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	355031	A. BUILDING _____ B. WING _____	C 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**

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 06/08/25 and concluded 06/10/25. The issues identified by the complainant were found non-compliant with regulatory requirements.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		7/15/25

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

Electronically Signed | 07/02/2025

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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	F 584	F584 Privacy Curtain Dirty: Resident #23 privacy curtain replaced by Housekeeping Services Manager or designee on 6/9/25. Facility in house residents have the potential to be affected by the alleged practice. Privacy curtains audited for cleanliness with corrective actions completed as needed. Re-education provided to Housekeeping staff by Regional Housekeeping Manager regarding policy “Room-Bathroom Cleaning Policy” by 7/15/25. Executive Director or designee will audit cleanliness of all occupied room’s privacy curtains 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, and 1 time weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Debris on Ceiling Vent and Ceiling:	

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F 584	Continued From page 2 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. * 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	F 584	Resident #16, #23, and #7 ceiling vents and area around ceiling vent cleaned 6/9/25.Resident #23's wall and wallpaper cleaned 6/9/25 by Housekeeping Director or designee. Facility in-house residents have the potential to be affected by the alleged practices. Ceiling vents, walls, wallpaper and area around ceiling vents audited for cleanliness by Regional Housekeeping Manager or designee with cleaning completed if needed by 7/15/25. Re-education provided to housekeeping staff by Regional Housekeeping Manager regarding policy "Room-Bathroom Cleaning Policy" by 7/15/25. Executive Director or designee will complete random audit of rooms for cleanliness including ceiling vent, walls, wallpaper and ceiling of 5 rooms weekly for 4 weeks, 3 rooms weekly for 4 weeks, then 1 room weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Painter's Tape: Painter's tape was removed Regional MDS Consultant, Maintenance Director and Director of Nursing) from resident #4, #25, and storage room door on 6/9/25. Facility in house residents have the potential to be affected by alleged practices. Audit completed by Maintenance Director or designee on 7/1/25 for painter's tape in place for over 24 hours. Removal of painter's tape	

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F 584	Continued From page 3 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).	F 584	occurred if necessary. Re-education to be provided to IDT, Nursing Staff, Housekeeping, and Dietary Staff by Maintenance Director regarding removal of painter's tape within 24 hours of painting by 7/15/25. Maintenance Director or designee will audit for painters' tape 3 time's weekly for 4 weeks, then weekly for 8 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Lights Not Working; Light Cover Missing; Window Screen Holes; Broken Thermostat Cover: Resident #3's nonfunctioning light replaced by Maintenance Director or designee on 6/9/25. Resident #16's light cover was replaced by Maintenance Director or designee on 6/9/25. Resident #9's thermostat cover replaced by Maintenance Director or designee on 6/9/25. Resident #9 and #23's window screens will be repaired by Maintenance Director or designee by 7/15/25. Resident #133's torn wallpaper will be replaced/covered by Maintenance Director or designee by 7/15/25. Facility in-house residents have the potential to be affected by alleged practices. Audit of resident rooms was completed by Maintenance Director or designee for broken light cover, lights not working, torn screens, torn wallpaper and broken thermostats completed 7/1/25. Items repaired or replaced if needed.	

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F 584	Continued From page 4	F 584	Re-education provided to facility staff starting 7/2/25 on who to report items in need of repair or areas of cleanliness including facility work order entry procedure. The Executive Director or designee will provide re-education to the Interdisciplinary Team on environmental rounding by 7/15/25. Maintenance Director or designee to audit random rooms for items needing repair 5 times weekly for 12 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation.	
F 628 SS=E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a	F 628		7/15/25

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F 628	Continued From page 5 copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §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 (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,	F 628		

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F 628	Continued From page 6 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; (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	F 628		

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F 628	Continued From page 7 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). §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 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	F 628		

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F 628	Continued From page 8 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. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: 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	F 628	F628 Bed Hold- Resident #3 bed was held on 2/21/25 and resident returned to facility 2/25/25 was	

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F 628	Continued From page 9 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	F 628	discharged home and subsequently had celestial discharge at home. Resident #11 hospitalization for 10/17/24 to 10/20/24 with resident returning to facility and facility reissued updated behold for hospitalization from 4/4/25 to 4/8/25 with reserve payment amount notated by 7/15/25. Resident # 26's bed holds for 3/10/25 to 3/12/25 and 3/27/25 reissued with reserve payment amount notated by 7/15/25. Resident #32's bed was held for hospitalization from 3/31/25 to 4/03/25 and resident choose not to return to facility from hospital, but to the community. Facility residents who have hospitalizations have the potential to be affected by the alleged practice. Licensed Nurses, Business Office Manager and Business Office Assistant were re-educated starting on 7/2/25 on the procedure titled, "Bedhold Notice Policy" by Director of Nursing or designee. Audits will be conducted by the Business Office Manager or designee to ensure notice of bed hold coverage is accurately provided to residents or decision makers. Audits begin the week of 7/6/25 and will be completed 2 times weekly for 12 weeks or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Transfer/DC: Resident#3's, #11, #26, #32, #7 Notice of	

