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 _____	03/21/2024

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 The standard Medicare/Medicaid recertification survey started on 03/18/24 and concluded 03/21/24.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to	F 657	1. Corrective actions for residents affected by the deficient practice include	4/18/24

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

Electronically Signed | 04/19/2024

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 _____	03/21/2024

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 657	Continued From page 1 review and revise the comprehensive care plan to reflect the resident's current status for 3 of 14 sampled residents (Resident #13, #25, and #32). Failure to revise the care plan for Residents #13 and #32 limited the staff's ability to communicate care needs and ensure continuity of care for each resident and failure to update Resident #25's transfer status placed the resident at risk for injury. Findings include: The facility failed to provide a care plan policy. - Review of Resident #13's medical record occurred on all days of survey. The care plan stated, ". . . TOILET USE: Requires assist of 1 staff with mechanical stand lift for toileting. . . . TRANSFER: The resident requires assist of 1 staff w/ [with] mechanical stand lift . . ." A physician's order, dated 01/04/24, stated, "Resident will transfer using mechanical stand lift with assist of 1 and gluteal [buttock] strap." Observation on 03/19/24 at 9:59 a.m. showed two certified nurse aides (CNAs) (#7 and #9) assisted Resident #13 with toileting. The CNAs applied the lift sling around the resident's waist and started to raise the lift. The resident unable to grasp the handles and the CNA (#9) stated, "We better use the other strap [gluteal strap]." The CNAs then lowered the stand lift, applied the gluteal strap, and transferred the resident to the toilet. Observation on 03/20/24 at 12:24 p.m. showed a CNA (#9) transferred Resident #13 from the wheelchair to the bed using the mechanical stand	F 657	modifying the care plans for residents #13, 25 & 32, after discussion with the inter-disciplinary team (IDT), to ensure the current health status, focus and interventions are reflected in said care plans. 2. All residents have the potential to be affected by this deficient practice. The IDT will review care plans to determine whether/which other residents might be affected. 3. The DON/ADON, Resident Care Coordinator and MDS nurse will work together to review and update care plans, with input from other Department Managers (Activities, Social Services, Dietary) as appropriate. This information will be gathered from recent doctor visits and orders; CNA and nurse documentation; and observation of overall health status of all the residents. Licensed nursing staff will be educated on updating and revision of care plans at the department meeting scheduled for 4/29/24. At this same meeting the Comprehensive Care Plan Policy will be reviewed. A temporary position has been filled for the Resident Care Coordinator, who has been on Medical Leave of Absence since February. Having this gap in care filled should better help with keeping up with changes to Care Plans and CNA worksheets. 4. The IDT will meet 4/7 days, and will	

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 _____	03/21/2024

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 657	Continued From page 2 lift and failed to use the gluteal strap. Resident #13's care plan lacked an intervention to use the gluteal strap when transferring the resident with the mechanical stand lift. - Review of Resident #25's medical record occurred on all days of survey. The current care plan showed, ". . . Walking Program . . . Walk with 4WW [4 wheeled walker] 2x/day [twice a day] distance as tolerated assist x 1 [of 1 person] with gait belt. Initiated 07/19/23 . . ." Physical Therapy ended Resident #25's walking program on 02/20/24. The current resident care card, used by the CNAs, dated 03/04/24, showed ". . . Amb. [ambulate] w/ [with] FWW [front wheeled walker] short dist. [distance] . . . " Resident #25's current care card lacked updated ambulation information to match the care plan. During an interview on 03/21/24 at 10:39 a.m., administrative staff members (#4, #5, and #6) confirmed Resident #25's care card, which the CNAs follow, lacked the resident's current ambulation status. - Review of Resident #32's medical record occurred on all days of survey. Diagnoses included atrial fibrillation (irregular heartbeat). Current physician's orders showed Rivaroxaban (a blood thinning medication) 15 mg (milligrams) one time a day related to atrial fibrillation and Mirtazapine (an antidepressant) 7.5 mg at bedtime for mood.	F 657	read over the 24 hour report to make note of any changes in status or daily care needs that would require an updated care plan. This will be done in addition to scrutiny of care plans at the quarterly meetings as they come up. Nurse management will discuss any noted discrepancies or concerns and modify care plans as agreed upon; therapy consults will be done as appropriate and as ordered. Monitoring for care plan changes will be done 3/7 days for four weeks, 3/7 days for four weeks, then weekly for three months. Random checks will be done for another month. Should compliance not be meeting standards of updating with changes, more frequent monitoring will continue. The MDS/IC/QA Nurse, along with the Resident Care Coordinator and/or the DON or ADON will complete audits. Reporting will be done at monthly and quarterly QA meetings. 5. As of 4/18/24, residents' #13 and #32 care plans have been updated to include the following incomplete information – gluteal strap with standing lift use (#13), and depression/antidepressant and afib/anticoagulant (#32). The CNA worksheet for resident #25 has been updated to reflect what is on her current care plan re: ambulation. Monitoring of care plans will be ongoing per # 4 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 _____	03/21/2024

