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 _____	C 11/26/2024

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 unannounced onsite investigation survey regarding a facility reported incident was completed on November 26, 2024. During the report investigation the facility was found to be non-compliant with regulatory regulations.	F 000		
F 600 SS=G	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 observation, record review, review of the facility reported incident, review of facility policy, and staff interviews the facility failed to ensure residents remained free from abuse from 1 of 1 sampled resident (Resident #1) who displayed verbal and physical behaviors towards residents. Failure to provide necessary services to protect residents from abuse resulted in physical and psychosocial harm. Findings include:	F 600	1. Corrective action for residents affected by the deficient practice included keeping a log of MT's (Resident #1232) behaviors, or instances that required nursing staff to separate him from another resident or otherwise intervene. 2. Any resident could be affected by this deficient practice. There was one instance when another female resident was sought after, but no subsequent issues with her have been reported. There is ongoing monitoring by nursing	1/6/25

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

Electronically Signed | 12/27/2024

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 _____	C 11/26/2024

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 600	Continued From page 1 Review of the facility policy titled "Abuse Prohibition Policy" occurred on 11/26/24. This policy, dated July 2021, stated, ". . . Residents must not be subjected to abuse by anyone, including, but not limited to . . . other residents . . ." Review of the facility reported incident identified on 11/02/24 at 7:30 p.m. Resident #1 kicked Resident #2 in the leg. - Review of Resident 1's medical record occurred on 11/26/24. The quarterly MDS, dated 08/24/24, identified severely impaired cognition. The care plan included, ". . . [Resident #1] has a behavior problem e/b [evidenced by] verbal taunting, seeks out others, has been physically aggressive at times r/t [related to] Dementia and cognitive decline. . . . Anticipate and meet [Resident #1's] needs. . . . Assist [Resident #1] to develop more appropriate methods of coping and interacting. Encourage him to express feelings appropriately. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him as passing by. . . . Follow behavior plan and interventions. See print out in nurses [sic] for reference. . . . 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. . . . Minimize potential for [Resident #1's] disruptive behaviors by offering tasks which divert attention such as hands on activities, 1-1s [sic] talking sports. . . . Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential	F 600	staff for others who may be targeted. 3. To help ensure this deficient practice does not persist, the following measures were put into place: A behavior plan for MT (Resident #1232), and a safety plan for CM (Resident #1233). These were added to their Plans of Care on 11/11 and 11/19/24, respectively. Nursing staff was informed in a memo in Point Click Care on 11/15, and at a department meeting on 11/25/24. The inter-disciplinary team (IDT) phone consulted with Dr. Berg on 11/19. Behavior topics were added to Falls Committee meetings, held monthly. 4. To monitor for effectiveness of corrective actions, core members of the IDT meet three-five days/week, and the 24-hour report is read, noting any situations that call for discussion or further action. The Behavior/Falls Committee reviews nurses' notes and doctor's round notes, and discusses any changes, and effectiveness or lack thereof. Social Services reports on findings from inquiries re: placement elsewhere. 5. Corrective action is ongoing at this time. The 30 days of monitoring for improvement with using Positive Approaches to Care, logging interactions requiring supervision/intervention, and checking out referrals was up on 12/19/24. A new medication, Sertraline, was started 12/17. Social Services continues to reach out to check for other placement options. Dr. Berg discussed the case with Nurse Practitioner M. Hammer on 12/16. Social Services and	