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F 628	Continued From page 10 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 10/17/24 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 04/04/25 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. - 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	F 628	Discharge provided to Ombudsman by Social Worker or designee by 7/15/25. In house residents discharging or transferring from facility have the potential to be affected by the alleged practice. Residents discharged or transferred from the facility last month were audited by Social Worker or designee for notification to Ombudsman and notice provided to responsible party or resident and notification completed to Ombudsman if necessary by 7/15/25. Re-education provided to Interdisciplinary Team by Executive Director beginning by 7/15/25 for notification of Ombudsman and Policy “Transfer and Discharge (including AMA)” .Licensed Nursing staff education will be completed by 7/15/25 on policy “Transfer and Discharge” (including AMA)”. Executive Director or designee to audit for Transfer/Discharge Form and notification to Ombudsman weekly x 12 weeks or until substantial compliance is maintained . Results of audits will be brought to QAPI for review and recommendation.	

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F 628	Continued From page 11 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.	F 628		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 641		7/15/25

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F 641	Continued From page 12 This REQUIREMENT is not met as evidenced by: 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	F 641	F641- Accuracy of Assessments Section A-Identification Information PASRR 1. Resident #23's Significant Change in Status Assessment MDS ARD 9/25/2024 was modified on 6/30/25 by the Director of Clinical Reimbursement to reflect A1500 to 1 "yes" and A1510 to yes Serious Mental illness. 2. Current facility residents have the potential to be affected by this practice. MDS's completed in the last 3 months were reviewed for coding accuracy of section A1500, A1510, and A1550 with modifications made by 7/15/25 by Regional MDS Specialist. 3. Regional MDS Specialist educated MDS Coordinator on RAI Manual Section A1500 and A1510 on 7/2/2025. 4. Audits of section A1500 and A1510 will be conducted by the Director of Clinical Reimbursement or designee for 12 weeks. Beginning on week of 7/6/25 5 random MDS's weekly x 4weeks then 3 residents weekly x 4 weeks then 1 resident weekly x4 weeks, or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Section A-Discharge Location 1. Resident #30 Discharge MDS ARD 4/10/25 was modified on 6/30/25 by Director of Clinical Reimbursement to	

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F 641	Continued From page 13 05/06/24 stated, ". . . You meet PASRR inclusion criteria for Serious Mental Illness . . ." A significant change in status assessment MDS, dated 09/25/24 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 04/10/25, 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 03/16/25, failed to include an active diagnosis of depression. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI User's Manual,	F 641	reflect A2105 as discharge location to= 01. Community. 2. Residents discharged from the facility have the potential to be affected by this practice. Discharge MDS's completed in the last 12 months have been audited for coding accuracy of section A2105 with modifications made. 3. Regional MDS Specialist educated MDS Coordinator on RAI Manual Section A2105 on 7/2/25. 4. Audits of section A2105 will be conducted by the Director of Clinical Reimbursement or designee for 12 weeks. Beginning on the week of 7/6/25 (5) random MDS's weekly x 4weeks then 3 residents weekly x 4 weeks then 1 resident weekly x4 weeks, or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Section I-Active Diagnoses 1. Resident #7 Quarterly MDS ARD 3/16/25 was modified on 6/30/25 by the Director of Clinical Reimbursement to reflect Depression, as an active diagnosis in question I5800. 2. Residents with a diagnosis of depression have the potential to be affected by alleged practices. An Audit of current residents' MDS Section I5600 completed by 7/15/25 by Regional MDS Specialist to ensure accurate coding of Depression diagnosis with modifications made. 3. Regional MDS Specialist educated MDS coordinator on RAI Manual Section I	

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F 641	Continued From page 14 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. . . ." 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 03/17/25 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	F 641	7/2/2025. 4. Audits of section I5600 will be conducted by Director of Clinical Reimbursement or designee for 12 weeks. Beginning on week of 7/6/25 5 random MDS's weekly x 4weeks then 3 residents weekly x 4 weeks then 1 resident weekly x4 weeks, or until substantial compliance is maintained. Results of audits will be brought to QAPI for review and recommendation. Section J- Health Conditions and Section O-Special Treatments, Procedures, and Programs 1. Resident #20's Significant Change MDS ARD 3/17/25 corrected with modification of questions J1800 to yes and O0110.K1.B to yes by Director of Clinical Reimbursement on 6/30/25 2. Residents receiving hospice care have potential to be affected by alleged practices. Audit of facility residents' last comprehensive MDS reviewed for hospice services or terminal diagnosis, with corrections made by 7/15/25 by Regional MDS Specialist. 3. Regional MDS Specialist educated MDS coordinator on RAI Manual Section J1800 and Section O0110.K on 7/2/2025. 4. Audits of question J1800 and question O0110.K will be conducted by the Director of Clinical Reimbursement or designee for 12 weeks. Beginning on week of 7/6/25 (5) random MDS's weekly x 4weeks then 3 residents weekly x 4 weeks then 1 resident weekly x4 weeks, or until substantial compliance is	