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 657	Continued From page 3 Resident #32's current care plan lacked problems and interventions related to use of an antidepressant and anticoagulant. During an interview on 03/21/24 at 10:39 a.m., administrative staff (#4, #5, and #6) agreed Resident #32's care plan should include a problem and interventions for use of an antidepressant and anticoagulant.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to provide care and services for 1 of 1 sampled residents (Resident #25) reviewed for edema (fluid retention) and 1 of 2 sampled residents (Resident #26) observed wearing a splint. Failure to apply compression stockings as ordered may result in worsening edema and failure to obtain an order for use of a splint may result in worsening pain. Findings include: - Review of Resident #25's medical record occurred on all days of survey. A physician's	F 684	1. Corrective action for deficient practices related to residents #25 and #26 included clarification of the order for tubigrip vs. compression stockings (resident #25), and changing the order for resident #26's wrist splint to prn (it is not currently being used, as pain and swelling have resolved). 2. Any resident has the potential to be affected by this deficient practice. The inter-disciplinary team (IDT) will monitor for this during care plan and 24 hour report review, and after provider rounds.	4/29/24

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 _____	03/21/2024

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 684	Continued From page 4 order, dated 08/30/23, stated, "Compression stockings to be utilized for edema management." A physicians note, dated 02/20/24, stated, ". . . bilateral lower extremity edema. Chronic. . . . Continue with compressions [stockings] as directed. . . ." The care plan stated, ". . . Staff to apply compression stockings to BLE [bilateral lower extremities] for edema management . . ." Observations of Resident #25 showed the following: * On 03/19/24 at 03:26 p.m., wearing non compression stockings. The resident reported she has "those socks [compression stockings] but not sure if I have them on." * On 03/20/23 at 12:30 p.m., wearing non compression stockings. * On 03/21/24 at 08:45 a.m., dressed for the day, wearing slippers without socks or compression stockings. During an interview on 03/21/24 at 10:39 a.m., administrative staff members (#4, #5, and #6) agreed they expected staff to apply compression stockings as ordered. - Review of Resident #26's medical record occurred on all days of survey. Observations on all days of survey showed Resident #26 wore a splint to the left hand/wrist. During an interview on 03/20/24 at 4:05 p.m., when asked about the splint to the left hand, Resident #26 stated, "It was all swollen and very painful and the physician didn't know what was wrong with it so he told me to use this brace all	F 684	3. Staff will be educated at a nursing department meeting scheduled for 4/29/24, on the importance of following through with orders as written. With the Resident Care Coordinator's position being (temporarily for now) filled, the IDT will be better equipped to monitor order follow-through and plans of care for accuracy. During the 24 hour report and care plan review, and after new orders are obtained, the IDT will be looking for discrepancies. 4. The IDT will review the 24 hour report, making note of any changes in orders that require an updated care plan. Nurse management will discuss any noted discrepancies or concerns and communicate these to caregivers and charge nurses. Monitoring for such changes will be done 3/7 days for four weeks, 2/7 days for four weeks, then weekly for three months. Ongoing monitoring will be done at random for another month. If at any time improvement is not noted, monitoring will continue at the previous rate until improvement is attained. Reports will be made at monthly and quarterly QA meetings re: progress toward goal. Nursing management or designee, the MDS/IP/QA Nurse, and/or Resident Care Coordinator will carry out the auditing. 5. As of 4/18/24, the order was changed to tubigrips for resident #25, and the order for the wrist splint has been changed to prn. Staff will be educated at the	

