included: Review of the facility policy titled Resident Dignity occurred on 04/17/24. This policy, dated November 2023, stated, . PURPOSE To maintain the dignity of all residents . To promote, encourage, support and enhance the residents' self-esteem . - Review of Resident #14's medical record occurred on all days of survey. The Minimum Data Set (MDS), dated [DATE], identified dependent on assistance with dressing. Observations showed: * 04/14/24 at 11:40 a.m. Resident #14 wore pants soiled with food debris when staff brought the resident to the dining room for lunch. * 04/15/24 at 8:37 a.m. Resident #14 in the wheelchair in her room wearing pants soiled with food debris. The resident's roommate was in the bed with food debris noted on the bed beside her. - Review of Resident #6's medical record occurred on 04/14/24. The MDS, dated [DATE], identified dependent on assistance with dressing. Observation on 04/14/24 at 11:55 a.m. showed Resident #6 wore a shirt and pants soiled with food debris. During an interview on 04/16/24 at 3:45 p.m., an administrative nurse (#1) stated staff are expected to change residents' clothing if soiled and pull pants back up following a check and change.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 4 sampled residents (Resident #17) with weight loss. Failure to notify the physician of these changes may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Review of the facility policy titled Weight and Height - R/S, LTC [rehab/skilled, long term care] occurred on 04/17/24. This policy, dated 09/18/23, stated, . To ensure that resident maintains acceptable parameters of nutritional status regarding weight . To report changes in a resident's clinical condition (significant weight change) immediately to physician . 8. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days, and 10 percent in 180 days. 9. The licensed nurse should immediately notify the medical provider regarding any significant weight change . Review of Resident #17's medical record occurred on all days of survey. Diagnoses included dementia and diabetes. Review of the significant change Minimum Data Set (MDS), dated [DATE], identified weight loss and supervision/set-up assistance for eating. The progress notes identified the following: * 01/16/24 at 9:46 a.m., Nutritional Status - Dietitian Assessment . Nutrition Admit Note: . Wt [weight]-176.5# [pounds] . MNA [mini nutrirional assessment] score was a 12 which puts her w/in [within] normal nutritional status. Plan to continue to monitor & [and] allow time for her to adjust to the facility. * 02/20/24 at 10:41 a.m., Care Conference Note . Resident meal and fluid intakes are poor. Resident does need encouragement with food and fluids. Resident current weight is 169.5lb [pounds]. * 03/19/24 10:02 a.m., Care Conference Note . Resident is currently 167 pounds. meal intake is 50% [percent] or more of meals. Resident shows a weight loss, since admission. * 03/26/24 at 11:08 a.m., Nutritional Status - Dietitian Assessment . Current wt-168# . Weight is down 17# since 1/23/24 (9.2%). MNA score was a 10 which has declined & puts her at risk for malnutrition. * 04/15/24 at 12:16 p.m., Nutritional Status - Dietitian Assessment . Wt-163# . Weight is down 18# in 90 days (9.9%); & 22# in 180 days (11.9%). MNA score was a 9 which has declined. Plan to continue to monitor her nutritional status & will be following up as needed. The medical record lacked documentation of provider notification of Resident #17's significant weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/16/24 at 4:30 p.m., an administrative nurse (#1) confirmed facility staff failed to notify the provider of the significant weight loss for Resident #17.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 3 of 14 sampled residents (Resident #20, #29 and #35) and one supplemental resident (Resident #44). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Failure to code discharge status may affect appropriate discharge planning and follow-up if needed. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI Manual, revised October 2023, Section A, page A-42 stated, . A 2105 Discharge Status . Steps for Assessment 1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Select the two-digit code that corresponds to the resident's discharge status. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility . Review of Resident #44's medical record occurred on 04/17/24. A physician's order dated, 03/28/24, stated, Discharge to [facility name] Assisted Living . A progress note, dated, 03/28/2024 9:56 [a.m.] Discharge-Home, Assisted Living . Resident #44's Discharge MDS dated [DATE] identified facility staff coded item A2105 discharge status: 04 Short-Term General Hospital. The MDS is incorrectly coded for a discharge to a hospital. During an interview on 04/17/24 at 11:55 a.m., a staff member (#11) confirmed staff failed to correctly code Resident #44's discharge MDS. SECTION K: WEIGHT LOSS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Long-Term Care Facility RAI User's Manual, revised October 2023, Section K: Swallowing/Nutritional Status, pages K-3 through K-6, stated, . K0200B: Weight: 1. Base weight on the most recent measure in the last 30 days. K0300: Weight Loss . Steps for Assessment: This item compares the resident's weight in the current observation period with their weight at two snapshots in time: . At a point closest to 30-days preceding the current weight. At a point closest to 180-days preceding the current weight. