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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 The standard Medicare/Medicaid recertification survey started on 05/23/22 and concluded on 05/26/22.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		6/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/24/2022

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 582	Continued From page 1 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, review of Medicare Part A letters/notices, and staff interview, the facility failed to ensure the resident and/or their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) for 1 of 3 supplemental residents (Resident #87) discharged from Medicare Part A in the past six months. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights in regard to Medicare Part A services. Findings include: Review of Medicare Part A beneficiary notices identified Resident #87 discharged from Medicare Part A on 01/17/22. The SNFABN failed	F 582	1.) The facilities procedure titled, To NOMNC or Not to NOMNC: That is the Question. was reviewed by the Quality Assurance Committee on 6/7/2022. Resident #87 has discharged 1/17/22. 2.) Facility residents who discharge from Medicare have the potential to be affected by the alleged practice. 3.) The facility Social Worker, MDS Nurse, Director of Nursing, Assistant Director of Nursing, Business Office Manager, and Administrator were educated by the Administrator on 6/8/22 for the procedure titled, To NOMNC or Not to NOMNC: That is the Question. Social Worker or designee will review and document SNFABN options with the	

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 582	Continued From page 2 to identify if the resident/representative chose to continue or discontinue services or request a demand bill. Review of Resident #87's medical record occurred on 05/25/22. The record lacked documentation the resident/representative was made aware of options related to billing when Medicare Part A coverage ended. During an interview on 05/25/22 at 4:38 p.m., an administrative staff member (#2) and a social services staff member (#3) confirmed staff failed to ensure the resident/representative chose an option on the SNFABN and failed to document any resident/representative discussions.	F 582	resident and/or representative at the end of Medicare Part A coverage. 4.) Audits will be conducted by the Social Worker or designee on ensuring notice of Medicare non coverage is accurately provided to residents. Audits begin 6/27/22 and will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		6/30/22

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 623	Continued From page 3 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 623	Continued From page 4 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident or their	F 623	1.) Resident #20 had transferred on 4/10/22 and returned to facility on 4/22/22	

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 623	Continued From page 5 representative and the State Long Term Care Ombudsman written notice of transfer for 1 of 10 sampled residents (Resident #20) with a recent hospital transfer. Failure to provide a notice of transfer does not allow the resident and/or their representative to make informed decisions regarding their rights or inform the Ombudsman of the transfer. Findings include: Review of Resident #20's medical record occurred on all days of survey. The record identified a hospitalization on April 10-22, 2022. A progress note, dated 04/10/22, stated, ". . . Attempted to call POA [Power of Attorney] [name] at [phone number] stated mail box is full. Also, attempted to call resident's brother [name] at [phone number] stated mail box was full and unable to leave message." The medical record lacked documentation the facility provided the resident's representative a written copy of the transfer form. During an interview on 05/25/22 at 3:40 p.m., an administrative nurse (#1) confirmed staff failed to document the representative was contacted and received a written copy of the transfer notice.	F 623	to same room and bed as prior to transfer. 2.) Facility residents who discharge have the potential to be affected by the alleged practice. 3.) ADHOC QAPI conducted on 6/20/22 reviewed the policy titled, Discharge-Transfer of Resident. Facility nursing staff were educated by the Director of Nursing by 06/30/22 on the procedure titled, Discharge-Transfer of Resident. Facility residents and/or resident representatives will receive written notice following transfer from the facility. 4.) Audits will be conducted by Medical Records or designee on ensuring notice of discharge-transfer is accurately provided to residents including Resident #20. Audits begin 6/27/22 and will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625		6/30/22

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 625	Continued From page 6 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident or their representative a written copy of the bed hold notice for 1 of 10 sampled residents (Resident #20) with a recent hospital transfer. Failure to provide a written bed hold notice does not allow the resident and/or their representative to make an informed decision regarding their rights. Findings include: Review of Resident #20's medical record occurred on all days of survey. The record identified a hospitalization on April 10-22, 2022. A progress note, dated 04/10/22, stated, ". . .	F 625	1.) Resident #20 bed was held on 4/11/22 and returned to facility on 4/22/22 to same room and bed as prior to transfer. 2.) Facility residents who have hospitalizations have the potential to be affected by the alleged practice. 3.) Nursing staff were educated by the Director of Nursing at an in-service by 06/30/22 on the procedure titled, Bed-Hold Policy. In non-emergent transfers, written bed hold notification will be performed by nursing staff at the time of transfer. When bed hold unable to be obtained at time of transfer, facility will	