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 _____	03/21/2024

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 684	Continued From page 5 the time. I'm having an MRI [magnetic resonance imaging] on Monday to see what's wrong with it." During an interview on 03/20/24 at 4:20 p.m., when asked about the left hand splint, a nurse (#10) stated, "He had swelling in that hand and was using ace wraps until the last time he returned from the hospital he had the splint on. I was told he is to wear it at all times." Review of the March 2024 treatment administration record (TAR) identified an order, for a splint to left wrist for left wrist pain was discontinued on 03/11/24. The facility failed to obtain a physician's order for Resident #26 to wear the left hand splint after he returned from the hospital, monitor if the splint was in place, and failed to update the care plan to identify the splint was to be worn at all times. During an interview on 03/21/24 at 11:08 a.m., an administrative staff member (#5) stated, "When the resident returned from the hospital he did not have an order for the splint, so it was discontinued on the TAR." The staff member agreed staff failed to clarify the order for the splint when Resident #26 returned from the hospital.	F 684	mandatory nursing department meeting on 4/29/24 on importance of accurate order follow-through. Staff unable to attend will be given handouts and briefed.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		4/29/24

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 _____	03/21/2024

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 689	Continued From page 6 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, facility policy, and staff interviews, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 2 of 14 sampled residents (Residents #13 and #19). Failure to provide supervision of certified nurse aides (CNAs) by a licensed nurse regarding resident transfer modes and failure to utilize safe/proper technique during transfers may result in unnecessary pain, falls and/or injury for residents. Findings included: Review of the North Dakota Administration Code (NDAC) online at www.ndlegis.gov/information/acdata/pdf/33-43-01.pdf stated, ". . . 33-43-01-12. Supervision and delegation of nursing interventions. An individual on the department's nurse aide registry [CNA] may perform nursing interventions which have been delegated by a licensed nurse. An individual on the departments's nurse aide registry as delegated and supervised by a licensed nurse . . ." Review of the facility policy titled "STANDING LIFT" occurred on 03/21/24. This policy, dated December 2017, stated, ". . . The knee rest has a built-in leg strap to be used on residents without much control. . . . it is not advised that the standing lift be used if the resident cannot assist with his/her hands and arms. . . ." - Review of Resident #13's medical record	F 689	1. Corrective action for Residents #13, and #19: Staff were instructed on following the physician's order/care plan of transferring residents & especially with residents with a gluteal strap, during CNA meeting on 3/25/24. Resident #19's care plan updated to transfer with 1 staff; Will educate staff during Nursing/CNA department meeting on 4/29/24 as well, as policy will be reviewed. Plan to provide education to staff at upcoming meeting on calling the nurse if they feel resident is having increased weakness, increased confusion, or cannot use hands to hold on to standing lift, etc. 2. All residents who use a standing lift or assistance from staff have the potential to be affected by this deficient safety practice. 3. Nurses and CNAs will be provided with a copy of the Policy & Procedure on Standing Lift use at nursing meeting on 4/29/24, & education will be provided on following physicians' orders/nursing care plan on transfers & in times of residents' weakness, increased confusion, or inability to hold onto the standing lift, to have the charge nurse assess. Ongoing monitoring of proper transfer of resident will be done, per CNA skill checklist, on annual review. CNAs will be audited by charge nurse, DON, ADON, or designee on transferring practices; see #4. Other	