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 180 days ago. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss. Coding Instructions . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of . 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. - Review of Resident #35's medical record occurred on all days of survey. An admission MDS, dated [DATE], identified the resident's weight as 190 pounds. A quarterly MDS, dated [DATE], identified the resident's weight as 140 pounds, a weight loss of 25% in 180 days. The quarterly MDS failed to identify Resident #35's weight loss. During an interview on 04/17/24 at 12:00 p.m., a dietary manager (#12) confirmed she coded Resident #35's Quarterly MDS incorrectly for weight loss. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages M-8 stated, M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage . Determine Present on Admission For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement. 1. Review the medical record for the history of the ulcer/injury. 2. Review for location and stage at the time of admission/entry or reentry. Pages M-12 through M-13 stated, . M0300B: Stage 2 Pressure Ulcers . Steps for Assessment . Identify the number of these pressure ulcers that were present on admission/entry . Coding Instructions for M0300B . M0300B1 . Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2 . M0300B2 . Enter the number of these Stage 2 pressure ulcers that were first noted at the time of admission/entry . Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry. Review of Resident #20's medical record occurred on all days of survey. Diagnoses included pressure ulcer to right and left buttock, stage two. The annual MDS, dated [DATE], identified 2 for number of stage two pressure ulcers present and 2 for number of stage two pressure ulcers present on admission. The quarterly MDS, dated [DATE], identified 2 for number of stage two pressure ulcers present and 0 for number of stage two pressure ulcers present on admission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/24 at 10:58 a.m., an administrative nurse (#1) confirmed Resident #20's bilateral stage two pressure ulcers to the buttocks were present on admission. During an interview on 04/17/24 at 11:55 a.m., an administrative nurse (#9) confirmed staff failed to code Resident #20's quarterly MDS correctly regarding pressure ulcers present on admission. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-1, and N-6 to N-8 stated, Section N Medications . N0415: High-Risk Drug Classes: Use and Indication . Coding Instructions . N0415E1. Anticoagulant (e.g., [for example] warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., . clopidogrel) was taken by the resident at any time during the 7-day observation period. Review of Resident #29's medical record occurred on all days of survey. A physician's order, dated 11/08/21, stated, Clopidogrel Bisulfate Tablet . Give 75 mg [milligrams] by mouth one time a day for antiplatelet/AFib [atrial fibrillation]. The quarterly MDS, dated [DATE], identified the use of an anticoagulant medication and failed to identify the use of an antiplatelet medication. During an interview on 04/17/24 at 12:16 p.m., an administrative nurse (#9) confirmed staff failed to code Resident #29's MDS correctly regarding anticoagulant/antiplatelet medication use. 45873

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42397 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 5 of 14 sampled residents (Resident #17, #27, #29, #35, and #41). Failure to revise the care plan limited the staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled, Care Plan .LTC [long term care] occurred on 04/17/24. This policy, revised, 11/01/23, stated, . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. This plan of care will be modified to reflect the care currently required/provided for the resident. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. - Review of Resident #17's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2, atrial fibrillation, and chronic congestive heart failure. Current physician's orders identified a diuretic and insulin. A progress note, dated 03/26/24 at 11:08 a.m., stated, . At risk for malnutrition . Has had a weight loss . Weight is down 17# [pounds] since 1/23/24 (9.2%). Resident #17's current care plan lacked problems and interventions related to risk for malnutrition, actual weight loss, use of a diuretic, diabetes, and insulin use. - Review of Resident #27's medical record occurred on all days of survey. Diagnoses included osteomyelitis right ankle, sepsis, and pneumonia. The current care plan stated, . The resident is on medications with FDA [federal drug administration] Boxed Warnings or warnings of adverse consequences R/T [related to] use of IV [intravenous] Vancomycin [antibiotic]. Physician's orders showed IV Vancomycin discontinued on 01/09/24, and Doxycycline (oral antibiotic) 500 mg (milligrams) twice a day ordered on 01/09/24. On 04/08/24, the Doxycycline was renewed to continue through 05/01/24. On 04/01/24, a physician's order stated, .100% weight bearing to right ankle, when wearing the cam boot [Controlled Ankle Motion boot - an orthopedic device prescribed for the treatment and stabilization of severe sprains, fractures, tendon, or