STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	**600 S MAIN ST , MINOT, North Dakota, 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
F0000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a complaint was completed on November 24, 2025. During the complaint investigation, the facility was found noncompliant with regulatory requirements.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from abuse/neglect for 1 of 1 sampled resident (Resident #4) who utilized a commode for toilet needs. Failure to place the call light within reach and check on the resident while on the commode resulted in discoloration to the resident's buttocks, a bruise to the wrist, and has the potential to cause anxiety, fear, and psychosocial harm. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following discovery of the incident. Findings include:	F0600	"Past Noncompliance - no plan of correction required"	12/23/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST , MINOT, North Dakota, 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
F0600 SS = G	Continued from page 1 The surveyor determined a deficient practice existed on 09/07/25. The facility implemented corrective action immediately, completed corrective action on 09/07/25, and continued with staff education and monitoring. Review of the facility policy titled "Abuse, Neglect, and Exploitation" occurred on 11/24/25. This policy, revised 07/15/22, stated, ". . . Definitions . . . 'Neglect' means failure of the facility, its employees . . . to provide . . . services to a resident that are necessary to avoid . . . mental anguish, or emotional distress . . . C. Training will include: . . . 2. Identifying what constitutes . . . neglect . . . 3. Recognizing signs of . . . neglect . . . of a resident . . . such as . . . psychosocial indicators . . . III. Prevention of . . . Neglect . . . assure that staff assigned have knowledge of . . . residents' care needs . . . ." Review of Resident #4's medical record occurred on 11/24/25. Diagnoses included anxiety disorder and aphasia (inability to verbalize needs) following a stroke. The care plan stated, ". . . Impaired communication severe expressive aphasia . . . Ensure resident has call light secured to bedside commode and within reach when toileting . . ." An annual Minimum Data Set (MDS), dated 04/20/25, identified intact cognition and dependent on staff for toileting. A progress note dated 09/07/25, stated, "Writer was informed that resident was found on bedside commode for an extended period of time last night. Writer performed skin assessment: blanchable redness noted to bilateral buttocks, blanchable light purple area noted to right buttock, bruise to left wrist. Resident denied any pain, no s/s [signs or symptoms] of pain noted. Resident's mood is at baseline, showing okay sign, requested to stay in bed as she was fatigued." During an interview on the afternoon of 11/24/25, an administrative nurse (#2) stated on the evening of 09/06/25, the certified nurse aides (CNAs) (#3 and #4) transferred Resident #4 to the bedside commode, failed to place the call light within reach, and failed to check on the resident for a period of approximately six hours. The administrative nurse (#2) indicated the resident sustained a bruise to the wrist from banging on the wall for assistance. The facility failed to ensure staff followed the care plan for toileting and failed to check on Resident #4 while on the bedside commode. Based on the following information, non-compliance at	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST , MINOT, North Dakota, 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
F0600 SS = G	Continued from page 2 F600 is considered past non-compliance. The facility implemented corrective actions for all residents who may be affected by the deficient practice as follows: * Completed an investigation into the incident involving Resident #4. * Suspended both CNAs from work until completion of the investigation and provided written warnings to both CNAs. * Re-educated all staff via text message regarding following residents' care plans for toileting, rounding, and call light placement on 09/07/25. * Updated agency staff orientation to include rounding and call light placement.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0609	Corrective Action taken for those residents alleged to have been affected by the deficient practice are: 1. State Survey Agency completed complaint survey November 24, 2025.Facility investigation of incident for Resident #4 reviewed by state surveyor. Facility changed ownership 10/1/25, regional DON and owner reviewed reporting expectations with Administrator and DON upon transition. Care Plan of resident #4 was reviewed and updated as deemed necessary. Actions taken to identify additional residents that may have been affected by the deficient practice are: 2. Facility residents have potential to be affected by stated deficiency; Since ownership changeover facility has self-reported any further alleged abuse/neglect/misappropriation incidents to the state; There have been no reportable similar findings and/or negative effects that have been identified by this alleged deficient practice. The measures the facility will take to ensure the problem will be corrected and will not reoccur: 3. Starting December 22, 2025 the Interdisciplinary Team and Licensed Nurses will be educated on facility policy titled, “Accident/Incident Process and Reporting Policy and Procedure”. Starting January 7, 2026 additional facility staff not listed above will also be educated on policy “Accident/Incident Process and Reporting Policy and Procedure.”	01/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	600 S MAIN ST , MINOT, North Dakota, 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
F0609 SS = D	Continued from page 3 Based on review of facility policy, record review, and staff interview, the facility failed to report an incident of abuse/neglect to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #4) left on the commode for toilet needs. Failure to report incidents of neglect may result in Resident #4 and other residents experiencing abuse and/or neglect and psychosocial harm. Findings include: Review of the facility policy titled "Abuse, Neglect, and Exploitation" occurred on 11/24/25. This policy, revised 07/15/22, stated, ". . . Definitions . . . “Neglect” means failure of the facility, its employees . . . to provide . . . services to a resident that are necessary to avoid . . . mental anguish, or emotional distress . . . Policy and Compliance Guidelines . . . Reporting of all alleged violations to the . . . state agency . . . a. Immediately, but no later than 2 hours after the allegation is made, if the events that . . . result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not . . . result in serious bodily injury . . . " Review of Resident #4's medical record occurred on 11/24/25. Diagnoses included anxiety disorder and aphasia (inability to verbalize needs) following a stroke. The care plan stated, ". . . At risk for traumatization of . . . Impaired communication severe expressive aphasia . . . Ensure resident has call light secured to bedside commode and within reach when toileting . . . The Minimum Data Set (MDS), dated 10/20/25, identified intact cognition and dependent on staff for toileting. A progress note dated 09/07/25, stated, “Writer was informed that resident was found on bedside commode for an extended period of time last night. Writer performed skin assessment: blanchable redness noted to bilateral buttocks, blanchable light purple area noted to right buttock, bruise to left wrist. Resident denied any pain, no s/s [signs or symptoms] of pain noted. Resident’s mood is at baseline, showing okay sign, requested to stay in bed as she was fatigued.” An administrative nurse (#2) indicated the resident's sustained the left wrist bruise from banging on the wall for assistance. During an interview on the afternoon of 11/24/25, an administrative nurse (#2) confirmed the facility failed to report this incident to the SSA.	F0609	Continued from page 3 Specifically, this education will focus on the facility’s responsibility to ensure alleged violations involving misappropriation, neglect and/or abuse are immediately reported to the Administrator and respective State Agency as indicated. New facility staff members will be educated upon orientation and ongoing during annual inservices. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: 4. Administrator or designee will perform random audits, in the form of resident and staff interviews to include that residents and staff feel safe within the facility, that appropriate services are provided, processes and procedures are in place to avoid physical and emotional harm, and staff and residents know the proper procedure for reporting abuse and/or neglect. These audits beginning the week of 1/12/26 will be completed weekly x 4 weeks x 5 people, bi-weekly x 2 weeks x 3 people, and monthly x 1 month x 3 people or until results are satisfactory to ensure ongoing and sustained compliance with this alleged deficient practice. Any adverse findings will be immediately reported to the NHA, investigated and reported to the State Agency as deemed necessary.	