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 _____	03/21/2024

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 689	Continued From page 7 occurred on all days of survey and included diagnoses of weakness and dementia. The current care plan stated, ". . . TRANSFER: The resident requires assist of 1 staff w/ [with] mechanical stand lift . . ." The certified nurse aide (CNA) pocket care guide stated, ". . . Standing lift assist of 1 with gluteal strap . . ." A physician's order, dated 01/04/24, stated, "Resident will transfer using mechanical stand lift with assist of 1 and gluteal strap." Observation on 03/19/24 at 9:59 a.m. showed two CNAs (#7 and #9) attempted to transfer Resident #13 from the wheelchair to the toilet utilizing a mechanical sit-to-stand lift without applying the gluteal strap. The CNA (#9) began to lift the resident and he/she failed to hold onto the handles. The CNA (#9) stated, "We better use the other [gluteal] strap." The CNAs then utilized the gluteal strap. When asked if staff always use two assist with the sit-to-stand lift, the CNA (#9) stated, "No, just with [Resident #13's name] we do because she does not always stand very good." During an interview on 03/20/24 at 11:29 a.m., when asked how she knows when to use two staff with transfers the CNA (#9) stated, "It was in report a long time ago." Observation on 03/20/24 at 12:24 p.m. showed a CNA (#9) utilized the sit-to-stand mechanical lift to transfer Resident #13 from the wheelchair to the bed. The resident appeared restless and unable to follow commands. The CNA transferred the resident to the bed without using the gluteal strap, leg strap, and without the resident grasping onto the stand handles. The CNA stated,	F 689	residents will be reviewed for this as well. 4. The DON, ADON, or charge nurse will monitor the CNAs' transferring practices during cares or during toileting, by QA audits. This will be monitored as follows: Weekly for 4 weeks, biweekly for 4 weeks, then monthly for six months. Any concerns noted during this period will be addressed and corrective action/teaching will be provided to the individual CNA and increased audits, if need be. This will be reported and followed up on during Monthly Quality Assurance meetings and Quarterly meetings through the duration of 2024, if determined staff are no longer showing need for improvement or correction. 5. Corrective action done immediately on 3/25/24 at CNA meeting and will be further done on 4/29/24 at the mandatory Nursing department meeting. Any staff who have missed or will miss these dates will be provided with handouts on meeting minutes & policies reviewed. Ongoing auditing & education will be done during QA monitoring period as noted in section 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 _____	03/21/2024

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 689	Continued From page 8 "sometimes we can use one with her and the sit-to-stand." When asked how the CNA knows to use one or two staff the CNA stated, "We decide based on her day and her behaviors and how she is standing." The CNAs failed to use the leg and gluteal straps while transferring Resident #13. - Review of Resident #19's medical record occurred on all days of survey. The current care plan stated, ". . . TOILET USE: Assist of 1-2 . . . TRANSFER: The resident is able to transfer with extensive of 1-2 assist. . . ." The CNA pocket care guide stated, ". . . SBA [stand by assist] of 1/FWW[front wheeled walker]/Gait belt Assist of 1 . . ." Observation on 03/18/24 at 6:34 p.m. showed a CNA (#11) applied a gait belt and assisted Resident #19 to the bathroom. The resident ambulated slowly and grimaced the majority of the way to the bathroom. Observation on 03/20/24 at 10:02 a.m. showed a CNA (#12) assisted Resident #19 off the toilet and ambulated the resident back to his wheelchair. When asked how the CNA knows to use one or two assist the CNA stated, "I only use one because that's what his care card says. It just depends upon what kind of a day he is having if we need 2 staff." When asked who makes the decision to use one or two assist the CNA stated "We, the CNAs do depending upon what kind of day he is having." During an interview on 03/20/24 at 5:15 p.m., when asked how she knows whether to use one	F 689		

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 _____	03/21/2024

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 689	Continued From page 9 or two assist to transfer/ambulate Resident #19 the CNA (#13) stated, "I usually only use one for him depends on how he is feeling. If weaker I take him with the wheelchair into the bathroom and then he can just grab the bar and get up instead of walking into the bathroom. At night we use two when getting him out of bed." When asked who makes the decision to use one or two assist the CNA stated, "I do depending on how he is standing." During an interview on 03/21/24 at 11:53 a.m., an administrative staff member (#5) confirmed being unaware CNAs could not determine the number of staff needed to transfer and stated she expected staff to use the leg and gluteal straps when transferring Resident #13.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		4/29/24

