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 _____	04/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 03/30/25 and concluded 04/01/25.	F 000		
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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and 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;	F 880		5/6/25

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

Electronically Signed | 04/15/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	04/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 (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. 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, record review, review of facility policy, and staff interview, the facility failed	F 880	F880 - Infection Prevention & Control. 4/2025	

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 _____	04/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 to follow standards of infection control and prevention for 1 of 2 sampled residents (Resident #9) observed with an indwelling catheter. Failure to practice infection control standards related to enhanced barrier precautions (EBP), urinary catheters, and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 04/01/25. This policy, dated April 2024, stated, ". . . Enhanced Barrier Precautions refers to the use of gown and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms. . . . Signage will be posted on the door or wall of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. . . . High-contact resident care activities . . . Transferring . . . Providing hygiene . . . Device care or use: . . . urinary catheter . . ." Review of the facility policy titled "HANDWASHING SPECIFICS" occurred on 04/01/25. This policy, dated January 2015, stated, ". . . Handwashing decreases contamination of the hands and prevents the spread of pathogens . . . WHEN SHOULD YOUR HANDS BE WASHED? . . . Before and after handling in-use patient/resident care devices. . . . after handling urinals, bedpans and similar contaminated items. . . ." Review of the facility policy titled "Catheter Bag	F 880	1. Corrective action for Resident #1: All nursing staff will be reeducated on Enhanced Barrier Precautions (EBP), Hand hygiene practices, Incontinent care hygiene, Foley catheter care and proper disposal of collection bag waist. Infection control standards will be added in with each teaching as it applies. 2. All residents have the potential to be affected by the deficient infection prevention and control practices. 3. All nursing staff were provided with an EBP in skilled nursing facilities paper to read and sign for immediate correction was handed out. Electronic pamphlets on EBP and UTI will be reviewed by all nursing staff. Copies of the following policies and procedures for “Enhanced Barrier Precautions (EBP)” “Hand Washing Specifics” and “Catheter Bag Draining” will be provided for review of all nursing staff. These Policies and Procedures will be reviewed and revised, if necessary, by the management team. The areas of concern related to this tag will be reviewed and discussed at the next nurses and CNA meeting for staff acknowledgement. Auditing QA program related to the areas of concern will be implemented to correct any further noncompliance if any and reinforce proper techniques. 4. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist (IP), and Resident Care Coordinator (RCC) will work together to monitor and perform QA Audits on Hand hygiene, EBP, Catheter	

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 _____	04/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 Draining" occurred on 04/01/25. This policy, dated October 2016, stated, ". . . Leg bag: . . . Dispose of urine in the toilet. Rinse out the collection container using the bedpan washer [wand sprayer]. . . ." Review of Resident #9's medical record occurred on all days of survey. The record identified an indwelling urinary catheter. Review of the care plan identified, ". . . Urology notes that catheter will be long term. . . . On enhanced barrier precautions (EBP) . . . TRANSFER: requires total assistance by 2 staff with the use of total mechanical lift for transfers. . . ." Observation on 03/30/25 at 1:43 p.m. showed Resident #9's room with signage for EBP and a supply cart located at the entrance of the room. The certified nurse aide (CNA) (#2) entered the room, applied gloves, failed to apply a gown, and emptied the urine contents from the leg bag into a collection container. The CNA then discarded the urine into the toilet, held the contaminated container under the sink faucet of a shared bathroom, obtained water, rinsed, and emptied the contents of the container into the toilet. The CNA removed her gloves, failed to complete hand hygiene, obtained the full body mechanical lift from the hallway, applied gloves, and paged for transfer assistance. The staff nurse (#3) stood at the doorway and instructed the CNA (#2) to apply a gown before the resident transfer, and both staff transferred Resident #9 into the bed. The CNA (#2) completed a brief change, cleansed an incontinent bowel movement, failed to remove her gloves, and applied skin barrier cream to the perineal area. The CNA applied a clean brief, removed her gloves and without	F 880	cares/hygiene, and Incontinent cares, during the designated time. QAs will be performed on a schedule of Weekly X4, Monthly X4, and Quarterly X2. QA audits will start the week of 4/20/25. Any concerns noted during this QA period will be addressed and corrective action/teaching will be provided to the individual CNA or Nurse and increased audits if indicated. This will be reported and followed up on during Monthly Quality Assurance meetings and Quarterly meetings through the duration of 2025 or until the monitoring period is complete and staff are no longer showing need for improvement or correction on stated above subjects. EBP information paper was handed out post survey for EBP refresher for all nursing staff to sign 4/2/25. EBP and UTI electronic pamphlets were handed out 4/11/25 to all nursing staff to watch for reeducation, this is done by the Infection Preventionist. All the stated above will be discussed and staff education will begin at the next Nurses and CNA meeting scheduled for 4/28/25 by DON, ADON, IP, and RCC. 5. Corrective action started immediately on 4/2/25 and is ongoing through the QA process starting 4/20/25 and Nursing department meeting on 4/28/25. Compliance with these corrections will be done by 5/6/25.	

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 _____	04/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 performing hand hygiene, applied the nasal cannula/oxygen, and placed the call light for Resident #9. During an interview on 04/01/25 at 10:17 a.m., an administrative staff member (#1) reported she expected staff to change gloves after incontinence cares, perform hand hygiene after removing gloves, use the spray wand to rinse contaminated containers, and wear a gown for residents in EBP when providing high-contact care tasks.	F 880		