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	355031	A. BUILDING _____ B. WING _____	11/09/2022

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 11/07/22 and concluded 11/09/22.	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		12/9/22

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

Electronically Signed | 12/07/2022

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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 review of Medicare Beneficiary Notices and staff interview, the facility failed to submit a demand bill request for 1 of 3 supplemental residents (Resident #25) reviewed for termination of Medicare Part A services. Failure to submit a demand bill request violated the resident's right to appeal the termination of Medicare Part A coverage. Findings include: Review of Resident #25's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) identified a Medicare Part A discharge date of 05/09/22. The resident checked "Option 1" on the SNFABN, which identified he wanted to appeal his termination of skilled services (i.e., a	F 582	It is the policy of the facility that residents have the option to appeal Medicare Part A coverage. 1. Resident #25 interviewed regarding desire to appeal Medicare Part A coverage by the Executive Director on 12/05/2022; resident #25 declined to appeal the termination of skilled services. 2. Current facility residents who may utilize their Medicare benefit have the potential to be affected by the alleged practice. Residents with demand bills from May 2022 to November 2022 were evaluated for selection of option 1. One other resident was identified as being affected and decline to appeal the termination of skilled services.	

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F 582	Continued From page 2 demand bill). Resident #25's billing records failed to identify the facility submitted his claim for Medicare review. During an interview on 11/09/22 at 10:15 a.m., a managerial nurse (#1) identified the facility business office is responsible for letting the central office know if there is a demand bill. The nurse confirmed the facility failed to submit Resident #25's request for a demand bill.	F 582	3. Facility office personnel were re-educated on 11/30/22 by the Director of Clinical Reimbursement to ensure Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) and resident option selections to appeal are handled appropriately. Education included review of the procedure titled, Beneficiary Notices and procedure titled, TO NOMNC OR NOT TO NOMNC: That is the Question. 4. Audits will start by 12/9/22 and will be completed by the Social Worker or designee to ensure SNFABN option responses follow the appeals process. Audits will be completed to observe SNAFBNs beginning weekly for 16 weeks, then monthly for three months or until substantial compliance is maintained. Results of audits will be brought to the Quality Assurance Performance Improvement (QAPI) committee and triple check for review and recommendation. 5. Date of Completion 12/9/22	
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: 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of	F 658	F658 #1 Controlled Medication Administration It is the policy of the facility that residents	12/9/22

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F 658	Continued From page 3 medication administration during 1 of 3 observations of medication administration (the afternoon of 11/07/22). Failure to administer medications according to physician's orders and reconcile controlled medications timely resulted in a medication error and may result in adverse drug effects. Findings include: Review of the facility policy titled "Medication Administration - General Guidelines" occurred on 11/09/22. This policy, revised October 2022, stated, ". . . Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. . . . Medications are administered in accordance with written orders of the attending physician. . . . The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. . . ." Review of the facility policy titled "Controlled Medication Storage" occurred on 11/09/22. This policy, revised October 2022, stated, ". . . At each shift change, or per facility policy, a physical inventory of all controlled medications is conducted by two authorized med [medication] passers . . ." Review of Resident #24's medical record occurred on all days of survey. The physician's orders identified Gabapentin (an anticonvulsant used to treat nerve pain) 600 milligrams (mg) three times per day (TID), increased on 10/28/22. The prior Gabapentin order identified 300 mg TID.	F 658	receive timely and necessary medications. 1. Resident #24 assessed by an RN on 11/9/22 with no ill effect noted. Resident□s physician was notified on 11/9/22. 2. Current facility residents with orders for controlled medications have the potential to be affected by the alleged practice. The controlled medication reconciliation record audited on 11/8/22 by the Vice President of Success for identification of inconsistent logged times or doses with no discrepancies noted. 3. Facility nursing staff were re-educated by the Administrator or designee, starting by 12/07/22 on the need to review and follow residents□ medications as ordered. Education included reviewing facility policies titled Controlled Medication Storage and Medication Administration □ General Guidelines. 4. Audits of medication administration documentation comparisons of the electronic medical record (eMAR) to the controlled medication book to verify date, time, and dose of controlled medications will start by 12/9/22 and will be completed by the Director of Nursing or designee. Audits will be conducted 3 times weekly for 12 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, and then once bi-weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to the Quality Assurance Performance Improvement (QAPI) committee for review and	

