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	06/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, review of facility policy, review of facility housekeeping checklist, and resident and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment for 6 of 14 sampled residents (Resident #3, #7, #16, #23, #25, #133) and 2 supplemental residents (Resident #4 and #9) and 1 of 1 storage rooms. Failure to maintain equipment and maintain a safe, clean, sanitary environment may result in injuries does not provide a homelike living area for residents or promote quality of life. Findings include: Review of the facility policy, Resident/Patient Room Cleaning, occurred on 06/10/25. This policy, dated 02/02/25, stated, SCOPE: . committed to providing a safe, clean, and hygienic environment for residents, staff, and visitors . Room Cleaning: . Rooms will be regularly cleaned and disinfected . Walls . Between scheduled cleanings, walls will be spot-cleaned when they are visibly soiled. Privacy curtains should be changed whenever they are visible dirty or damaged, . and /or on a regular schedule as determined by Environmental Services management and Infection Preventionists. Review of the facility HKP [housekeeping] Daily Sheet occurred on 06/10/25. This undated checklist stated, . Steps - DEEP CLEAN . Clean ceilings, vents, . Observation on June 8-9, 2025, showed the following in resident rooms: * Resident #3: a non-functioning light in the bathroom. The resident stated the light had not been working for about two weeks and that he told a couple of staff members about it. * Resident #4: masking tape with dried paint covering the edges of the kick plate on the bottom half of the door to the resident's room. * Resident #7: visible dust/debris on the ceiling vent in the bathroom. * Resident #9: a window screen with a large hole and a broken thermostat on the wall outside of the bathroom. * Resident #16: visible dust/debris on the ceiling vent and a missing cover on the ceiling light in the bathroom. (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
	355031	A. Building B. Wing	06/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Resident #23: soiled wallpaper, visible debris to the vent/fan, and brown spots around the vent/fan in the resident's bathroom. The privacy curtain next to the resident's bed had dark spots approximately halfway down. The resident stated, This is someone's blood. The north wall, adjacent to the door, showed a black substance the length of the wall. A window screen showed three holes the resident taped cotton over To block the bugs from coming in. * Resident #25: blue painter's tape with dried paint covering the bottom half of the outside of the door to the resident's room. * Resident #133: torn wallpaper next to the sink in the resident's room. * Storage Room: blue painter's tape with dried paint covering the edges of the kick plate on the bottom half of the door to the storage room in the north wing hallway. During an interview on 06/09/25 at 2:45 p.m., the housekeeping supervisor (#3) confirmed staff clean privacy curtains weekly and when visibly soiled and confirmed Resident #23's privacy curtain was soiled. The supervisor also confirmed staff deep clean all resident rooms monthly. During an interview on 06/10/25 at 3:38 p.m., two administrative staff members (#4 and #5) confirmed the facility failed to remove the painter's tape in a timely manner. An administrative staff member (#4) stated staff had not informed him/her of the missing cover on the bathroom light in Resident #16's room or the non-functioning light in Resident #3's bathroom. The administrative staff members stated they expected staff to report maintenance concerns/needs by completing a maintenance request form or entering the request into the TELS system (The Equipment Lifecycle System - a computer program to track maintenance).