ligament tears in the ankle of foot] . Resident #27's current care plan lacked updated information addressing the discontinuation of Vancomycin and addition of Doxycycline, and the care associated with the resident's cam boot. - Review of Resident #29's medical record occurred on all days of survey. A nursing progress note dated 01/29/24 at 3:29 p.m., stated, . Writer received written orders to d/c [discontinue] oxygen continuously . The current care plan stated, . Oxygen therapy: I am on 2L [liters] of O2 [oxygen] via NC [nasal cannula] continuously. The facility failed to update Resident #29's care plan related to oxygen use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #35's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2, chronic congestive heart failure, and lymphedema. Current physician's orders identified a diuretic and oral hypoglycemics (medications used to treat diabetes). Review of Resident #35's progress notes showed the following: * 11/20/23 at 2:11 p.m., . Nutrition Risk Note: . is triggering due to . poor meal intakes & low MNA [mini-nutritional assessment] score of 11. Wt [weight] -186# [pounds]. Intakes are averaging 59% at meals. * 01/17/24 at 3:09 p.m., . Nutrition Risk: . is triggering due to poor meal intakes. Wt-140.5# . (a 25% weight loss in 2 months) The current care plan failed to identify nutrition risk, actual weight loss, use of a diuretic, diabetes, and use of oral hypoglycemic medications. - Review of Resident #41's medical record occurred on all days of survey. Diagnosis included chronic congestive heart failure, atherosclerotic heart disease, and trochanteric fracture of right femur. Physician's orders showed Furosemide 40 mg and Spironolactone 25 mg (diuretics) every morning for heart failure. Oxycontin 10 mg twice a day, discontinued 03/06/24 and Oxycodone (narcotic pain medications) 5 mg every 8 hours as needed, discontinued 03/12/24. The current care plan stated, . I am on medications with FDA Black Boxed Warnings R/T [related to] use of Oxycontin [and] Oxycodone . The resident has acute/chronic pain/discomfort R/T arthritis & Right hip fracture E/B [evidenced by] able to vocalize pain. Takes scheduled Tylenol and Oxycontin. Has Oxycodone as needed. A review of Resident #41's progress notes, dated, 03/26/2024, showed, . Nutrition Risk Note: [resident name] is triggering due to weight loss, . Wt-110# . Weight is down 18# in 30 days (14.1%). The current care plan failed to identify nutrition risk and weight loss, use of diuretics, and discontinuation of oxycodone and oxycontin. During an interview on 04/16/24 at 4:40 p.m., an administrative nurse (#1) confirmed she expected care plans to be updated with the resident's current orders, medication changes, and when new problems are identified. 45873

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42397 Based on observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 1 of 1 resident (Resident #29) observed during administration of intermediate acting insulin. Failure to administer intermediate-acting insulin within fifteen minutes of a meal may result in a hypoglycemic (low blood sugar) reaction. Findings include: Prescribing information for Humalog Mix 75/25 insulin (an intermediate acting insulin), found at https://www.humalog.com/mixes, occurred on 04/17/24, and stated, . Inject HUMALOG Mix75/25 subcutaneously within 15 minutes before a meal. Review of Resident #29's medical record occurred on all days of survey. A current physician's order stated, HumaLOG Mix 75/25 KwikPen Subcutaneous Suspension Pen-injector (75-25) 100 UNIT/ML [unit/mL] . Inject 18 unit subcutaneously one time a day . with supper. Observations on 04/14/24 showed the following: * 5:19 p.m., a nurse (#3) prepared and administered 18 units of Humalog 75/25 to Resident #29. * 5:44 p.m., Resident #29 seated at the dining room table waiting for the supper meal to be served. (25 minutes later) The facility failed to follow prescribing instructions for timing of Resident #29's Humalog 75/25 insulin. During an interview on 04/16/24 at 3:30 p.m., an administrative nurse (#1) confirmed she expected staff to administer intermediate insulin within 15 minutes of a meal. 45873

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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. 45873 Based on observation, record review, staff interview, and review of facility policy, the facility failed to ensure staff provided care and services for 1 of 1 sampled resident (Resident #27) with orders for a CAM Boot (Controlled Ankle Motion boot - an orthopedic device prescribed for the treatment and stabilization of severe sprains, fractures, tendon, or ligament tears in the ankle of foot). Failure to document application and removal of an orthopedic device, and to follow physician's orders for elevating legs/heels, may result in pain and/or worsening of resident's condition. Findings include: Review of the facility policy titled Care Plan - LTC [Long Term Care], Therapy & Rehab occurred on 04/17/24. This policy, dated 11/01/23, stated, . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being . The care plan will emphasize the care of the whole person ensuring that the resident will receive appropriate care and services. Review of Resident #27's medical record occurred on all days of survey and included a diagnosis of nondisplaced trimalleolar (lower leg sections that form the ankle joint) fracture of right lower leg. Physician's orders showed 100% weight bearing to right ankle when wearing the CAM boot and to keep right foot elevated every shift. The current care plan showed, . The resident has actual impairment to skin integrity R/T [related to] surgical incision/surgical wound E/B [evidenced by] recent surgery on right ankle fracture. Elevate heels off bed. Review of Resident #27's treatment administration record (TAR) and certified nurse aide (CNA) documentation, dated 04/01/24 through 04/17/24, failed to show who is responsible for application and removal of the CAM Boot or documentation to elevate the right foot. Review of the CNA Kardex showed Repositioning/Skin Care: Elevate heels off bed. Observations throughout the survey showed Resident #27 wore a CAM boot to his right foot. Further observations showed: * 04/14/24 at 2:30 p.m. Seated in the wheelchair without his right foot elevated. * 04/15/24 at 9:45 a.m. Two CNAs (#4 and #7) transferred the resident into bed and failed to elevate the resident's heels. * 04/15/24 at 3:05 p.m. In bed without his heels elevated. *04/15/24 at 4:25 p.m. A nurse (#3) performed wound care. Upon completion, the nurse failed to elevate the resident's heels off the bed. * 04/16/24 at 9:40 a.m. Seated in the wheelchair without his right foot elevated. * 04/16/24 at 1:15 p.m. In bed, without his heels elevated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 04/17/24 at 9:00 a.m. Seated in the wheelchair without his right foot elevated. During an interview on 04/17/24 at 12:15 p.m., an administrative staff member (#1) stated she expected nursing staff to determine who will be responsible for following the order and add it to the TAR or CNA Kardex, and she expected staff to follow the plan of care or order. The facility failed to provide care according to physician's orders, develop and follow the plan of care, and to direct the staff responsible to document the removal/application of the orthopedic device (CAM boot).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42397 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate and sufficient supervision and/or assistive devices for 1 of 5 sampled residents (Resident #35) who required staff assistance and a gait belt with transfers. Failure to provide adequate assistance and/or use the assistive devices appropriately during transfers placed the residents at risk for accidents, falls, and/or injuries. During the standard survey, the team determined an Immediate Jeopardy (IJ) situation existed on 04/16/24 at 5:15 p.m. The IJ resulted from staff failure to provide sufficient supervision and use the assistive device (gait belt) in a manner to avoid a fall and/or potential injury. * 04/16/24 at 5:29 p.m., The survey team contacted the State Survey Agency (SSA) to report the findings and discuss potential immediate jeopardy (IJ). * 04/16/24 at 6:30 p.m., The survey team notified the administrator and the director of nursing (DON), of the IJ situation, provided them with the IJ template, and requested they develop a plan for removal of the immediate jeopardy. * 04/16/24 at 6:35 p.m., The SSA notified the CMS (Centers for Medicaid & Medicare Services) location of the IJ situation. * 04/16/24 at 8:40 p.m., The facility provided (via email) an IJ removal plan. * 04/17/24 at 8:30 a.m., The SSA reviewed and accepted the IJ removal plan. The removal plan contained the following: * Inservice and education on appropriate actions/interventions per care plan specific to toileting and transfers to meet residents needs and prevent injury, with the staff member directly involved in the deficient practice, all nursing staff on duty, and on-coming staff. * Review of Resident's transfer requirements as outlined in their individual care plans. * Review of facility policies and resources for questions/concerns. * 04/17/24 at 10:12 a.m., the survey team verified the implementation of the removal plan. The deficient practice remained at a D scope and severity following the removal of the IJ. Findings include: (continued on next page)

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Souris Valley Care Center	300 Main St S Velva, ND 58790

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled Fall Prevention and Management - Rehab/Skilled [R/S], Therapy & [and] Rehab occurred on 04/17/24. This policy, dated 04/02/24, stated, . To promote resident well-being by developing and implementing a fall prevention and management program . Proactive Approach before a Fall occurs . 2. Complete the Falls Tool UDA [user defined assessment] for fall screening and identifying fall risk factors. 3. Care Plan the appropriate interventions . 4. Communicate fall risks and interventions to prevent a fall before it occurs . Review of the facility policy titled Care Plan - R/S, LTC [Long Term Care], Therapy & Rehab occurred on 04/17/24. This policy, dated 11/01/23, stated, . Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being . The care plan will emphasize the care of the whole person ensuring that the resident will receive appropriate care and services. Review of Resident #35's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated [DATE], identified Resident #35 had severely impaired cognition. The current care plan stated, . I am at risk for falls r/t [related to] balance difficulty, weakness and unsteadiness. I do have a hx [history] of falls r/t dementia and poor safety awareness, weakness and ambulatory dysfunction. I will not sustain serious injury through the review date. TOILET USE: I need extensive assist of two with transfers . TRANSFERS: Transfers with assist of two with gait belt . I will at times try to transfer myself in the restroom . Review of nursing progress notes identified the following: * 04/13/24 at 4:43 p.m., . Staff called nurse to resident room and stated that he is in the bathroom on the floor and bleeding from his head and blood on the floor and his hands and arms. Nurse assessed and resident cleansed and noted laceration to right side of forehead and skin tears to right elbow and top of hand. Resident was self transferring and lost balance and fell and then pulled call light. Pressure applied to laceration and vital signs obtained. Call placed to family and provider on call . and rec'd [received] verbal order to send to ER [emergency room] via ambulance. * 04/13/24 at 5:00 p.m., . Call placed to . hospital switchboard and requested to be connected to provider on call . Updated that resident had unwitnessed fall with injury and has a laceration to right side of forehead and skin tears to right elbow and top of hand. She stated to send resident to ER for evaluation of head laceration and because this is the 3rd fall resident has had since 4/11/24 and 2nd within 24 hours. * 04/14/24 12:20 a.m., . Resident returned to facility following ER visit d/t [due to] fall with head laceration. Resident returns with 6 sutures to lacerated area on right side of forehead. Observations showed the following: * 04/14/24 at 12:13 p.m., Resident #35 seated in a wheelchair in the dining room eating lunch. The resident had sutures to the right side of the forehead and a tegaderm [transparent adhesive bandage] to the right forearm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* 04/14/24 at 4:30 p.m., Resident #35 sat in a wheelchair by the dining room and stated he needed to use the bathroom to staff member (#2). The staff member (#2) opened the door to the public bathroom in the hallway for the resident, and asked Are you good? Resident #35 responded Yes. The staff member (#2) walked away. Resident #39, also cognitively impaired, pushed Resident #35 in the wheelchair into the bathroom and closed the door. The surveyor notified the nurse (#3). The nurse (#3) entered the bathroom, stopped Resident #35 from self-transferring to the toilet, placed a gait belt on Resident #35 and assisted the resident to the toilet. Resident #35 used the toilet. The nurse (#3) assisted the resident to stand and pivot back into the wheelchair with a gait belt. * 04/15/24 at 4:35 p.m., Resident #35 sat on the bed and transferred himself from the bed to the wheelchair. No staff were present in the room. * 04/16/24 at 9:35 a.m., Two certified nurse aides (CNAs) (#4 and #5) assisted Resident #35 to transfer from the wheelchair to the toilet. The resident transferred himself to the toilet before they could apply the gait belt. Once the resident was seated on the toilet the CNA (#4) applied a gait belt to the resident. Resident #35 used the toilet and the CNAs (#4 and #5) lifted under Resident #35's arms to assist him to stand, completed perineal cares and both CNAs held the resident under his arms and by the waistband of his pants, to pivot transfer to the wheelchair. During an interview on 04/16/24 at 3:20 p.m., an administrative nurse (#1) confirmed she expected staff to follow the care plan for transfers to ensure resident safety, and to use gait belts appropriately. Facility staff failed to follow the care plan to provide sufficient supervision and assistance with transferring and toileting, and use a gait belt with a resident who was identified as a fall risk, who had a recent fall with injury, and had the potential to for further falls.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42397 Based on record review, review of facility policy, and staff interview, the facility failed to maintain acceptable parameters of nutritional status or 1 of 4 sampled residents (Resident #35) with weight loss. Failure to reassess/monitor weight variances may delay needed treatment for weight loss and alter the resident's ability to maintain sufficient nutritional status. Findings include: Review of the facility policy titled Weight and Height - R/S, LTC [rehab/skilled, long term care] occurred on 04/17/24. This policy, dated 09/18/23, stated, . To ensure that resident maintains acceptable parameters of nutritional status regarding weight . To report changes in a resident's clinical condition (significant weight change) immediately to physician . To accurately measure weight . All residents are weighed at a minimum of weekly for the first four weeks following admission . 7. If weight varies by more than three percent, reweigh resident and document. Report weight to licensed nurse. 8. The licensed nurse should notify the director of food and nutrition (DFN) within 24 hours regarding significant weight change. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days, and 10 percent in 180 days. Review of Resident #35's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, chronic heart failure, lymphedema, and diabetes. Physician's orders identified: * 11/01/23, Weekly weight on bath day. * 11/01/23, Metolazone [a diuretic medication] 10 milligrams in the morning. The medical record identified staff failed to weigh Resident #35 weekly from 11/13/23 until 12/04/23. During this three week period, the weights showed a 52 pound weight loss (from 186 lbs. to 134 lbs.), which represents a 27% weight loss. The medical record failed to identify the significant weight loss and/or its possible causes. During an interview on 04/17/24 at 10:12 a.m., the dietary manager (#12) and dietician (#13) agreed the facility failed to identify Resident #35's significant weight loss and address any causes. The dietary manager (#12) stated she recalled a conversation with nursing, and that the team felt the first two weights were inaccurate; however, they failed to re-weigh Resident #35 and document the conversation. Facility staff failed to perform weights and re-weighs as ordered/per facility policy, identify the significant weight loss, and assess any related causes for Resident #35.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on record review, policy review, and resident and staff interviews, the facility failed to provide care and services to control pain for 1 of 1 sampled resident (Resident #31) reviewed for pain management. Failure to administer as needed (prn) pain medications and inform the physician of increased use of prn pain medication resulted in Resident #31 experiencing anxiety and mental anguish and may have contributed to the resident experiencing increased and/or unresolved pain. Findings include: Review of the facility policy titled Pain Management occurred on 04/17/24. This policy, dated February 2024, stated, . PURPOSE To provide residents assistance in pain management. To promote well-being by ensuring that residents are as comfortable as possible. Individualized approaches will be developed to address the resident's pain management in a holistic manner. Review of Resident #31's medical record occurred on all days of survey. A Minimum Data Set (MDS), dated [DATE], identified intact cognition and frequent pain rated 10 on a 0-10 scale. A second MDS, dated [DATE], identified pain affected her sleep occasionally and interfered with therapy activities and day to day activities frequently. Resident #31's care plan stated, . I have chronic pain/discomfort . E/B [evidenced by] limited mobility and verbalization of pain. I will not have an interruption in normal activities due to pain . Physician's orders included: * 01/19/24, Acetaminophen Oral Tablet (Acetaminophen) [tylenol] Give 1000 mg [milligrams] by mouth three times a day related to BILATERAL PRIMARY OSTEOARTHRITIS OF KNEE . BILATERAL PRIMARY OSTEOARTHRITIS OF HIP. * 01/19/24, Ultram 50 mg (TraMADOL HCL) [narcotic analgesic] *Controlled Drug* Give 50 mg by mouth as needed for pain Take up to three times daily as needed if pain unrelieved by tylenol. * 01/29/24, LORazepam [antianxiety medication] Oral Tablet 0.5 MG Give 0.5 mg by mouth as needed for anxiety/agitation related to ANXIETY DISORDER . Take up to one time daily. During an interview on 04/14/24 at 12:54 p.m., Resident #31 stated, I have had issues getting my pain and anxiety medications which has created a lot of anxiety for me not knowing if I would get them [pain and antianxiety medications] or not. A nurse refused to give me my tramadol and Ativan [lorazepam] when I requested them. Review of Resident #31's progress notes and medication administration record (MAR) identified the following: *01/22/24 at 9:16 p.m. Resident . Stated she wanted her Ultram, Tylenol and Ativan so she can sleep. Did not give them. She stated she did not know why she cant [sic] get them three times a day like in the last place. Explained this is new facility and we don't have an order for it that often. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The MAR identified Resident #31 did not receive any PRN doses of Tramadol or Ativan on this day. * 01/23/24 at 12:44 p.m. fax sent to Dr. [doctor] . re: [regarding] resident is very upset that her Tramadol is not scheduled at 0900 [9:00 a.m.], 1500 [3:00 p.m.], and at bedtime, Tramadol was scheduled at these times at her last place of residence, resident states she needs it scheduled because of her back and knee pain, can we schedule it as resident wishes? . * 01/23/24 at 3:58 p.m. fax received from Dr. stating NO Keep it prn referring to the Tramadol . * 01/26/24 at 11:31 p.m. Resident was calm and cooperative. Requesting Tramadol told her could not give she already received it 3 times today. Stated that I needed to go research and bring her the Tramadol. Restated I could not give her any because she already received it 3 times today. The MAR identified Resident #31 only received two doses of Tramadol on this day, and did not receive Ativan until 11:10 p.m., almost two hours after she requested it. The facility failed to administer prn pain and antianxiety medications as ordered and when Resident #31 requested. Review of a physician's progress note, dated 02/21/24 for Resident #31 stated, . She [Resident #31] states for years, she was on lorazepam 2-3 times daily as needed for anxiety . She also notes that the tramadol she has previously taken 2-3 times per day and that is not being given as often since her admission to the nursing home. She is wondering if those can be adjusted. She makes it a point that she is [AGE] years old and has been on the anxiolytics and tramadol for a number of years without problems and I do not see