STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minot Health and Rehab, LLC	600 S Main St Minot, ND 58701

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 - 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. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from abuse/neglect for 1 of 1 sampled resident (Resident #4) who utilized a commode for toilet needs. Failure to place the call light within reach and check on the resident while on the commode resulted in discoloration to the resident's buttocks, a bruise to the wrist, and has the potential to cause anxiety, fear, and psychosocial harm. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following discovery of the incident.Findings include:The surveyor determined a deficient practice existed on 09/07/25. The facility implemented corrective action immediately, completed corrective action on 09/07/25, and continued with staff education and monitoring.Review of the facility policy titled Abuse, Neglect, and Exploitation occurred on 11/24/25. This policy, revised 07/15/22, stated, . Definitions . 'Neglect' means failure of the facility, its employees . to provide . services to a resident that are necessary to avoid . mental anguish, or emotional distress . C. Training will include: . 2. Identifying what constitutes . neglect . 3. Recognizing signs of . neglect . of a resident . such as . psychosocial indicators . III. Prevention of . Neglect . assure that staff assigned have knowledge of . residents' care needs . Review of Resident #4's medical record occurred on 11/24/25. Diagnoses included anxiety disorder and aphasia (inability to verbalize needs) following a stroke. The care plan stated, . Impaired communication severe expressive aphasia . Ensure resident has call light secured to bedside commode and within reach when toileting . An annual Minimum Data Set (MDS), dated [DATE], identified intact cognition and dependent on staff for toileting.A progress note dated 09/07/25, stated, Writer was informed that resident was found on bedside commode for an extended period of time last night. Writer performed skin assessment: blanchable redness noted to bilateral buttocks, blanchable light purple area noted to right buttock, bruise to left wrist. Resident denied any pain, no s/s [signs or symptoms] of pain noted. Resident's mood is at baseline, showing okay sign, requested to stay in bed as she was fatigued. During an interview on the afternoon of 11/24/25, an administrative nurse (#2) stated on the evening of 09/06/25, the certified nurse aides (CNAs) (#3 and #4) transferred Resident #4 to the bedside commode, failed to place the call light within reach, and failed to check on the resident for a period of approximately six hours. The administrative nurse (#2) indicated the resident sustained a bruise to the wrist from banging on the wall for assistance.The facility failed to ensure staff followed the care plan for toileting and failed to check on Resident #4 while on the bedside commode. Based on the following information, non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions for all residents who may be affected by the deficient practice as follows:* Completed an investigation into the incident involving Resident #4.* Suspended both CNAs from work until completion of the investigation and provided written warnings to both CNAs.* Re-educated all staff via text message regarding following residents' care plans for toileting, rounding, and call light placement on 09/07/25.* Updated agency staff orientation to include rounding and call light placement.

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Minot Health and Rehab, LLC	600 S Main St Minot, ND 58701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and staff interview, the facility failed to report an incident of abuse/neglect to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #4) left on the commode for toilet needs. Failure to report incidents of neglect may result in Resident #4 and other residents experiencing abuse and/or neglect and psychosocial harm.Findings include:Review of the facility policy titled Abuse, Neglect, and Exploitation occurred on 11/24/25. This policy, revised 07/15/22, stated, . Definitions . Neglect means failure of the facility, its employees . to provide . services to a resident that are necessary to avoid . mental anguish, or emotional distress . Policy and Compliance Guidelines . Reporting of all alleged violations to the . state agency . a. Immediately, but no later than 2 hours after the allegation is made, if the events that . result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not . result in serious bodily injury . Review of Resident #4's medical record occurred on 11/24/25. Diagnoses included anxiety disorder and aphasia (inability to verbalize needs) following a stroke. The care plan stated, . At risk for traumatization of . Impaired communication severe expressive aphasia . Ensure resident has call light secured to bedside commode and within reach when toileting . The Minimum Data Set (MDS), dated [DATE], identified intact cognition and dependent on staff for toileting.A progress note dated 09/07/25, stated, Writer was informed that resident was found on bedside commode for an extended period of time last night. Writer performed skin assessment: blanchable redness noted to bilateral buttocks, blanchable light purple area noted to right buttock, bruise to left wrist. Resident denied any pain, no s/s [signs or symptoms] of pain noted. Resident's mood is at baseline, showing okay sign, requested to stay in bed as she was fatigued. An administrative nurse (#2) indicated the resident's sustained the left wrist bruise from banging on the wall for assistance.During an interview on the afternoon of 11/24/25, an administrative nurse (#2) confirmed the facility failed to report this incident to the SSA.