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 _____	C 11/26/2024

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 600	Continued From page 2 causes. . . . Praise any indication of [Resident #1's] progress/improvement in behavior. . . . Provide a program of activities that is of interest and accommodates residents status. . . ." Review of Resident #1's progress notes included the following: * 11/02/24 at 7:30 p.m., ". . . Resident was bickering with another resident [Resident #2] and sought her out in the day room. When she [Resident #2] tried to move away from him he kicked her several times in the lower leg. . . ." * 11/06/24 at 12:50 p.m., ". . . [Resident #1] was seen kicking [Resident #2]. Writer removed [Resident #1] from [Resident #2]. After removing [Resident #1] was chasing [Resident #2] down the hall. [Resident #2] was taken into own room away from [Resident #1]. * 11/07/24 at 12:30 p.m., ". . . charge nurse reported that resident kick [sic] resident [Resident #2] in the lower leg. This is the 3rd resident to resident contact made in three days. . . ." * 11/07/24 at 12:30 p.m., ". . . Resident seen by [physician's name] for 60 day recert [recertification]. Shortly before seeing him charge nurse reported that resident kick [sic] [Resident #2] in the lower leg. This is the 3rd resident to resident contact made in three days. Order received from [physician's name] 'I recommend this resident be transferred to a facility with a locked special care unit'. Message left with [power of attorney]. Awaiting call back to inform of recommendations. . . ." * 11/09/24 at 12:29 p.m., ". . . Resident was seeking out resident [Resident #2]. Resident was antagonizing [Resident #2]. [Resident #2] was motioning with her arms for him to go away. CNA	F 600	DON phone conferenced with Administrator S. Harding on 12/24/24. We will work to move CM to a different hallway this week. If no significant improvement has been noted after four-six weeks, and no placement has been found elsewhere, Dr. Berg may consider a psych consult.	

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 _____	C 11/26/2024

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 600	Continued From page 3 [certified nurse aide] has separated the two residents 3 times in the last 30 minutes. . . ." * 11/09/24 at 8:09 p.m., ". . . at 1820 [6:20 p.m.] [Resident #1] said 'I'm going to get her' and then proceeded to try and kick [Resident #2]. At 1825 [6:25 p.m.] he [Resident #1] started chasing [Resident #2] and when asked why he said 'she wants me to' this writer explained to him that she doesn't and to please go the other way. At 1840 [6:40 p.m.] he trapped [Resident #2] in the dining room and she yelled 'get out of the way' he said 'no' and was intercepted by staff and denied doing it. At 1843 [6:43 p.m.] resident was in hallway, turned his head then his chair and stopped [Resident #2] and yelled 'now who is following who?' At 1845 [6:45 p.m.] he waited for [Resident #2] to turn the corner looked around him then followed her but acted surprised when staff stopped him and said that he didn't do anything. At 1855 [6:55 p.m.] he started mocking [Resident #2] and had to be pulled away from her. . . ." * 11/10/24 at 12:30 p.m., ". . . resident in the dinning [sic] room at [Resident #2] table. He was found shaking her wheelchair and kicking at her. . . ." * 11/10/24 at 10:21 p.m., ". . . between 1835 [6:35 p.m.] and 1905 [7:05 p.m.] resident had to be re-directed 8 times away from [Resident #2]. Wouldn't let resident pass X3 [three times] tried to approach her X3 and followed her X3. He would wait for her and say 'there she comes again' and then follow her. 'there she goes, I should chase after her'. [Resident #2] tried to avoid him by doing a u-turn through the nurse's station and yelled 'leave me alone what's the matter with you?' Resident was told multiple times to leave her alone and he kept it up even	F 600		

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 _____	C 11/26/2024

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 600	Continued From page 4 once saying 'lets take her to the woods' . . ." * 11/11/24 at 1:36 p.m., ". . . CNA behavior log: "intercepted 4 times in 10 mins [minutes]when he started chasing down [Resident #2] Intervention: 'tried offering snack or to go to room.' outcome: 'behavior got worse, resident became combative, resident became agitated. resident started kicking at staff when interventions were placed'. . . ." * 11/11/24 at 3:48 p.m., ". . . Writer faxed on-call [physician] about behavior changes, blood pressure, and not sleeping at night. On-call [ordered] '3mg melatonin [an over the counter sleep aid] 30 mins before bed as needed for insomnia. Referral placed for psychiatry due to recent behavioral changes.' * 11/11/24 at 4:54 p.m., ". . . resident was found kicking at [Resident #2]. [Resident #2] wheelchair hit the wall. . . ." * 11/15/24 at 7:27 p.m., ". . . Within a short time he was calling [Resident #2] names and persistently chasing after her until staff intervened. He then stated 'do you want to end up on the floor?' When he was turned to be taken away from the situation, he began to swing the remote and raise his voice. . . ." * 11/16/24 at 3:54 a.m., ". . . Resident had been picking on just one or two residents now he's starting to just yell and chase any of them around. Staff needs to keep a close eye on him when he is out of his room. . . ." * 11/19/24 at 11:00 p.m., ". . . Management team met with [physician's name] today to discuss this resident and incidents which have been often occurring. Resident seems to be fixated on one specific resident and we met to discuss what can be done to help the situation. A resident behavior plan has been created that will be introduced to	F 600		