at this point any reason why we cannot be more liberal with the anxiolytics and the tramadol. She already has the tramadol ordered 3 times daily as needed if pain is unrelieved by Tylenol and I think that is adequate for now to continue with that order. The lorazepam however, will be increased to twice daily. Monthly pharmacy review progress notes for Resident #31 included the following: * 02/28/24 . Pain: freq [frequent] moderate - severe. PRN Meds: tramadol 76 (+58) [indicating the resident requested and received tramadol 58 more times in February then she did in January]. Lorazepam now scheduled, . assess need to schedule a dose of tramadol to help control pain. * 03/28/24 . Pain: frequent moderate-severe pain mostly relieved with PRN tramadol. PRN Meds: tramadol 75 [prn doses] . for pain control, may consider scheduling for better pain control next month. The facility failed to inform the physician of Resident #31's increased use of prn pain medication and suggestions for scheduled doses as indicated by the pharmacy reviews. During an interview on 04/16/24 at 11:50 a.m., an administrative nurse (#1) stated she was not aware of Resident #31's concerns with not receiving her prn pain and antianxiety medications. The also reported she did not notify the physician of the pharmacy monthly reviews since it was not noted specifically as a recommendation. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/16/24 at 1:29 p.m., an administrative nurse (#1) agreed Resident #31 could have received Tramadol and Ativan on 01/22/24 when she had requested it and on 01/26/24 she could have received prn tramadol when she requested it. The administrative nurse stated she expects staff to administer medications as ordered and as requested by the resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40489 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/25/23 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 2 sampled resident (Resident #24) who received an as needed (PRN) psychotropic. Failure to limit PRN psychotropic use to 14 days unless reevaluated by a practitioner placed the resident at risk of receiving unnecessary medications and experiencing adverse drug effects. Findings include: Review of the facility policy titled Psychotropic Medications occurred on 04/17/24. This policy, dated December 2023, 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. Review of Resident #24's medical record occurred on all days of survey. A physician's order, dated 10/02/23, included Lorazepam (antianxiety) 0.5 milligrams every 4 hours as needed for anxiety/agitation. The facility failed to obtain an order to extend the psychotropic medication beyond the original 14 days and failed to include the rationale/specific circumstances for its extended use and a stop date established by the prescriber. During an interview on 04/16/24 at 10:48 a.m., an administrative nurse (#1) confirmed the facility failed to obtain a new order for the extended use of Resident #24's Ativan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42397 Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 6 sampled residents (Resident#17, #35 and #195) observed with enhanced barrier precautions (EBP). Failure to practice infection control standards related to linen handling, hand hygiene, and glove use, and ensure staff use the proper personal protective equipment (PPE) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Standard and Transmission-Based Precautions, All Service Lines - Enterprise occurred on 04/17/24. This policy, revised 04/02/24, stated, . Purpose . To prevent the spread of infection . Enhanced Barrier Precautions . Enhanced barrier precautions expand the use of PPE [Personal Protective Equipment] beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi drug resistant organisms] . Enhanced barrier precautions are needed for residents with chronic wounds (pressure ulcers .) . and Residents with Indwelling Medical devices (. indwelling urinary catheters .) . Review of the facility policy titled Laundry, Resource Packet - Collecting Soiled Clothes and Linens occurred on 04/17/24. This undated policy stated, . Soiled laundry will be collected to prevent the spread of potential infectious disease. All soiled linens, soiled with bodily material, will be treated as if it is potentially infectious. Clothes and linens should be placed directly into plastic bags. Review of the facility policy titled Hand Hygiene - Enterprise occurred on 04/17/24. This policy, dated 03/29/22, stated, . All employees in patient care areas . will adhere to the 4 Moments of Hand Hygiene . 2. Before Clean Task 3. After Bodily Fluid/Glove removal . Gloves are a protective barrier for the HCW [health care worker] according to standard precautions. 