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	06/10/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 provide the resident or their representative and the State Long Term Care Ombudsman a written notice of transfer and bed-hold notice for 4 of 4 sampled residents (Resident #3, #7, #11, and #26) and 1 closed record (Resident #32) reviewed for hospital transfers. Failure to provide a written notice of transfer, a written copy of the bed-hold notice that includes the reserve bed amount, or notify the State Ombudsman of the transfer does not allow the residents and/or their representative to make informed decisions regarding their rights or inform the State Ombudsman of the transfer. Findings include: Review of the facility policy titled Transfer and Discharge (including AMA) [against medical advice] occurred on 06/10/25. This policy, dated 2022, stated, . Emergency Transfers/Discharges-initiated by the facility for medical reasons . Complete and send with the resident (or provide as soon as practicable) a Transfer Form . Social Services Director, or designee, shall provide notice of transfer to a representative of State Long-Term Care Ombudsman via monthly list. Review of the facility policy titled Bed Hold Notice occurred on 06/11/25. This policy, dated 04/23/25, stated, . the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices . at the time of, a transfer for hospitalization . the facility will provide the resident and/or the resident representative written information that specifies: . b. The reserve bed payment policy . - Review of Resident #3's medical record occurred on all days of survey and identified a hospitalization from 02/21/25 to 02/24/25. The facility failed to provide a bed hold to the resident/representative, and failed to provide the State Ombudsman a copy of the transfer notice. -Review of Resident #7's medical record occurred on all days of survey and identified a hospitalization from 03/07/25 to 03/09/25. The facility failed to provide the State Ombudsman a copy of the transfer notice. - Review of Resident #11's medical record occurred on all days of survey and identified the following: * hospitalized [DATE] to 10/20/24. The medical record lacked a written notice of bed hold or transfer notice form and lacked documentation the facility notified the State Ombudsman of the transfer. * hospitalized [DATE] to 04/08/25. The written bed hold notice lacked a reserve bed payment amount and the transfer notice form lacked evidence the facility notified the State Ombudsman of the transfer. - Review of Resident #26's medical record occurred on all days of survey and identified hospitalizations on 03/10/25 to 03/12/25 and 03/23/25 to 03/27/25. The written bed hold notices lacked a reserved bed payment amount and the transfer notices lacked evidence the facility notified the State Ombudsman of the transfers. (continued on next page)

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	06/10/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #32's closed medical record occurred on 06/10/25 and identified a hospitalization from 03/31/25 to 04/03/25. The facility failed to provide the resident and/or resident representative with a notice of transfer or bed hold. During interviews ont the afternoon of 06/09/25, an administrative nurse (#1) confirmed the above records lacked the required documentation for transfer notices, bed holds, and notification to the State Ombudsmen regarding transfers.

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	06/10/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 4 of 14 sampled residents (Resident #5, #7, #20, and #23) and one closed record (Resident #30). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the resident. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2024, pages A-30 through A-32, stated, A1500: Preadmission Screening and Resident Review (PASRR) . Complete if SCSA [significant change in status assessment] . Review the PASRR report provided by the State if Level II screening was required . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . Page A-42, stated, Discharge Status. Review the medical record including the discharge plan and discharge orders for documentation of discharge location. Code 01, Home/Community: if the resident was discharged to a private home . - Review of Resident #23's medical record occurred on all days of survey. A PASRR, dated 05/06/24 stated, . You meet PASRR inclusion criteria for Serious Mental Illness . A significant change in status assessment MDS, dated [DATE] failed to identify a serious mental illness. - Review of Resident #30's medical record occurred on 06/10/25. A progress note dated 4/10/2025 at 8:00 a.m., stated, Late Entry: Resident indicates she would like to DC [discharge] home today. Husband [name] indicates he is okay taking resident home. A Transfer Notice completed 04/10/25 and a physician's order written 04/10/25 identified discharge to home. The Admission/Discharge Return Not Anticipated MDS, dated [DATE], identified Resident #30 discharged to a nursing home. SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2024, page I-1, stated, . code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments . Review of Resident #7's medical record occurred on all days of survey. A physician's order dated 01/04/25 identified, Duloxetine, an antidepressant, for depression. The quarterly MDS, dated [DATE], failed to include an active diagnosis of depression. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page J-27, stated, . J1400: Prognosis . Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. (continued on next page)

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	06/10/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's medical occurred on all days of survey. A physician's order dated 03/10/25, admission to hospice care. A progress noted dated 03/10/25, stated, [name of nurse] with [name of hospice] here to admit resident to hospice. The significant change MDS dated [DATE] failed to identify the resident's prognosis in section J1400. SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages M-37 and M-38, stated, . Skin and Ulcer/Injury Treatments . Review the medical record, including treatment records . for documented skin treatments during the past 7 days . Coding instructions Check all that apply in the last 7 days . M1200I, Application of dressings to feet (with or without topical medications) . Review of Resident #5's medical record occurred on all days of survey. A physician's order, dated 11/22/24, stated, Cleanse bilateral lower extremities with hibiclens [antibacterial] soap, apply calcium alginate dressing [highly absorbent wound dressings] to open areas, apply 4x4 gauze, wrap with roll gauze, and secure with tape. Review of the February 2025 treatment administration record identified facility staff changed the dressings to Resident #5's bilateral lower extremities on three of seven days during the look back period. The quarterly MDS, dated [DATE], failed to include application of a dressing. SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS The Long-Term Care Facility RAI User's Manual, revised October 2024, page O-3, stated, . Coding Instructions for Column b. While a Resident. Check all treatments, procedures, and programs that the resident received . within the last 14 days. Page O-7 stated, Hospice Care. Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of Resident #20's medical record occurred on all days of survey and identified a physician's order dated 03/10/25 for admission to hospice care. A progress noted dated 03/10/25, stated, [name of nurse] with [name of hospice] here to admit resident to hospice. The significant change MDS dated [DATE] failed to identify hospice care. During an interview the afternoon of 06/10/25, an administrative nurse (#1) confirmed the facility failed to accurately code Resident #5, Resident #7, Resident #20, Resident #23, and Resident #20's MDSs.