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F 658	Continued From page 4 Review of Resident #24's MAR and controlled medication reconciliation record identified staff administered a 300 mg dose of Gabapentin on 11/02/22 at 8:00 p.m. The MAR lacked identification of a Gabapentin dose due at that time. Additionally, the reconciliation record identified discrepancies with the Gabapentin count. During an interview on 11/08/22 at 5:26 p.m., a managerial nurse (#1) confirmed the 8:00 p.m. dose of Gabapentin was a medication error. She identified the discrepancies noted on the reconciliation record were documentation errors, as the nurse failed to follow policy and sign out the Gabapentin at the time of administration. As a result, the nurse attempted to correct the count at the end of her shift. 2. Based on observation, record review, review of facility policy and staff interview, the facility failed to follow professional standards of practice for 1 of 6 residents observed (Resident #7) with orders for oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications and ineffective management of a resident's condition. Finding include: Review of the facility policy titled "Oxygen Administration" occurred on 11/08/22. This policy, revised June 2017, stated, ". . . PURPOSE: To deliver oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues . . . label humidifier with date and time opened . . . change humidifier and tubing per	F 658	recommendation. 5. Date of Completion 12/9/22 F658 #2 Oxygen It is the policy of the facility that residents receive timely and necessary oxygen supplies. 1. Resident #7□s oxygen tank was set at the physician ordered flow rate, oxygen saturations were assessed and monitored by facility nursing staff. Resident #7□s oxygen saturations noted to remain above 90% with no ill effect noted. 2. Current facility residents have the potential to be affected by the alleged practice. Documentation will be reviewed at morning clinical meetings by the Director of Nursing or designee for dated oxygen tubing and humidifiers, and oxygen saturations. Documentation will be compared to observed dating on oxygen supplies and flow rates being administered by the Director of Nursing or designee. 3. Facility nursing staff were re-educated by the Administrator or designee, starting by 12/07/22 on the need to review and follow residents□ oxygen orders and care plans. Education will include reviewing the policy titled Oxygen Administration. 4. Audits of oxygen flow rates and dated supplies will start by 12/9/22 and be completed by the Director of Nursing or designee. Audits will be conducted 3 times weekly for 12 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, and then once bi-weekly for 4 weeks or	

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F 658	Continued From page 5 facility policy . . . check and clean tubing and cannula equipment . . . at regular intervals, check liter flow contents of oxygen cylinder . . . a reserve full oxygen tank should be available to provide continuity of care . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included chronic hypoxia (low levels of oxygen in body tissues), and respiratory failure. The current physician's order stated, ". . . oxygen 2 liters nasal cannula continuously . . . change oxygen tubing weekly on Sundays and PRN [as needed] . . . date and initial new tubing . . ." The current care plan stated, ". . . administer oxygen therapy per physician orders . . . change oxygen tubing and humidified water as ordered . . ." Observation on 11/07/22 at 11:45 a.m. identified Resident #7 with an oxygen cannula in her nose, connected to an oxygen tank, set to zero. Staff failed to turn on Resident #7's oxygen, date the nasal cannula and change the other oxygen equipment as ordered. Observation on 11/07/22 at 12:20 p.m. showed a nurse (#4) checked Resident #7 portable oxygen tank after the resident stated she was not getting any air out of her nasal cannula. The nurse (#4) identified Resident #7's portable oxygen tank as empty, and replaced it with a full tank. Observation showed the resident did not have oxygen for approximately 40 minutes. Resident #7's medical record showed a nurse (#5) signed the electronic treatment record on 11/06/22 to identify she changed the oxygen tubing and humidified water container. However,	F 658	until substantial compliance is maintained. Results of audits will be brought to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendation. 5. Date of Completion 12/9/22	

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F 658	Continued From page 6 observations on all days of survey showed Resident #7's oxygen tubing and humidified water container dated 10/30/22. During an interview on 11/08/22 at 3:01 p.m., a managerial nurse (#1) stated she expected nursing staff to document only tasks they complete, and complete physician's orders as ordered.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		12/9/22