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 _____	03/21/2024

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 690	Continued From page 10 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of a professional reference, and staff interview, the facility failed to provide appropriate toileting for 2 of 12 sampled residents (Resident #8 and #13) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed residents at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: The facility failed to provide a policy related to toileting of residents. Kozier & Erb's "Fundamentals of Nursing: Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, "Fecal and Urinary	F 690	1. Corrective action for this deficient practice is as follows: CNAs were informed, during day-to-pm shift change, and the CNA meeting on 3/25/24, of the importance of adhering to toileting schedules, or informing charge nurse of deviations and reasons for deviations, especially with regard to residents #8 & 13. Since 3/21, nurses and CMAs have been reminded, and have been noted to, assist with toileting residents when their CNA/other CNAs are otherwise occupied at that time. 2. Any resident who needs assistance with toileting is at risk of being affected by this deficient practice. 3. The Management of Incontinence policy has been reviewed, and will be	

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 _____	03/21/2024

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 690	Continued From page 11 Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . . . also contribute to skin excoriation [area of loss of the superficial layers of the skin . . .]. Any accumulation of secretions . . . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. . . ." Page 1221 stated, "Managing Urinary Incontinence . . . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . . ." - Review of Resident #8's medical record occurred on all days of survey. The care plan stated, ". . . has an ADL [activities of daily living] self-care performance deficit r/t [related to] Alzheimer's disease. . . . TOILET USE: The resident requires supervision-limited assistance by 1 staff for toileting. . . . is at risk for falls r/t diagnoses of Alzheimer's and tremors, and has a hx [history] of falls. . . . Bed and chair alarms . . ." The certified nurse aide (CNA) pocket care guide stated, ". . . Assist of 1 w/ [with] toileting q [every] 2-3 hr [hours] & prn [as needed] Pull ups-Assist to chge [change] prn . . ." Review of Resident #8's toileting record, dated February 21 through March 20, 2024, identified 43 occasions where staff failed to assist the resident with toileting as care planned. The log showed gaps of approximately 3.5 to 14 hours between staff assistance with toileting.	F 690	presented at the nursing department meeting on 4/29/24. At that same meeting, nurses and CNAs will be educated on the necessity of following the plan of care and toileting residents per their needs. As noted in #1 above, this has been done verbally and shift change and at the 3/25 CNA meeting. Reminders will continue to be given, auditing will be done, and at the nursing department meeting on 4/29/24, opportunity will be offered for staff input and questions re: the policy. Positive Approach to Care dementia training by a certified instructor is planned, in an effort to educate staff on more effectively dealing with residents who may be difficult or uncooperative. The first set of classes for this year is scheduled for May 1 & 2, for new staff; refresher classes will be scheduled for staff who have taken the training, and another full class will be scheduled when several nursing staff return from leaves of absence. 4. Auditing will be done by nursing management or designee, and/or the Resident Care Coordinator, on toileting of residents #8 & 13, and others who are identified as at risk re: this practice. Monitoring will be done two days/week for six weeks, once/week for six weeks, and at random for another two months. Outcomes will be monitored at monthly and quarterly QA meetings, with continued auditing for any expected outcome shortcomings.	

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 _____	03/21/2024

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 690	Continued From page 12 Progress notes stated the following: * 1/9/24 at 12:30 a.m. ". . . found [Resident #8's name] resting on buttocks in front of door . . . with his shoulders resting against the door. Bed alarm was not sounding. . . . He said he had just been to the bathroom . . . Said after he was done on toilet he slipped. Skin tear to L) [left] elbow and 3 abrasions in a line down R) [right] elbow. He complained of pain to the ulnar [sic] side [one of the two bones in the forearm] ofhis [sic] R) hand. . . ." * 01/09/24 at 12:19 p.m. ". . . Writer informed on-call provider of fall with injury to right hand. Writer described resident's difficulty with moving 4th and 5th digits of right hand, swelling and bruising to lateral side of right hand. Provider ordered x-ray of right hand to be read stat[immediately]. . . ." * 01/09/24 at 1:45 p.m. ". . . Writer received call from on-call provider notifying that resident's x-ray revealed a broken 5th metacarpal. Provider applied splint to resident's hand and ordered orthopedics consult. . . ." During an interview on 03/19/24 at 2:17 p.m., a CNA (#7) stated, [Resident #8's name] is independent with toileting, he takes himself and does his own thing." During an interview on 03/20/24 at 11:33 a.m., a CNA (#12) stated, "Most of the time [Resident #8] goes by himself once in a while he will put his call light for help but not very often." When asked if he was able to use the bathroom himself , the CNA stated, "Oh yes he does all the time."	F 690	5. At day-to-pm shift change, verbal instruction has been given to CNAs and nurses (there have been nurses on vacation since 3/21/24, but as they return to work, they will also be informed) of the deficiency and need to follow toileting schedules. Review and discussion of the policy will be completed on 4/29/24 at the nursing department meeting.	

