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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40489 45873 Based on observation, record review, and resident and staff interview, the facility failed to 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 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. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40489 45873 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 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40489 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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 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.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40489 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 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. 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]. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 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. - 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 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39685 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 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.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47896 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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39685 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 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 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. (continued on next page)

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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45873