

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/02/2025
FORM APPROVED
OMB NO. 0938-0391

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 C 12/31/2024	
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 S MAIN ST MINOT, ND 58701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 600 SS=K	An unannounced onsite investigation survey regarding a facility reported incident was completed December 30-31, 2024. During the investigation the facility was found noncompliant with regulatory requirements. Based on the results of the investigation an extended survey was also completed. Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility documents, Medicaid Fraud Control Unit (MFCU) investigation and interview, review of facility policy, and staff interview, the facility failed to ensure residents remained free from sexual and mental abuse for 5 of 30 residents (Resident #1, #2, #3, #4, and #5) and 1 of 1 closed record (Resident #7) identified on a staff members electronic device through the review of images/videos. Failure to protect residents from			F 600	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/23/2025

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.

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F 600	Continued From page 1 sexual abuse may result in mental and emotional distress, and physical injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. During the on-site investigation of the facility reported incident, the survey team consulted with the State Survey Agency (SSA) on 12/30/24 at 5:17 p.m. and determined an Immediate Jeopardy (IJ) situation existed. Investigation determined IJ began on 06/06/24 when the first image/video of a facility resident was sent by a staff member. On 12/13/24 law enforcement notified an administrative staff member (#1) of the arrest of a staff member (#2) who had inappropriate images/videos of possible residents on an electronic device. The survey team notified the administrator of the IJ on 12/30/24 at 6:08 p.m. The survey team confirmed by interview and record review that the IJ was removed on 12/13/24, and the deficient practice corrected on 12/19/24, prior to the start of the survey and was therefore past non-compliance. Findings include: Review of the facility policy titled "Abuse, Neglect and Exploitation" occurred on 12/31/24. This policy, revised July 2022, stated, ". . . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . . . 'Staff' includes employees . . . 'Willful' means the individual must have acted deliberately . . . 'Sexual Abuse' is non-consensual sexual contact of any type with a resident . . . 'Mental Abuse' . . .			F 600			

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F 600	Continued From page 2 includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). . . . The components of the facility abuse prohibition plan . . . 1. Screening . . . Potential employees will be screened for a history of abuse . . . I. Background, reference, and credentials' checks shall be conducted on potential employees . . . II. Employee Training . . . A. New employees will be educated on abuse . . . B. Existing staff will receive annual education through planned in-services and as needed. C. Training topics will include: 1. Prohibiting and preventing all forms of abuse . . . 2. Identifying what constitutes abuse . . . III. Prevention of Abuse . . . The facility will implement policies and procedures to prevent and prohibit all types of abuse . . . A. Establishing a safe environment . . . by establishing policies and protocols for preventing sexual abuse . . . B. Identifying, correcting and intervening in situations in which abuse . . . is more likely to occur . . . IV. Identification of Abuse . . . A. The facility will have written procedures to assist staff identifying the different types of abuse . . . B. Possible indicators of abuse include . . . 9. Evidence of photographs or videos of a resident tat are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status. . . ." Review of the facility policy titled "Employee Social Media Use" occurred on 12/31/24. This policy, revised June 2022, stated, ". . . It is the policy of this company to avoid inappropriate use of social media and to protect the residents . . . 1. Employees are strictly prohibited from	F 600			

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F 600	Continued From page 3 transmitting by way of any electronic media any resident-related image or information that may be reasonably anticipated to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident. 2. Photographs or recordings of a resident . . . without . . . written consent, is prohibited. Examples include taking unauthorized photographs/videos of: . . . d. taking unauthorized photographs or recordings of residents in any state of dress or undress . . ." Emailed documentation received from MFCU on 12/20/24 identified the actions of a staff member which involved images and videos of residents of the facility. During an interview on 12/27/24 at 5:00 p.m., a MFCU investigator (#1) confirmed the identity of 6 residents of the facility. - Review of Residents #1's medical record occurred on 12/30/24. A quarterly Minimum Data Set (MDS), dated 10/20/24, identified intact cognition. - Review of Residents #2's medical record occurred on 12/30/24. A quarterly MDS, dated 10/03/24, identified intact cognition. - Review of Residents #3's medical record occurred on 12/30/24. A quarterly MDS, dated 10/08/24, identified moderately impaired cognition. - Review of Residents #4's medical record occurred on 12/30/24. A quarterly MDS, dated 11/09/24, identified moderately impaired			F 600			

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F 600	Continued From page 4 cognition. - Review of Residents #5's medical record occurred on 12/30/24. A quarterly MDS, dated 07/09/24, identified severely impaired cognition. - Review of Resident #7's closed record occurred on 12/30/24. A discharge return not anticipated MDS, dated 09/09/24, identified severely impaired cognition. During an interview on 12/30/24 at 12:30 p.m., an administrative staff member (#1) confirmed law enforcement contacted the facility to report staff member (#2's) arrest, and confirmed the steps the facility completed in response. The facility completed the following steps to remove the immediacy and correct the deficient practice: * Terminated staff member (#2) on 12/13/24. * Educated all staff on-duty and all on-coming staff on facility's policy/procedure for abuse, neglect and exploitation, and social media use on 12/13/24. * Completed assessments of all residents on 12/13/24. * Notified the medical director. * Reviewed facility policies and resources and updated as necessary by 12/19/24. * Interviewed all staff to identify any allegation of misconduct to include taking of inappropriate photos/videos of residents, beginning 12/14/24 and concluding 12/19/24. * Maintained contact with law enforcement agencies to identify possible affected residents and appropriate next steps. * Implemented behavior monitoring for all			F 600			

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F 600	Continued From page 5 residents identified.	F 600			