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 _____	03/21/2024

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 690	Continued From page 13 - Review of Resident #13's medical record occurred on all days of survey. The care plan stated, ". . . has an ADL self-care performance deficit r/t dementia . . . TOILET USE: Requires assist of 1 staff with mechanical stand lift for toileting. . . . is at risk for skin breakdown related to incontinence, decreased mobility and cognitive decline. . . . Open skin area to R lateral foot. . . . . is at risk for falls. . . . Resident uses chair and bed electronic alarm. . . ." The CNA pocket care guide stated, ". . . Toilet q 2-3 hr & PRN-Inc.[incontinent] bladder-brief . . ." Review of Resident #13's toileting record, dated February 21 through March 20, 2024, identified 82 occasions where staff failed to assist the resident with toileting as care planned. The log showed gaps of approximately 3.5 to 13 hours between staff assistance with toileting. Observation on 03/20/24 at 9:53 a.m. showed two CNAs (#7 and #14) attempted to assist Resident #13 to the bathroom. The resident appeared restless, agitated and failed to hold onto the sit-to-stand lift. The CNA (#7) stated, "We'll give her some time to calm down and try again in ten minutes." During an interview on 03/20/24 at 11:29 a.m., when asked if they had attempted to take Resident #13 to the bathroom again, the CNA (#7) stated, "We tried again about 45 minutes ago, but [Resident #13] started crying so we didn't take her then either." Observation on 03/20/24 at 12:24 p.m. showed a CNA (#7) attempted to take Resident #13 to the bathroom. Using the sit-to-stand mechanical lift	F 690		

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 _____	03/21/2024

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 690	Continued From page 14 the CNA assisted the resident to the bed for a check and change. The resident's incontinent product appeared very wet with urine. When asked how long it had been since the CNA had toileted/checked and changed the resident, the CNA stated, "Not since I got her up this morning about 7-7:30 [7 am -7:30 am]." Five hours prior to the resident being checked and changed. During an interview on 03/20/24 at 12:40 p.m., a licensed nurse (#10) stated the CNAs had not informed her Resident #13 wasn't able to stand or, hold onto the sit-to-stand mechanical lift, having behaviors, and not been toileted or changed since 7:00-7:30 this morning. During an interview on 03/21/24 at 11:53 a.m., an administrative staff member (#5) confirmed Resident #8 is not independent and expected staff to toilet/check and change residents per the care plan.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		4/29/24

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 _____	03/21/2024

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 761	Continued From page 15 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications in 1 of 1 medication carts. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medication Administration" occurred on 03/20/24. This policy, revised 2016, stated, ". . . The medication cart should be locked when left unattended . . . Medications should not be left on top of the medication cart . . . if the nurse or CMA [certified medication aide] is in a resident room and the medication cart is not locked . . . it has to be in an area where the nurse or CMA can see it . . ." Observation on 03/19/24 at 11:47 a.m., showed a staff nurse (#8) left the medication cart unattended for over eight minutes with six insulin pens/vials on top of the medication cart. The medication cart remained unlocked in the hallway	F 761	1. Corrective action for the deficient practice of leaving insulins on the medication cart in the hallway (while the nurse left the cart unattended) included talking with nurses and med aides who worked the week of the survey, reminding them of the importance of leaving the cart secure and without medications on it, when away from it. 2. Any resident or staff member could be affected by the medication cart being left open and unattended and with medication left in the open. Since 3/21, all nurses and medication aides have been spoken with regarding this practice. 3. The Medication Administration Policy has been posted on the medication room counter for review by nurses & med aides, and will be gone over at the nursing meeting on 4/29/24. This meeting will be open for discussion, and questions/concerns addressed.	

