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	04/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) investigations, review of facility policy, and resident interview, the facility failed to ensure residents remain free from abuse for 2 of 2 sampled residents (Resident #2 and #4) who were subjected to physical abuse by Resident #1. Failure to protect residents from physical abuse may result in injury, fear, anxiety, mental anguish, and emotional distress.Findings include:Review of the facility policy, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, occurred on 04/29/26. This policy, dated 07/07/21, stated, . all residents have the right to be free from verbal, sexual, physical . abuse . Residents must not be subject to abuse by anyone, including, . other residents .Incident between Resident #1 and #4Review of the facility's initial FRI investigation, dated 01/25/26 at 9:30 p.m. stated, . Incident happened in the west hallway where [Resident#1] grabbed another residents [Resident #4] arm and grabbed, pulled, and squeezed. The final investigation stated, . The resident [Resident #4] was interviewed on 1/25 after the incident happened. She [Resident #4] stated that the other resident [Resident #1] was strong but said her arm was okay. Resident [#4] was interviewed again on 1/28 and she stated that she was in the hall and tapped the other resident [#1] on the shoulder and commented on (sic) pretty her sweater was. Resident [#1] smiled and raised her arms in happiness. [Resident #1] then grabbed this resident arm hard, and the resident said she had to pull away.- Review of Resident 1's medical record occurred on 04/29/26. Diagnoses included Alzheimer's disease, restlessness and agitation, and anxiety disorder. The admission Minimum Data Set (MDS), dated [DATE], identified severely impaired cognition. The care plan stated, [Resident's name] can have aggressive mood fluctuations r/t [related to] Dementia, Anxiety . HX [history] of physical contact with another resident. Distance from others when appropriate for safety.- Review of Resident 4's medical record occurred on 04/29/26. Diagnosis included non-Alzheimer's dementia, anxiety disorder, and depression. The quarterly MDS, dated [DATE], identified intact cognition.During an interview on 04/29/26 at 1: 20 p.m., when asked about the incident with Resident #1, Resident #4 stated, I didn't get hurt from it. [Resident #1's name] was a sweet gal, but she would just turn at times and get really angry and mean.Incident between Resident #1 and #2Review of the facility's initial FRI investigation, dated 02/06/26, stated, . [Resident #1's name] and [Resident #2's identification number] are both confused so cannot be interviewed. [Resident #1] has been in . Hospital since 2/3/2026 for pain/medication management.- Review of Resident #1's progress note, dated 02/03/26 at 12:22 a.m., stated, At 2040 [8:40 p.m.] on 02/02/2026 [Resident #2's identification number] was sitting next to [Resident #1's name] and talking to her. [Resident #1] started yelling and swinging at [Resident #2], hitting her in the face multiple times. [Resident #2] said, 'She just started hitting me in the face, so I moved away from her. I think she needs a shot or something.' [Resident #2] was assessed and no injuries were noted at this time and she denied any pain. [Resident #1] was moved to a quiet area and talked to by this writer, encouraged deep breathing and was reassured she was safe. Resident #1 did stop crying and calm down. Both residents are now on safety checks.- Review of Resident 2's medical record occurred on 04/29/26. Diagnoses included dementia, anxiety, behavior disturbance, (continued on next page)

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.

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

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	04/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and psychotic disorder. The annual Minimum Data Set (MDS), dated [DATE], identified severely impaired cognition. During an interview with Resident #2 on 04/29/26 at 1:15 p.m., when asked if she felt safe at the facility she stated, I'm at my home right where am I. Resident could not recall the altercation on 02/02/26.The facility failed to protect Resident #2 and #4 from Resident #1's physical abuse.

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	04/29/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) investigations, review of facility policy, and resident interviews, the facility failed to investigate alleged violations of abuse for 2 of 2 sampled residents (Resident #2 and #4). Failure to investigate Resident #1's incidents of abusive behavior, ensure the protection of other residents during the investigation, implement corrective actions, and evaluate the effectiveness of the actions, placed all residents at risk for mistreatment, verbal abuse, and/or experiencing anxiety/fear. Findings include:Review of the facility policy titled Abuse, Neglect, Mistreatment, and misappropriation of Resident Property occurred on 04/29/26. This policy, dated 07/07/21, stated, . The investigation is the process used to try to determine what happened. The nurse begins the investigation immediately. A root cause investigation and analysis will be completed . The investigation will consist of at least the following . An interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident. Interviews with the resident's roommate, family members, and visitors. A root cause analysis of all circumstances surrounding the incident .Review of the FRI report, dated 01/25/26 at 9:30 p.m. stated, . Incident happened in the west hallway where [Resident#1] grabbed another residents [Resident #4] arm and grabbed, pulled, and squeezed . The facility's final investigation stated, . The resident [Resident #4] was interviewed on 1/25 after the incident happened. She [Resident #4] stated that the other resident [Resident #1] was strong but said her arm was okay. Resident [#4] was interviewed again on 1/28 and she stated that she was in the hall and tapped the other resident [Resident #1] on the shoulder and commented on pretty her sweater was. Resident [#1] smiled and raised her arms in happiness. [Resident #1] then grabbed this resident arm hard, and the resident said she had to pull away.Another FRI report dated 02/02/26 at 8:40 p.m. stated, [Resident #2] was sitting next to [Resident #1] and talking to her. [Resident #1] started yelling and swinging at [Resident #2], hitting her in the face multiple times. [Resident #2] said, 'She just started hitting me in the face, so I moved away from her. I think she needs a shot or something.' [Resident #2] was assessed and no injuries were noted at this time and she denied any pain. [Resident #1] was moved to a quiet area and talked to by this writer Both residents are now on safety checks. - Review of Resident #1's medical record occurred on 04/29/26. Diagnoses included Alzheimer's disease, restlessness and agitation, and anxiety disorder. The admission MDS, dated [DATE], showed severely impaired cognition. The care plan stated, [Resident's name] can have aggressive mood fluctuations r/t [related to] Dementia, Anxiety . HX [history] of physical contact with another resident. Distance from others when appropriate for safety.- Review of Resident #4's medical record occurred on 04/29/26. Diagnosis included non-Alzheimer's dementia, anxiety disorder, and depression. The quarterly MDS, dated [DATE], identified intact cognition. - Review of Resident #2's medical record occurred on 04/29/26. Diagnoses included dementia, anxiety, behavior disturbance, and psychotic disorder. The annual Minimum Data Set (MDS), dated [DATE], identified severely impaired cognition.During an interview on 04/29/26 at 1: 20 p.m., when asked about the incident with Resident #1, Resident #4 stated, I didn't get hurt from it. [Resident #1's name] was a sweet gal, but she would just turn at times and get really angry and mean. During an interview with Resident #2 on 04/29/26 at 1:15 p.m., when asked if she felt safe at the facility she stated, I'm at my home right where am I. Resident could not recall the altercation on 02/02/26.The facility reported the incidents that occurred on 01/25/26 and 02/02/26 to facility administration and the state agency but failed investigate the altercations, implement appropriate interventions, and evaluate the effectiveness of the interventions. An investigation into the first incident between Resident #1 and #4 may have prevented the physical abuse inflected upon Resident #2 by Resident #1 during the second incident.