

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Nelson County Health System Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 7 sampled residents (Resident #1, #3 #5, #6, and #16) and one supplemental resident (Resident #20) observed during cares. Failure to practice infection control standards related to transmission based precautions (TBP), enhanced barrier precautions (EBP), and hand hygiene, has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled [NAME] County Health System Care Center Enhanced Barrier Precautions occurred on 06/10/26. This policy, dated April 2025, stated, . 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. An order for enhanced barrier precautions will be obtained for residents with . wounds and/or indwelling medical devices (. urinary catheter .) . High-contact resident care activities - . Transferring . assisting with toileting . device care or use: . urinary catheter . Review of the facility policy titled Isolation Precautions occurred on 06/10/26. This policy, dated April 2025, stated, . 'Contact precautions' are measures that are intended to prevent transmission of infectious agents . which are spread by direct or indirect contact with the patient or patient's environments . will use standard approaches, as defined by the CDC [Centers for Disease Control], for . contact . The category of transmission-based precautions will determine the type of personal protective equipment (PPE) to be used. Review of the facility policy titled Gloves occurred on 06/10/26. This policy, dated January 2015, stated, . change gloves between tasks on the same patients/residents. Remove promptly after use, before touching non-contaminated items and surfaces. Wash hands immediately after glove removal. Review of the facility policy titled Hand Hygiene occurred on 06/10/26. This undated policy stated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. 'Hand hygiene' is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. -Review of Resident #1's medical record occurred on all days of survey and identified the presence of (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
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a feeding tube and a diagnosis of Methicillin-resistant Staphylococcus aureus (MRSA) and physician's orders for contact precautions due to an active MRSA infection of the finger. Observation on 06/08/26 at 4:23 p.m. showed a Contact Precautions sign on Resident #1's door and identified gown and gloves required prior to entering the resident room. A certified nurse aide (CNA) (#7) applied a gown and gloves and entered the room. A second CNA (#8) applied an untied gown, entered the room, dropped a glove on the floor, picked it up and applied it. While providing bowel movement cares, the CNA's (#8) gown fell forward to her elbows. The CNA (#8) removed the soiled gloves, and without performing hand hygiene or glove application, tied her gown. The CNAs (#7 and #8) placed a sling under the resident and transferred him/her to a wheelchair with a mechanical lift. The CNAs failed to perform hand hygiene after completing personal cares and before touching clean items. The CNA (#8) failed to properly apply the gown and applied a soiled glove that had fallen on the floor. The CNAs (#7 and #8) failed to perform hand hygiene after glove removal and failed to wear gloves during all resident cares. -Observation 06/09/26 at 2:20 p.m. showed a nurse (#6) applied gloves and administered water into Resident #1's feeding tube. The nurse (#6) failed to apply a gown prior to administering the water bolus. -Observation on 06/10/26 at 10:32 a.m. showed a nurse (#9) provided feeding tube cares to Resident #1 at the bedside. The nurse failed to apply a gown and gloves before providing cares. The nurse (#9) then exited the room, applied a gown and gloves, re-entered the room, and continued to clean the feeding tube site. The nurse removed the soiled gloves and, without performing hand hygiene, applied new gloves, and placed a dressing on the feeding tube site. The nurse removed the gloves, and without performing hand hygiene, applied new gloves, applied ointment to the resident's right palm, and removed the gloves. Without performing hand hygiene or applying gloves, the nurse placed gauze and tape on the resident's right fingers. The nurse applied gloves, applied ointment and a bandage to the resident's coccyx, placed a gripper device in the resident's left hand and removed the soiled gloves. The nurse applied one new glove on her right hand, applied ointment to the resident's shoulder, removed the soiled glove and placed a gripper device in Resident #1's right hand. The nurse removed the gown and exited the room. The nurse (#7) failed to wear a gown and gloves while performing cares in a contact precaution room, failed to wear gloves during all cares, and failed to perform hand hygiene between glove changes and when exiting the room. -Observation on 06/09/26 at 9:28 a.m. showed Resident #3 seated in a wheelchair with a urinary drainage bag. The CNA (#3) performed hand hygiene, applied a gown and gloves, emptied the resident's urinary drainage