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	06/10/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review, review of professional reference, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 5 sampled residents (Resident #21) reviewed for unnecessary medications. Failure to transcribe physician's orders and obtain laboratory tests as ordered may result in adverse health effects. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, Nurses are expected to analyze procedures . ordered by the physician or primary care provider. If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. Review of Resident #21's medical record occurred on all days of survey and identified a physician's order, dated 03/26/25, for six blood tests. The medical record lacked documentation of the completion of the laboratory tests. During an interview on 06/09/25 at 11:20 a.m., two administrative staff members (#1 and #2) identified facility staff failed to transcribe the written order for the blood tests into the electronic medical record and failed to ensure collection of the blood specimens.

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	06/10/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, family interview, and staff interview, the facility failed to provide the necessary services to 1 of 7 sampled residents (Resident #17) dependent on staff for bathing. Failure to provide bathing as scheduled may result in poor personal hygiene and decreased self-esteem. Findings include: During an interview, on 06/09/25, at 12:28 p.m., a family member (A) stated Resident #17's fingernails have not been clean and questioned if the resident is getting his/her weekly baths. The family member stated, according to staff, the resident will refuse bathing at times. Observations of Resident #17's fingernails on 06/09/25 and 06/10/25 showed two nails on each of Resident #17's hands with dark areas under the nails. Review of Resident #17's medical record occurred on all days of survey. The care plan stated, ADL [activities of daily living] self-care deficit as evidenced by weakness . Bathing/Showering: Assist of 1, Transfer: Assist of 2 . Review of Resident #17's ADL Tasks/Intervention documentation showed bath/showers scheduled once a week on Mondays. - Review of Resident #17's March, April, and May 2025 bathing record records showed the following: * March: received two and refused two of five scheduled baths/showers. The medical record lacked documentation of refusal or completion of one scheduled bath/shower. * April: refused four of four scheduled baths/showers. The medical record lacked documentation of any completed baths/showers. * May: received one and refused one of four scheduled baths/showers. The medical record lacked documentation of refusal or completion of two scheduled baths/showers. During an interview on 06/10/25 at 5:45p.m., an administrative nurse (#1) confirmed Resident #17's bathing record lacked documentation staff provided bathing assistance as scheduled.

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	06/10/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the hospice contract, review of facility policy, and staff interview, the facility failed to ensure residents' records contained the hospice election form for 2 of 2 sampled residents (Resident #5 and #20) receiving hospice services. Failure to obtain the hospice election form limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: The hospice contract for (hospice agency name), signed August 6, 2018, stated, . Coordination of Services: . providing Facility with a copy of each Hospice Patient's hospice election form. Review of the facility policy titled, Hospice Services Facility Agreement, occurred on 06/10/25. This policy dated 07/15/22, stated, The designated member of the facility working with hospice representative is responsible for: . Obtaining the following information from the hospice: . Hospice election form. - Review of Resident #5's medical record occurred on all days of survey. A nurse's note, dated 08/19/24 at 4:00 p.m., stated, . Resident elected to enroll with [name] Hospice for end of life cares . The medical record lacked a hospice election of benefits form. - Review of Resident #20's medical record occurred on all days of survey. A physician's order dated 03/10/25 identified an order to admit to hospice. A nurse's note, dated 03/10/25 at 10:57 a.m., stated . [name of nurse] with [name of facility] Hospice here to admit resident to hospice. Resident #20's medical record failed to contain the hospice election form. During an interview on the afternoon of 06/10/25 at 5:12 p.m., an administrative nurse (#1) confirmed Resident #5 and #20's medical records lacked a hospice election form.