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 _____	03/21/2024

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 761	Continued From page 16 and out of view of the nurse. During an interview, on 03/20/24, an administrative nurse (#5) confirmed she expected staff to ensure medications are secured within the medication cart and to lock the cart when out of eyesight.	F 761	Nurses/CMAs have been reminded that keys are to be kept in their pocket or in locked med cart drawer (if using entry code system) at all times, and cart is to be kept locked when unattended, with medications secure inside cart. 4. The DON, ADON or designee, and/or the Resident Care Coordinator will be responsible to monitor medication and med cart security. These will be monitored weekly for six weeks, biweekly for six weeks, then monthly for three months. Any concern will be addressed with the individual nurse or CMA, with increased auditing done if needed. The DON will report audit results at Quality Assurance monthly and quarterly meetings for the duration of 2024. 5. Corrective action began on 3/21/24, when these issues were discussed with licensed nurses on duty. As different nurses and med aides have worked, they have been informed of this deficient practice and the need for correction. This will be completed at the nursing meeting on 4/29/24. QA monitoring will be done as noted in #4 above.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for	F 851		4/29/24

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 _____	03/21/2024

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 851	Continued From page 17 agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the	F 851		

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 _____	03/21/2024

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 851	Continued From page 18 individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on review of the Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Long-Term Care Facility Policy Manual and staff interview the facility failed to submit direct care staffing information based on payroll data to the Electronic Staffing Data Submission PBJ for 2 of 4 reporting periods. Failure to submit direct care staffing information may result in inaccurate representation of the level of staff in the facility which can impact the quality of care delivered. Findings include: The June 2022, version 2.6 Electronic Staffing Data Submission Payroll-Based Journal (PBJ), pages 1-3, stated, ". . . Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. . . Facilities that do not meet these requirements will be considered noncompliant and subject to enforcement actions by CMS. . ." Review of the PBJ Data Staff Report CASPER	F 851	1) Corrective action will be taken to conduct proper PBJ reporting in accordance with the requirements and recorded in a PBJ spreadsheet. 2) The entire facility has the potential to be affected. 3) Nelson County Health System Care Center PBJ reporting will be put on a monthly calendar with the PBJ spreadsheet being updated. QA will be completed monthly for 1 year to ensure the practice is in compliance. 4) Monthly meetings will be conducted to review the PBJ spreadsheet to ensure compliance, along with ensuring the report has been submitted. 5) Corrective action done immediately on 3/22/24 and will be further done as an ongoing QA check ensuring practices are being completed.	

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 _____	03/21/2024

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 851	Continued From page 19 Report 1705D FY (fiscal year) Quarter 4 (July 1 - September 30, 2023) and Quarter 1 (October 1 - December 31, 2023) occurred on 03/18/23, stated, ". . . Failed to Submit Data for the Quarter. . . Triggered. . ." During an interview on 03/19/24 at 4:40 p.m. an administrative staff member (#2) confirmed the facility failed to submit staffing data for the reporting periods listed on the reports.	F 851		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		4/29/24

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 _____	03/21/2024

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 880	Continued From page 20 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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 _____	03/21/2024