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F 641	Continued From page 15 lower extremities on three of seven days during the look back period. The quarterly MDS, dated 02/23/25, 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 03/17/25 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.	F 641	maintained. Results of audits will be brought to QAPI for review and recommendation. Section M 1. Resident #5 Quarterly MDS ARD 2/23/25 question M1200 was corrected on 6/30/25 by the Director of Clinical Reimbursement with modification to yes in section M1200. 2. Residents residing in the facility have the potential to be affected by alleged practices. Current residents' most recent MDS section M audited by Regional MDS Specialist by 7/15/25 for accurate coding of section M1200 with correction as needed. 3. Regional MDS specialist completed education with MDS coordinator 7/2/25 on RAI manual section M. 4. Audits of section M will be conducted by the Director of Clinical Reimbursement or designee for 12 weeks. Beginning on week of 7/6/25 5 random MDS's weekly x 4weeks then 3 residents weekly x 4 weeks then 1 resident weekly x4 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	F 658		7/15/25

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F 658	Continued From page 16 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 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.	F 658	F658 1.Resident #9 and physician notified of missed annual labs Director of Nursing on 6/9/25 and annual labs were completed by Director of Nursing 6/9/25. 2.Facility in house residents have the potential to be affected by alleged practice. Audit completed 6/9/25 of current in house residents completed for orders not transcribed with notification to MD and new orders if needed. Current residents reviewed with Medical Director for need for annual labs 7/1/25 and orders obtained if needed. 3.Facility nurses educated on order entry and 2nd nurse check of physician visits by 7/15/25 by Director of Nursing or designee. 4.Director of Nursing or designee to audit signed physician order summaries for orders entered correctly starting week of 7/6/25 5x's weekly x 4 weeks, then 3 x's weekly x 4 weeks. Results of audit will be brought to QAPI for review and recommendation.	

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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	F 677	F677 Resident #17 shower was completed by Nursing assistant on 6/30/25. Facility in house residents have the potential to be alleged by this practice. Audit completed 7/1/25 for shower completion in past week. Residents with refusals, no documentation or not applicable were re-offered showers for completion on 7/1/25 and 7/2/25. Director of Nursing or designee will provide re-education to licensed and unlicensed nursing staff by 7/15/25 on completing and documenting showers including refusal and reoffering. Director of Nursing or designee will audit compliance with showers on varying shifts and residents, four residents weekly for four weeks, then three residents weekly for four weeks, then two residents weekly for four weeks, then one resident weekly for four weeks or until substantial compliance is maintained. Audits will be submitted to the QAPI committee for review and recommendations. Resident #17 fingernails were cared for by Director of Nursing or designee on 7/2/25 and nail care schedules were	7/15/25

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F 677	Continued From page 18 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.	F 677	updated in plan of care or on MD orders for identified residents by Director of Nursing or designee. Facility residents have the potential to be affected by this practice. Director of Nursing or designee will be completing nail care audit by 7/15/25 for nail cleanliness and length per preference. Nail care will be completed if needed. Director of Nursing or designee will provide re-education to nursing staff by 7/15/25 on completing nail care on shower days and PRN. Director of Nursing or designee will audit compliance with fingernail care including documentation and visualization for four residents weekly for four weeks, then three residents weekly for four weeks, then two residents weekly for four weeks, then one resident weekly for four weeks or until substantial compliance is maintained. Audits will be submitted to the QAPI committee for review and recommendations.	
F 849 SS=D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services	F 849		7/15/25

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F 849	Continued From page 19 when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes	F 849		

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F 849	Continued From page 20 responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility	F 849		

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F 849	Continued From page 21 becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific	F 849		

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	355031	A. BUILDING _____ B. WING _____	C 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

(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 849	Continued From page 22 to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: 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.	F 849	F849 Resident #20's election of hospice paperwork obtained and uploaded to electronic health record 6/26/25. Resident #5's election of hospice paperwork will be obtained and uploaded to the electronic health record by 7/15/25. Facility in house residents receiving	

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F 849	Continued From page 23 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.	F 849	hospice have the potential to be affected by this practice. In house residents receiving hospice services audited 7/1/25. All affected hospice resident's election forms will be obtained and uploaded to their electronic health records by 7/15/25. Executive Director re-educated Interdisciplinary Team on policy "Hospice Services Facility Agreement" on 7/2/25. Executive Director or designee to will audit compliance with hospice election form in medical record weekly x 4 weeks, then monthly x 8 weeks or until substantial compliance is maintained. Audits will be submitted to the QAPI committee for review and recommendations.	