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F 761	Continued From page 7 by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure appropriate labeling of medications for 1 of 5 residents (Resident #24) observed during medication administration. Failure to ensure medication cards contain the correct dosage information may result in medication errors and adverse drug effects. Findings include: Review of the facility policy titled "Medication Labels" occurred on 11/09/22. This policy, revised October 2022, stated, ". . . Only the dispensing pharmacy can modify or change prescription labels. . . . Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy. . . . Medication labels are not altered, modified, or marked in any way by nursing personnel. . . . If the physician's directions for use change or the label is inaccurate, the nurse may place a "direction change - refer to chart" label on the container . . . The dispensing pharmacy is informed prior to the next refill of the prescription so the new container will show an accurate label. . . ." Observation during medication administration on the afternoon of 11/07/22 showed a nurse (#3) dispensed two 300 milligram (mg) capsules of Gabapentin (an anticonvulsant also used to treat nerve pain) for Resident #24. The pharmacy label on the medication card identified "Take 1 cap [capsule] by mouth three times daily . . . Gabapentin 300 mg capsule . . ." A hand-written entry on the medication card identified "Change dose - 2 tabs." The nurse stated Resident #24's	F 761	It is the policy of the facility that residents receive medications per physician orders with appropriate labels. 1. Resident #24□s medication label was reissued by pharmacy to the facility with the current physician order on 11/09/2022. 2. Current facility residents have the potential to be affected by the alleged practice. Medication order changes that occurred since 11/1/22 were audited by the Director of Nursing or designee by 12/9/2022. 3. Facility nursing staff were educated by the Administrator or designee, starting 12/07/22 on the need to review and follow residents□ medication labels and the process for indicating order changes on labels. Education included reviewing the facility policy titled Medication Labels. 4. Audits will start by 12/9/22 and be completed by the Director of Nursing or designee to ensure medication labels are accurate according to the physician orders. Audits will be conducted 3 times weekly for 12 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, and then once bi-weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendation. 5. Date of Completion 12/9/22	

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F 761	Continued From page 8 current Gabapentin dose is 600 mg three times per day. During this observation, new medications cards arrived from the pharmacy. The nurse identified the resident's new Gabapentin card still contained the old dosing information (300 mg three times per day). Review of Resident #24's medical record identified the physician increased the Gabapentin from 300 mg to 600 mg on 10/28/22. Resident #24's controlled medication record identified the facility received new medication cards on 11/01/22 and 11/07/22. Both cards contained inaccurate dosing information. The facility failed to clarify the medication label with the pharmacy to ensure correct dosing information. During an interview on the afternoon of 11/08/22, a managerial nurse (#1) agreed nursing staff should not hand write instructions on medication cards.	F 761		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility	F 888		12/9/22

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F 888	Continued From page 9 or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care,	F 888		

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F 888	Continued From page 10 treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the	F 888		

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F 888	Continued From page 11 contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on review of COVID-19 testing results, staffing schedules, facility policy and staff interview, the facility failed to follow their contingency plan related to unvaccinated staff for 1 of 3 staff members reviewed (Staff #2). Failure to test unvaccinated staff twice weekly increases the risk of spreading COVID-19 to residents,	F 888	It is the policy of the facility that staff follow COVID-19 policies and procedures. 1. Staff member tested negative on 12/3/22. 2. Current facility residents have the potential to be affected by the alleged practice.	

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 _____	11/09/2022

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 888	Continued From page 12 staff, and visitors. Findings include: Review of the facility policy titled "COVID-19 Vaccination and Accomodation [sic]" occurred on 11/09/22. This policy, dated November 2021, stated, ". . . Additional Precautions and Contingency Plans for Unvaccinated Staff . . . Staff who receive an exemption to the COVID-19 vaccine will be subject to additional precautions to mitigate the transmission and spread of COVID-19, which includes: Submission of COVID-19 testing twice-weekly, regardless of the status of community spread of facility required testing frequency. . . ." Review of Staff #2's COVID-19 testing records since October 16 identified the staff member tested at the facility on November 3. Review of staffing schedules identified Staff #2 worked at the facility on October 16, 18, 19, 20, 21, 22, 24, 25, 26, 28, 29, and November 2, 3, 4, and 7. The testing records failed to show Staff #2 tested twice weekly as per the facility's contingency plan. During an interview on the afternoon of 11/07/22, a managerial nurse (#1) confirmed the facility failed to ensure Staff #2 documented twice weekly testing.	F 888	3. Facility staff, including staff member #2, were educated by the Administrator or designee, starting by 12/07/22 on the facility□s QAPI-approved contingency plan for COVID-19 testing. Staff were educated on the policy titled, Employee COVID-19 Vaccinations. Ad-Hoc QAPI held on 12/6/2022. Per QAPI, vaccine-exempted staff will be required to wear a surgical facemask as source control, including at times of low, moderate, or substantial county transmission rates, and subject to change at the discretion of the facility□s QAPI committee. 4. Audits will start by 12/9/22 and be completed by the Executive Director or designee to ensure vaccine-exempted staff are testing as needed and wearing source control as determined by the QAPI committee. Audits will be conducted 3 times weekly for 12 weeks, 2 times weekly for 4 weeks, weekly for 4 weeks, and then once bi-weekly for 4 weeks or until substantial compliance is maintained. Results of audits will be brought to the Quality Assurance Performance Improvement (QAPI) committee for review and recommendation. 5. Date of Completion 12/9/22	