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 _____	C 11/26/2024

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 600	Continued From page 5 all staff to follow. Along with this, we will work with all staff and follow staff to ensure that the positive approach to care [PAC] [a specialized training specifically for taking care of patients with dementia] is being used, as we are trained and PAC certified. [Physician's name] is in agreeance with the following plan: buff up skills and alert staff as stated above, really working hard to approach resident positively; refer out to see options; Thursday, [physician's name] will see resident in regardsd [sic] to his compulsive tendancies [sic] with possible psych [psychiatry] eval [evaluation]. We will follow and document progress on situation. . . ." * 11/20/24 at 8:50 a.m., ". . . Writer heard [Resident #2] screaming 'get away from me' this resident was behind [Resident #2] laughing. . . ." * 11/21/24 at 1:36 p.m., ". . . Resident seen by [physician's name] for PRN [as needed] follow up visit. Reviewed behaviors. . . . Will start Paxil [a antidepressant medication] 10mg [milligrams] daily X 1 [times 1] week then increase to 20mg daily. Call placed to [power of attorney] to inform. He appreciated the call. Also notified of team members monitoring of behaviors plans. * 11/22/24 at 10:47 p.m., ". . . At 1830 [6:30 p.m.] resident approached and kicked the w/c of res [Resident #2], this writer removed [Resident #1] from the situation and . . . tried to re-direct him but he just became angry and tried to hit me and denied going near her. At 1840 [6:40 p.m.] he was removed from her again and . . . this writer tried to explain that she said 'stop bothering me' he denied going near her and this writer told him that I saw him do it and he said 'that's in the past I need to get her attention' this upset [another resident] who told him to 'buzz off' At 1845 [6:45 p.m.] approached [Resident #2], had to be	F 600		

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 _____	C 11/26/2024

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 600	Continued From page 6 removed . . . At 1846 [6:46 p.m.] he had to be removed from her again and kicked staff and raised his fist [sic] another [resident] then moved her chair between the 2 and said 'I will take care of her' At 1900 [7:00 p.m.] resident was again removed from [Resident #2], . . ." - Review of Resident #2's medical record occurred on 11/26/24. The MDS, dated 10/13/24, identified severely impaired cognition. On 11/26/24 at 12:24 p.m., this surveyor heard a female voice screaming loudly outside the conference room and then heard another voice say Resident #1's name. When this surveyor exited the conference room, observation showed Resident #1 and Resident #2 in the television area with two unidentified staff members in between them. When the staff members moved away Resident #1 immediately started to move his wheelchair towards Resident #2. Review of the facilities physical abuse altercation investigation which occurred on 11/02/24 between Resident #1 and #2 included interviews with staff directly involved with the physical abuse, notification to Resident #1 and #2's physician, notification to the facilities medical director, notification to Resident #1 and #2's families, and discussion with the resident care coordinator and licensed social worker. Interventions showed the following: - A behavior plan including a behavior log for Resident #1 - A safety plan for Resident #2 - Education to all nursing staff (CNAs and nurses) regarding Resident #1's behaviors/behavior plan and a safety plan for	F 600		

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 _____	C 11/26/2024

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 600	Continued From page 7 Resident #2. During an interview on 11/26/24 at 1:08 p.m., an administrative staff member (#2) stated all current staff have been trained in PAC training which is an 8 hour class she teaches. The administrative staff member (#2) also stated any new staff are trained immediately upon hire in the PAC training. During an interview on 11/26/24 at 1:41 p.m., an administrative staff member (#1) verified the facility had contacted 4 facilities with a memory care unit regarding possible transfer for Resident #1 and stated the other facilities did not have any openings at that time. The administrative staff member (#1) also stated the facility has a meeting scheduled on 12/03/24 with Resident #1's personal representatives and physician to discuss his behaviors and other possible options. The facility failed to provide necessary services to protect residents from verbal, psychosocial and physical abuse resulted in an unsafe environment and the potential for further harm.	F 600		