

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Minot Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on observation, review of facility policy, and resident and staff interview, the facility failed to promote care in a manner that maintained or enhanced residents' dignity for 2 of 4 sampled residents (Resident #11 and #14) who required assistance with personal hygiene/care. Failure to assist with personal hygiene and appropriately clothe residents does not promote the resident's mental well-being or dignity. Findings include: Review of the facility policy titled Promoting/Maintaining Resident Dignity occurred on 04/30/26 at 10:25 a.m. This undated policy stated, . Groom and dress residents according to resident preference. Review of the facility policy titled Grooming a Resident's Facial Hair occurred on all days of survey. This undated policy stated, . assist resident with grooming facial hair to help maintain proper hygiene. Observation on 04/29/26 at 11:20 a.m., showed noticeable facial hair of Resident #11. During an interview on 04/29/26 at 11:20 a.m., Resident #11 identified a preference to have facial hair shaved and Preferred an electric razor but the facility only had a straight razor. During an interview on 04/29/26 at 3:02 p.m., an administrative staff member (#1) stated all residents are shaved per resident preference and shaving materials are provided. During an observation on 04/29/26 at 1:13 p.m., a nurse (#6) and a certified nurse assistant (CNA) (#7) transferred Resident #14 from the wheelchair to the bed, completed perineal cares, applied a clean brief, and without pulling up the resident's pants, covered the resident with a blanket. During an interview on 04/30/26 at 10:15 a.m., an administrative staff member (#1) stated she expected staff to pull up or take off residents' pants in bed per resident preference.</p>		

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 1 sampled resident (Resident #2) observed during a pivot transfer. Failure to utilize gait-belts placed residents at risk for falls and/or injury. Findings include:Review of the facility policy titled Safe Resident Handling/Transfers occurred on 04/30/26. This undated policy stated, .It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risk for injury . Resident lifting and transferring will be performed according to the resident's individual plan of care.Review of Resident #2's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, muscle weakness, unsteadiness on feet, and abnormalities of gait and mobility. The current care plan stated, . Transfer: Stand pivot, 2 [staff] assist with gait belt .During an observation on 04/29/26 at 10:37 a.m., two certified nurse aides (CNAs) (#4 and #5) wheeled Resident #2 in front of the toilet. The resident utilized the grab bars to transfer from the wheelchair to the toilet with visible shakiness and an unsteady gait. The CNA (#4) assisted the resident to the toilet. After completion, the CNA (#4) cued the resident to stand and applied a clean brief and pants. The CNA (#4) placed her hands around Resident #2's ribcage and assisted to the wheelchair. The CNA (#4) failed to use a gait belt during the transfers. During an interview on 04/30/26 at 11:43 a.m., a CNA (#4) confirmed they failed to use a gait belt during toileting cares. During an interview on 04/30/26 at 10:15 a.m., three administrative staff members (#1, #2, and #3) stated they expect the facility staff to utilize a gait belt during transfers as care planned.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 4 sampled residents (Resident #1 and #11) observed during cares and storage of resident supplies. Failure to follow infection control practices while handling soiled linen, while providing cares for resident in enhanced barrier precautions (EBP), and disinfecting shared equipment has the potential to spread infection throughout the facility. Findings include:</p> <p>Review of the facility policy titled Infection Prevention and Control Program occurred on 04/30/26. This undated policy stated, . all reusable . equipment requiring . disinfection . shall be cleaned in accordance with our current procedures .</p> <p>Review of the facility policy titled Safe Resident Handling/Transfers occurred on 04/30/26. This undated policy, stated, .The lifts will be cleaned and disinfected according to manufacturer's instructions and after each resident use.</p> <p>Review of the facility policy titled Enhanced barrier precautions (EBP) occurred on 04/30/26. This undated policy, stated, .EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.</p> <p>-Observation on 04/29/26 at 1:02 p.m., a certified nurse aide (CNA) (#5) removed a full body mechanical lift from Resident #1's room and failed to disinfect it. When asked how often facility staff clean the full body mechanical lifts, The CNA (#5) stated lifts and wheelchairs are cleaned by the night shift.</p> <p>-Observation on 04/29/26 at 11:13 a.m. identified Resident #11 on EBP. Two CNAs (#4 and #5) entered Resident #11's room and applied gloves. The CNA (#5) placed the soiled linen from the floor into a bag. A nurse (#8) entered the resident's room and instructed the CNAs to apply personal protective equipment (PPE). The CNA (#5) applied a gown, removed Resident #11's soiled linen from the bed and placed it on the floor again. The nurse (#8) stated the soiled linens should be placed in a bag and not on the floor.</p> <p>During an interview on 04/30/26 at 10:15 a.m., an administrative staff member (#1) stated staff are expected to disinfect the full body mechanical lift after every use, avoid placing soiled linen on the floor, and wear gowns when entering rooms requiring EBP precautions.</p>		