bag, removed the soiled gloves, and without performing hand hygiene, applied new gloves and shaved Resident #3. The CNA assisted the resident from the wheelchair to the bed, removed the soiled gown and gloves, and without performing hand hygiene, offered the resident a drink of water, turned off the lights, performed hand hygiene and exited the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CNA (#3) failed to perform hand hygiene after removing soiled gloves and before performing other tasks. -Observation on 06/08/26 at 12:27 p.m. showed a CNA (#4) performed hand hygiene, applied gloves and transferred Resident #5 to the toilet. The CNA removed the soiled gloves, and without performing hand hygiene, applied new gloves, performed perineal care, pulled up the resident's brief and pants, and removed the gloves. The CNA transferred the resident back to the wheelchair, moved the resident out of the bathroom, then performed hand hygiene. The CNA (#4) failed to perform hand hygiene after removing soiled gloves, between glove changes and before performing other tasks. -Review of Resident #6's medical record occurred on all days of survey and identified the presence of a pressure ulcer to the sacrum and a physician's order for EBP. Observation on 06/09/26 at 9:13 a.m. showed an Enhanced Barrier Precaution sign on Resident #6's bathroom door and Resident #6 seated on the toilet. A CNA (#5) entered the room, applied clean gloves, and provided personal and perineal cares. The CNA (#5) failed to apply a gown prior to assisting Resident #6 with personal and perineal cares. -Observation 06/08/26 at 2:23 p.m. showed a CNA (#4) performed hand hygiene, applied gloves, provided incontinence cares for Resident #16, and assisted him to a wheelchair. The CNA (#4) removed the soiled gloves, and without performing hand hygiene, placed the gait belt on the back of the wheelchair, positioned Resident #16 at the sink, placed the wipes in the closet, handed the resident paper towels, moved the resident out of the bathroom and closed the bathroom door. The CNA (#4) then performed hand hygiene. The CNA (#4) failed to perform hand hygiene after removing soiled gloves and before performing other tasks. -Observation on 06/08/26 at 12:45 p.m. showed a CNA (#7) applied gloves, assisted Resident #20 to the toilet, removed the soiled brief, and removed the soiled gloves. Without performing hand hygiene, the CNA (#7) applied new gloves, assisted the resident to stand, performed perineal care, applied a new brief, and removed the soiled gloves. The CNA (#7) assisted the resident to lay down, then performed hand hygiene. The CNA (#7) failed to perform hand hygiene after removing soiled gloves, between glove changes and before performing other tasks. During an interview on 06/10/26 1:30 p.m., an administrative nurse (#2) stated she expected staff to perform hand hygiene after glove removal and before applying new gloves or touching other objects, and to wear gown and gloves when providing cares to residents in enhanced barrier or contact precautions.		

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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. Based on observation, record review, review of manufacturer's instructions, review of facility policy, and staff interview, the facility failed to provide necessary care and services for 1 of 1 supplemental resident (Resident #10) observed during administration of rapid-acting insulin. Failure to administer rapid-acting insulin according to the physician's order may result in a hypoglycemic (low blood sugar) reaction. Findings include: Review of the FIASP insulin manufacturer's instructions accessed at https://www.novomedlink.com/diabetes/patient-support/product-education/library/fiasp-instructions-for-use.htm occurred on 06/10/26. This instruction, revised June 2023, stated, .administration . subcutaneous injection . FIASP starts acting fast. inject at the start of a meal or within 20 minutes after starting a meal . Review of the facility policy titled Administration of Insulin occurred on 06/10/26. This policy, dated 04/30/25, stated, . All insulins will be administered in accordance with physician's orders. Insulin administration will be coordinated with mealtimes .Review of Resident #10's medical record occurred on 06/09/26. Diagnosis included type 2 diabetes mellitus. The physician's order for FIASP insulin (rapid-acting insulin) stated, Inject 6 units subcutaneously [directly under the layer of skin] with meals .Observation on 06/09/26 at 5:00 p.m. showed a nurse (#6) administer 6 units of FIASP insulin to Resident #10. The nurse left the room and failed to offer food. At 5:22 p.m. (22 minutes after receiving insulin), the resident received a glass of milk and a dish of ice cream. Resident #10 received the evening meal at 5:55 p.m. The nurse failed to follow the manufacturer's instruction and physician's order to administer the FIASP with the meal which may result in hypoglycemia. During an interview on 06/10/26 at 2:55 p.m., an administrative nurse (#1) stated she expected food to be consumed within 20 minutes of a FIASP insulin injection.		