1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal. Change gloves when moving from a dirty to clean or sterile activity performing hand hygiene in between changing gloves. - Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, . I require Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device:-Foley Catheter . Don gown and gloves when performing high contact care activities including: dressing . Observation on 04/15/24 at 12:00 p.m. showed a sign on Resident #17's door stating, Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities: Dressing . Changing Linens. A laundry aide (#8) wore a glove on the right hand, applied alcohol based hand rub (ABHR) to the gloved hand, entered Resident #17's room with clean laundry, and exited the room. Without removing the glove and performing hand hygiene, the laundry aide retrieved a set of clothes from the laundry cart, applied ABHR to the same glove on the right hand, and took the laundry into a different resident room. The laundry aide (#8) failed to follow facility policy for hand hygiene and glove use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/16/24 at 8:10 a.m. showed Resident #17 seated in a wheelchair by the bed and the resident's personal blanket on the floor. A certified nurse aide (CNA) (#7) wore a gown and no gloves and assisted the resident to don a shirt. The CNA performed hand hygiene and donned gloves. The CNA removed soiled linens from the bed and placed them directly on the floor. Without performing hand hygiene or donning clean gloves, the CNA (#7) applied clean linen to the bed, picked up Resident #17's the blanket off of the floor, folded it and placed it on top of clean linen at the foot of the bed. The CNA (#7) failed to wear appropriate PPE while performing high contact care activities, change gloves and perform hand hygiene per facility policy, failed to place the soiled linen in a plastic bag prior to placing it on the floor, and placed a soiled blanket back on Resident #17's bed. -Review of Resident #35's medical record occurred on all days. A Wound/Skin Assessment completed on 03/26/24 identified . Left Heel Unstageable Pressure Ulcer . Observation on 04/14/24 at 11:48 a.m. showed a sign on Resident #35's door stating, Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Transferring . Providing Hygiene . Changing briefs or assisting with toileting . Observation on 04/16/24 at 9:35 a.m. showed two CNAs (#4 and #5) assisted resident to transfer from the wheelchair to the toilet in the public bathroom. Both CNAs wore gloves but failed to don gowns. The CNA (#5) removed the resident's soiled brief and placed a new brief. The CNA (#5) cleaned urine off the floor, removed her gloves, and without performing hand hygiene donned new gloves. The CNAs assisted the resident from the toilet to the wheelchair after CNA (#4) performed perineal cares. The CNAs (#4 and #5) failed to don appropriate PPE while they toileted Resident #35 and the CNA (#5) failed to follow facility policy for hand hygiene and glove use. - Review of Resident #195's medical record occurred on all days of survey. A Wound/Skin Assessment completed on 04/12/24 identified Stage II PU [pressure ulcer] noted on coccyx. Physician notified. The current care plan stated, . I have an actual impairment to skin integrity R/T fragile skin, immobility, and incontinence E/B [evidenced by] Stage II pressure ulcer. Observation on 04/13/24 at 4:30 p.m. showed a sign on Resident #195's door stating, Enhanced Barrier Precautions. Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities .Transferring .Providing Hygiene . Changing briefs . A nurse (#14) and CNA (#11) performed hand hygiene, donned gloves, and entered the resident's room to provide cares and transfer the resident. Staff failed to don a gown. During an interview on 04/16/24 at 3:20 p.m., an administrative nurse (#1) stated she expected staff to handle linens and use gloves/perform hand hygiene per policy. During an interview on 04/17/24 at 12:15 p.m., an administrative nurse (#1) stated she expected staff to follow enhanced barrier precautions by donning correct PPE required for the cares being delivered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45873

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42397 Based on record review, review of facility policy, and staff interview, the facility failed to assess each resident's pneumococcal status and provide education to residents and/or their legal representatives regarding the benefits and potential side effects of receiving the vaccination for 1 of 5 sampled residents (Resident #17) reviewed for immunization status. Failure to offer pneumococcal vaccine to all residents, provide education to residents and their legal representatives, and document the administration or refusal has the potential for non-immunized residents to contract pneumonia and spread the infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19 [coronavirus], Other . LTC [long term care] . occurred on 04/17/24. This policy dated, 09/21/23, stated, . To provide residents and clients the opportunity to receive immunizations as they fit into their healthcare goals. Upon admission, each client, resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines . Review current vaccinations. Provide and document education on the benefits and potential side effects of the vaccinations for which the client/resident is eligible. Review of Resident #17's medical record occurred on all days of survey. The resident was admitted in January of 2024. The record lacked evidence the facility assessed the resident's pneumococcal immunization status on admission and provided education to the resident and/or their legal representative. The facility failed to follow their policy for pneumococcal vaccine administration. During an interview on 04/16/24 at 3:20 p.m., an administrative nurse (#1) verified the facility failed to assess Resident #17's pneumococcal immunization status and document history, offer and/or refusal of the pneumococcal vaccine.