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 880	Continued From page 21 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to ensure staff followed standard infection control practices for 2 of 10 sampled residents (Resident #6 and #16) and 1 supplemental resident (Resident#1). Failure to follow infection control practices related to hand hygiene and glove use has the potential for transmission of communicable diseases and infections to residents and staff. Findings include: Review of the facility policy, "Handwashing Specifics" occurred on 3/21/24. This policy, revised January 2015, stated, ". . . Handwashing decreases contamination of the hands and prevents spread of pathogens . . . personnel who perform procedures on residents . . . should wear gloves . . . even though gloves are worn, hands should still be washed . . . before, between and after all physical contacts with the resident . . . before and after performing any personal body function . . ." - Observation on 03/18/24 at 10:18 a.m., showed a certified nurse aide (CNA) (#15) performed incontinence cares on Resident #16 while in bed. Without performing hand hygiene, the CNA (#15) donned gloves, lowered the resident's pants and brief, cleaned the resident's perineal area of bowel movement (BM), and with the same gloves on, turned the resident onto their side, removed two barrier cream tubes from the bedside drawer, applied the creams to the resident skin, and	F 880	1) Corrective action for Residents #1, #6, and #16: Hand hygiene and infection prevention discussion/demonstration/hand-outs at nursing department meeting 4/29/24. Infection Control Nurse discusses on daily basis 3/22/24 and thereafter during general discussion among staff on proper hand hygiene and contamination of surfaces. Staff were instructed on hand hygiene with cares, washing hands before donning and after doffing of gloves and prevention of contaminating surfaces and overall cleanliness of surroundings and clean-to-dirty technique during incontinent cares. All stated above subjects will be discussed during Nursing department meeting 4/29/24 as well. 2) All residents have the potential to be affected by the deficient handwashing practices. 3) Nurses and CNAs were provided with a copy of the Policy & Procedure Hand hygiene. Infection Control and hand hygiene discussed at nursing department meeting 4/29/24. QA monitoring. 4) The Director and Assistant Director of Nursing along with the Infection Control Nurse and Nurse Coordinator will work together to monitor the CNA and Nurses hand hygiene practices during cares 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 _____	03/21/2024

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 880	Continued From page 22 returned the tubes to the drawer. The CNA (#15) removed her gloves, and without performing hand hygiene, exited the room. - Observation on 03/19/24 at 10:20 a.m., showed a CNA (#9) provided incontinence cares for Resident #1. The CNA (#9), without performing hand hygiene, donned gloves, lowered the resident's pants, and lowered the front side of the soiled brief to perform perineal cares. The CNA (#9), without removing used gloves and performing hand hygiene, removed tubes of cleansing cream and barrier cream from the bedside drawer, put the cleansing cream on disposable wipes and cleansed the buttocks. The CNA (#9) then applied a barrier cream, placed a new brief and repositioned the resident onto their back. Resident #1 started to void and the CNA placed wipes to catch the urine. The CNA removed her gloves, and without performing hand hygiene, went to the residents closet for gloves, applied them, removed the soiled wipes, applied barrier cream under the resident's abdominal folds and fastened the brief. The CNA (#9) removed her gloves and without performing hand hygiene, touched several other surfaces/items, applied Resident #1's oxygen and gave the resident a drink of water and then performed hand hygiene. -Observation on 03/19/24 at 10:54 a.m., showed a CNA (#15) used a stand lift to provide toileting cares to Resident #6. Without performing hand hygiene, the CNA donned gloves, lowered the residents pants and brief and lowered them on the toilet. The CNA (#15) cleaned the resident's perineal area of BM, put on a clean brief and pulled up her pants, moved the lift, touched the	F 880	general treatment tasks. This will be done by QA audits during cares/treatments of all residents and general observation on the floor. This will be monitored as follows: Weekly for six weeks, biweekly for six weeks, then monthly for six months. Any concerns noted during this period will be addressed and corrective action/teaching will be provided to the individual CNA/Nurse and increased audits if need be. This will be reported and followed up on during Monthly Quality Assurance meetings and Quarterly meetings through the duration of 2024 or until the monitoring period is complete and staff are no longer showing need for improvement or correction on stated above subject. 5) Corrective action done immediately on 3/22/24 and will be further done on 4/29/24 at the Nursing department meeting. Any staff that have missed or that will miss these dates will be provided with handouts on hand washing and briefed on proper incontinent care techniques this will be completed by 4/29/24. Hand washing return demonstrations will be done during QA monitoring period as noted in section 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 _____	03/21/2024

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 880	Continued From page 23 sink, the door handle, the wheelchair, and the leg pedals, then removed her gloves and exited the room without performing hand hygiene. The staff failed to perform hand hygiene between glove changes and touched numerous items in the resident's room. During an interview on the afternoon on 03/20/24, an administrative nurse (#5) confirmed she expected staff to perform good hand hygiene with resident cares.	F 880		