STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING _____ B. WING _____	R-C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	**108 E NYHUS AVE MCVILLE, ND 58254**

(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
{F 000}	INITIAL COMMENTS An on-site revisit survey was conducted on 01/28/25 to determine compliance with deficiencies identified during the facility reported incident survey completed on 11/26/24.	{F 000}		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	F 605		2/24/25

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

Electronically Signed | 02/13/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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.

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F 605	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 1 closed record (Resident #1) remained free from a chemical restraint (morphine sulfate-an opioid pain medication). Failure to attempt non-pharmacological interventions and/or utilize the least restrictive alternative medication does not allow the resident to attain and/or maintain his/her highest level of practicable well-being. Findings include: The facility failed to provide a policy on pain management or opioid use when requested. Review of Resident #1's medical record occurred on 01/28/25. Diagnoses included Alzheimer's disease, obsessive compulsive disorder, and dementia with agitation. The current care plan stated, ". . . [Resident #1] has behaviors e/b [evidenced by] verbal taunting, seeks out others, has been physically aggressive at times r/t [related to] Dementia and cognitive decline . . . 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. . . . Monitor behavior episodes and attempt to determine underlying cause . . . . Document behavior and potential causes. . . ." The care plan lacked a problem related to pain. Review of Resident #1's quarterly pain assessments, dated 08/23/24 and 11/22/24, identified the resident did not experience pain during the assessment period or display any	F 605	1. The resident affected by this practice was discharged 1/23/25, thus there was no opportunity for corrective action for this case. 2. The inter-disciplinary team (IDT) will identify any residents having the potential to be affected by this practice, when the 24 hour report is read during morning meetings, three to five days a week. 3. A Pain Management Policy has been put into place. Our Medical Director is aware of this new policy. This policy will be introduced and reviewed at a nursing department meeting on 2/24/25. At this time, nurses will be instructed to offer non-pharmacological pain control measures first, whenever possible, and to document such. At the Medical Staff meeting on 2/19, providers will be informed of this new policy. 4. During quarterly care plan assessment periods/care plan meetings, performance regarding this practice will be monitored. Any time there is a new onset of pain or a significant change, this will be addressed, as appropriate. This will also be included in monthly Quality Assurance (QA) meetings. 5. Corrective action will be completed on 2/24/25. Ongoing monitoring will take place at monthly QA meetings and during quarterly care plan meetings through the second quarter of this year (30 June), depending on compliance. If situations are found that are not addressed appropriately, monitoring will continue for	

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F 605	Continued From page 2 non-verbal indicators of pain. A quarterly Minimum Data Set (MDS), dated 11/24/24, identified a BIMS of 5 (indicating severely impaired cognition), physical and verbal behaviors, and "No" for presence of pain. Resident #1's physician's orders included: * 11/18/23, acetaminophen 325 milligrams (mg). Give 2 tablets orally every 4 hours as needed for mild pain or fever. * 01/19/25 at 6:10 a.m., morphine sulfate 2.5 mg by mouth one time only for anxiety for 1 day * 01/19/25 at 1:45 p.m., morphine sulfate 2.5 mg by mouth every 2 hours as needed * 01/20/25, morphine sulfate 2.5 mg by mouth every 2 hours as needed for anxiety/pain. Review of Resident #1's progress notes and Medication Administration Record (MAR), dated January 19-21, 2025, identified the following: * 01/19/25 6:05 a.m., "Late Entry: Resident up and dressed and is pacing in halls by nurses station in his w/c [wheelchair]. He is anxious as evidenced by facial scowl, repeated and troubled calling out to staff, clenched fists and repetitive negative comments. [Physician name] informed and order received for one time dose Roxanol [morphine sulfate] 2.5 mg for apparent signs of pain and anxiety." * 01/19/25 at 6:18 a.m., morphine sulfate administered for anxiety, "pacing in halls," and a pain rating of 8 out of 10. * 01/19/25 at 2:21 p.m., morphine sulfate administered for a pain rating of 8 out of 10. * 01/19/25 at 8:15 p.m., morphine sulfate administered. The record lacked a pain rating. * 01/20/25 at 4:50 a.m. "Behavior Note . . . sitting in w/c hollering 'help me.' Morphine sulfate 2.5	F 605	the third quarter (through 30 September).	

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F 605	Continued From page 3 mg. given. . . ." The record lacked a pain rating. * 01/20/25 at 10:21 a.m., morphine sulfate administered for a pain rating of 6 out of 10. * 01/20/25 at 6:20 p.m., morphine sulfate administered for, ". . . becoming agitated in day room now." The record lacked a pain rating. * 01/20/25 at 11:25 p.m., morphine sulfate administered for, ". . . Sitting at bedside hollering 'help me help me' then he starts making his other vocal noises. He didn't want anything. He was given morphine sulfate and assisted to lay down." The record lacked a pain rating. * 01/21/25 at 4:45 a.m., morphine sulfate administered for ". . . lying in bed hollering." The record lacked a pain rating. * 01/21/25 at 3:21 p.m., ". . . monitor behaviors every day and evening shift. Resident has been go [good] this shift so far." * 01/21/25 at 6:23 p.m., morphine sulfate administered for anxiety/pain . . ." The record lacked a pain rating. * 01/21/25 at 10:20 p.m., "Behavior Note. At 6:30 [p.m.] he was lying in bed hollering 'help me' but didn't need anything. Morphine Sulfate given. He has been sleeping since then." * 01/21/25 at 10:50 p.m., morphine sulfate administered for, ". . . needs to calm down." The record lacked a pain rating. The record showed the facility failed to administer acetaminophen in the month of January 2025. During an interview on 01/28/25 at 4:09 p.m., an administrative nurse (#1) confirmed Resident #1's medical record lacked pain documentation, use of non-pharmacological behavioral interventions, and/or use of the least restrictive	F 605		

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F 605	Continued From page 4 medications (acetaminophen) before administering Morphine. The facility failed to complete a pain assessment related to Resident #1's new onset of pain, provide a rationale for the initiation of morphine, and attempt non-pharmacological interventions or administer the least restrictive medication (acetaminophen).	F 605		