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 03/15/2023

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 The standard Medicare/Medicaid recertification and complaint survey started on 03/13/23 and concluded 03/15/23.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 609	1) Corrective action for deficiencies	4/4/23

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

Electronically Signed | 04/03/2023

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 03/15/2023

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 609	Continued From page 1 facility policy, and staff interview, the facility failed to investigate and report to the State Survey Agency (SSA) potential incidents of abuse/neglect for 2 of 2 sampled residents (Resident #13 and #29) who experienced injury. Failure to investigate and report allegations of abuse/neglect to the SSA places all residents at risk of potential abuse. Findings include: Review of the facility policy titled "ABUSE, NEGLECT, MISTREATMENT, AND MISAPPROPRIATION OF RESIDENT PROPERTY" occurred on 03/14/23. This policy, dated June 24, 2018, stated, ". . . It is the facility's responsibilities to prevent not only abuse, but also those practices and omissions that if left unchecked, lead to abuse. . . . Everyone must monitor the resident for possible signs of abuse: like suspicious or unexplained bruising . . . All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source . . . must be completed within 24 hours of the initial allegation report. Administration will provide a final written report to the North Dakota Department of Health, Division of Health Services within 5 days of the initial allegation. . . ." - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included left sided muscle weakness, dementia and history of falling. Observation showed Resident #29 wearing a right wrist splint on all days of survey.	F 609	related to reporting of alleged violations includes interviewing nursing staff who worked shifts leading up to first notation of Residents' #29 and #13 injury and bruises. CNAs were instructed on the importance of reporting any such findings to the charge nurse right away, and nurses were instructed on the importance of reporting any injury or bruise of an unknown origin to the nursing management and/or Social Services within 24 hours, or two hours for a serious injury of unknown origin. This instruction was accomplished at a nursing department meeting on 3/27/23; notes on this meeting were posted in the report room for all staff who were not present at meeting. Also posted was our policy on Injuries of Unknown Source. 2) Any resident has the potential to be affected by this deficient practice. Nelson County Care Center nursing staff will monitor & identify any such residents & notify appropriate staff. 3) Nurses were reminded to complete a Health Care Safety Zone report on any bruise or injury noted, unless a minor bruise could be linked to a specific cause (e.g., from a blood draw). Social Services provided a "cheat sheet" for Nursing to use to report an injury of unknown origin in the required time frame, in the event such an injury is noted on a weekend, holiday, or other time when management is not present. This was posted in the medication room, and nurses were	

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 03/15/2023

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 609	Continued From page 2 The nursing progress notes identified the following: * 02/10/23 9:28 p.m. "At 2050 [8:50 p.m.] one of the CNA's [certified nursing assistants] called this writer to pt [patient] room saying that he notice the pt right wrist swollen. This writer assessed pt, as the arm was red and painful to touch. This writer asked the pt what happened to his wrist? He said that he does not know what happen. Pt temp [temperature] was 98.1% [sig] This writer called at the hospital wanting to talk to the [name of provider] This nurse, [name of nurse] explained to [name of provider] about it and Dr [doctor] said that I should use cool ice pack on wrist until in the morning and try to call back if it does not resolve. This writer did that and also gave the pt Tylenol for pain. This writer later informed pt cousin, [name of cousin] about pt wrist. Will continue to monitor." * 02/11/23 6:30 a.m. "Writer assessed resident's right wrist, noting that it was reddened and swollen when compared with left. Wander-guard removed from right wrist. Resident is normally stoic regarding pain, but c/o [complain of] discomfort to wrist especially when touched. Writer called hospital to speak to on-call provider. On-call provider had ordered during the night shift that resident be brought to ER if he still had pain and swelling after area iced. Rt[right] wrist had ice packs applied during the night shift with no improvement to pain or swelling. NCHS staff brought resident to hospital . . . " * 02/11/23 11:55 a.m. "Late Entry: Res. [Resident] returned from ER [Emergency Room] per facility van and driver at 10:15. Res. to wear Spica splint to R) [Right] wrist at all times, except	F 609	informed of this via communication notebook and communication in Point Click Care. To prevent this problem from recurring, nursing management will review the 24-hour report at morning meetings and follow up on any injuries or bruises noted that have an undetermined source. The Abuse, Neglect, Exploitation and Injury of Unknown Source policies and procedures will be reviewed at the mandatory skills fair, to be scheduled for this spring. Required annual HealthCare Academy classes for staff includes coursework on Abuse and Neglect. 4) To ensure the sustenance of these measures, nursing will remind staff at department meetings of reporting requirements. Nurse management will review 24-hour report at morning meetings that area held daily Monday-Friday, and Health Care Safety Zone reports weekly, with follow-up as warranted. Health Care Safety Zone reports will be reviewed at monthly QA meetings. Any areas of concern will be discussed with individual staff members, with increased auditing as needed. These practices will continue through 2023. 5) Corrective action was done on 3/27/23, when nursing staff was informed at a department meeting and notices were posted. Travel staff and nursing staff not present at the meeting will be informed at the first opportunity; expected completion date is 4/4/23. Ongoing monitoring will be carried out as above	