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 625	Continued From page 7 Attempted to call POA [Power of Attorney] [name] at [phone number] stated mail box is full. Also, attempted to call resident's brother [name] at [phone number] stated mail box was full and unable to leave message." The medical record lacked documentation the resident's representative was contacted and received a written copy of the bed hold notice. During an interview on 05/25/22 at 3:40 p.m., an administrative nurse (#1) confirmed staff failed to document the representative was contacted and received a written copy of the bed hold notice.	F 625	provide written bed hold notifications within 24 hours of transfer to resident and/or resident representative. 4.) Audits will be conducted by Medical Records or designee to ensure notice of bed hold coverage is accurately provided to residents or decision makers. Audits begin 6/27/22, include Resident #20, and will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of practice for 3 of 15 sampled residents (Resident #8, #13, #18) who received medications per physician's orders. Failure to follow physician's orders for medication administration and documentation may result in ineffective management of a resident's condition. Findings include: Review of the facility policy titled "Pharmacy Services: Medication administration General	F 658	F658 #1 1.) Resident #8 had Lasix order reviewed by the physician on 5/24/22 and 5/27/22 and has exhibited no additional side effects. Resident #13 received baclofen on 5/23/22 and has received it per physician orders since, and MD was notified of delayed administration. 2.) Facility residents who receive medications with end dates reviewed from 5/23/22 have the potential to be affected by the alleged practice. 3.) Education was provided by the	6/30/22

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 658	Continued From page 8 guidelines" occurred on 05/25/22. This policy, revised September 2021, stated, ". . . Medications are administered in accordance with written orders of the attending physician . . . if questions regarding the resident's medications, the nurse calls the provider or pharmacy for clarification . . . if a dose of regularly scheduled medication is withheld, missed, or given at other than the scheduled time . . . it is to be noted on the MAR [medication administration record] and an explanatory note is entered in the area of the record . . . if no extra available dose . . . notify physician . . . when a controlled medication is administered, the licensed administering nurse enters the date and time of administration, amount administered, signature of the nurse administering the dose . . ." - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included cardiomyopathy (chronic heart failure), hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD). * Physician's orders included Furosemide (a diuretic) 40 milligrams (mg) two times a day (BID). The electronic Medication Administration Record (eMAR) showed the following: * No Furosemide administered on 05/23/22 * One dose of Furosemide 40 mg on 05/24/22 at 5:53 p.m. The Furosemide order expired on 05/22/22 and staff failed to contact the provider to renew the order until, 05/24/22 at 11:08 a.m. The facility failed to request a new order from the provider before the medication expired. -Review of Resident #13's medical record	F 658	Administrator on 06/16/22 to the consulting pharmacist, prescribing pharmacy, and physician regarding the policy titled Controlled Medication Storage and Medication Administration-General Guidelines and Prescriber Medication Orders. Education was provided by the Director of Nursing to nursing staff by 06/30/22 regarding the policy titled Controlled Medication Storage and Medication Administration-General Guidelines and Prescriber Medication Orders. 4.) Audits will be conducted by the Director of Nursing or designee to ensure medications are administered timely. Medication orders with end dates, if indicated, will be reviewed by DON or designee during clinical meetings to verify pending MD notification has occurred. Administration times of medications will be audited by the DON or designee to ensure timely administration of scheduled medications. Audits begin 6/27/22, include Resident #8 and #13 and residents requiring prescriber follow-up, and will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. F658 #2 1.) Resident #18 had no negative outcomes regarding late narcotic log documentation of a Lyrica, and narcotic	

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	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 658	Continued From page 9 occurred on all days of survey. Diagnoses included chronic pain, hemiparesis and hemiplegia (paralysis of side of body). Physician's orders included Baclofen (used for muscle paralysis/spasticity) 10 mg three times a day. The eMAR listed the administration times at 8:00 a.m., 1:00 p.m. and 8:00 p.m. The administrative history report, dated 5/24/22 at 11:36 a.m., showed staff failed to administer Resident #13's scheduled 1:00 p.m. dose of Baclofen on 5/23/22 until 4:27 p.m., 3 hours and 27 minutes past the scheduled time. - Observation on 05/24/22 at 11:15 a.m. of the narcotic medication count for medication cart #1, showed Resident #18's Lyrica (a controlled medication) lacked documentation the narcotic was administered to the resident. The electronic eMAR for Resident #18 showed the medication, Lyrica 100 mg was given at 7:28 a.m. on 05/24/22 by staff nurse (#4). Staff failed to document the administration of the medication in the narcotic log until 3 hours and 47 minutes later. During an interview on 05/25/22 at 8:25 a.m., the nurse (#1) confirmed staff failed to give medications in a timely manner and document a controlled medication per facility policy.	F 658	book was updated 5/24/22 and reviewed for accuracy. 2.) Facility residents who receive controlled medications have the potential to be affected by the alleged practice. 3.) Education was provided by the Administrator on 06/16/22 to the consulting pharmacist, prescribing pharmacy, and physician regarding the policy titled Controlled Medication Storage and Medication Administration-General Guidelines and Prescriber Medication Orders. Education was provided by the Director of Nursing to nursing staff by 06/30/22 regarding the policy titled Controlled Medication Storage and Medication Administration-General Guidelines and Prescriber Medication Orders. 4.) Audits will be conducted by the Director of Nursing or designee to ensure controlled medications are administered timely. Concurrent and retrospective audits will be conducted by DON or designee to verify documentation records are updated at the time medication is removed from the narcotic box. Audits begin 6/27/22, include Resident #18 and a sample of three residents, and will be completed 5 times weekly for 12 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, and then 2 times weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	