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 03/15/2023

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 609	Continued From page 3 for hygiene and cold packs. Will x ray again in 4 weeks time. Res. appears to have a non-displaced ulnar fracture of the R) [Right] wrist." During an interview on 03/15/23 at 2:40 p.m. administrative staff (#1 and #3) stated at the time of the injury, Resident #29 reported to the staff nurse, he fell. Staff (#1 and #3) failed to provide documentation with details of the fall and confirmed staff failed to complete an investigation of the injury, or report the incident to the SSA. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included dementia and anxiety disorder. Review of Resident #13's nurses notes identified the following: * 04/20/22 at 5:33 a.m. "resident has a bruise on her rt [right] front thigh that measures 7.5 x 7.5 cm [centimeters] the color is dark purple and red it is not warm to touch and the resident does not c/o [complain of] pain." * 04/22/22 at 12:23 p.m. "CNA reported that a bruise was noted on resident's right thigh. Upon assessment, a black purple bruise measuring 10cm x 11cm was noted to resident's right thigh. Resident denies any pain to the area and was unable to report how bruising occurred. . . ." On 04/22/22 at 11:20 a.m. the SSA received an "Initial Allegation of Mistreatment, Abuse, Neglect, or Theft and Facility Reported Incidents Reporting Form" identifying a bruise on the front thigh measuring 7.5 cm x 7.5 cm. The facility failed to notify the SSA within 24 hours of the initial report of bruising and send a final report	F 609	(#4).	

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 03/15/2023

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 609	Continued From page 4 within 5 days. Resident #13's nursing notes identified the following: 11/08/2022 at 6:16 a.m. "bruise discovered on outer part of left knee l[length]:6cm w [width]:5cm and raised approximately .1cm. Pt [Patient] denied pain in area no redness or swelling around bruise temperature is normal to touch will continue to monitor." The facility failed to investigate the cause of Resident #13's bruise to the left knee. During an interview on 03/15/23 at 2:40 p.m. administrative staff (#1 and #3) confirmed the facility failed to complete a final report for the bruise on 04/20/22 and failed to investigate the bruise on 11/08/22.	F 609		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who	F 888		3/20/23

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 03/15/2023

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 888	Continued From page 5 provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;	F 888		

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 03/15/2023

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 888	Continued From page 6 (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner	F 888		

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 03/15/2023

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 888	Continued From page 7 recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement policies and procedures that included additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19 for 2 of 2 unvaccinated staff (Staff A and B). Failure to implement additional precautions for staff who are not fully	F 888	1) Corrective action will include the requirement for each unvaccinated employee to screen their temperature and any symptoms prior to each shift. If the employee has any covid-19 sign/symptom they will be required to test for the virus immediately. 2) It has been identified that all residents have the potential to be affected by this	

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 03/15/2023

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 888	Continued From page 8 vaccinated may lead to increased risk of transmission and spread of COVID-19 among patients, staff, and visitors. Findings Include: Review of the policy titled "Employee COVID-19 Vaccinations" occurred on 03/15/23. This policy, revised 10/15/22, stated, ". . . This policy is developed to ensure that all eligible employees are vaccinated against COVID-19 . . . will implement additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated . . . They will continue to wear surgical masks, check in when getting to work per recommendations. . . ." Review of employee vaccination records identified Staff A and B completed appropriate COVID-19 vaccine exemptions. Observations showed the following: * 03/14/23 8:27 a.m. Staff A walked throughout the facility, administering medications without a face mask. * 03/15/23 9:00 a.m. Staff B walked alongside a resident to the therapy room without a face mask. During an interview on 03/15/23 at 9:05 a.m., Staff B stated she is not required to wear a surgical mask and if she felt ill the recommendation is to talk to the infection preventionist or nurse. During an interview on 03/15/23 at 10:30 a.m., two administrative staff (#1 and #2) agreed the facility failed to follow the policy for mitigation strategies for unvaccinated staff.	F 888	deficient practice. 3) To correct this deficient practice, the NCHS policy was updated on 3/20/23 to reflect that each unvaccinated employee will be required to screen their temperature and any symptoms prior to each shift. If the employee has any covid-19 sign/symptom they will be required to rapid covid-19 immediately. An monthly audit by IP will be done on screening documentation for the first 3 months followed by quarterly audits. 4) NCHS plans to monitor the new policy performance by auditing and maintaining the screening log for unvaccinated employees. The IP will review this screen log daily while in the building. If she is unavailable, it will be the duty of the charge nurse. A list of unvaccinated staff is available to both the IP and all charge nurses. This screening log began on 3/21/23. If employee's refuse to screen, they will be required to wear an n95 mask during all shifts to prevent the spread of Covid-19. 5) The deficient practice has been corrected. Corrective action was done on 3/20/23 when the policy was updated and the check in process began for unvaccinated staff.	

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 03/15/2023

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
F9999	FINAL OBSERVATIONS The complaint investigated in conjunction with the on-site revisit survey was not unsubstantiated.	F9999		