STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355065	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Drive - A Prospera Community	1011 Boundary St NW Mandan, ND 58554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398 Based on record review, review of a facility reported incident (FRI), review of facility policy, and staff interview, the facility failed to ensure a resident's right to be free of physical restraints imposed for purposes of convenience for 1 of 2 sampled residents (Resident #1) reviewed for restraints. Failure to use a restraint only if required to treat a resident's medical symptoms placed Resident #1 at risk for an unnecessary restraint and injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately after learning of the incident. Findings include: Review of the facility policy titled Restraints occurred on 06/19/24. This policy, dated 12/05/23, stated, . Policy: Residents are free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Physical Restraints - Any . material or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's own body. a. Physical restraints may include . soft ties . that the resident cannot remove. Also included as restraints . Using devices in conjunction with a chair such as trays, tables and belts that prevent a resident from rising. Procedure: . If the device, material or equipment is not a restraint for this resident, then the steps taken to make this decision must be documented in the medical record. Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident and a Physical Device and/or Restraint Evaluation and Review UDA [assessment] is completed by a Licensed Nurse. 1. Prior to the application of a non-emergency physical restraint, the following must be completed: . documentation in the legal medical record . to capture the observations that suggest a physical restraint is indicated and response to previous interventions attempted. designate a committee that reviews restraint use. evaluate the environmental, physical and psychosocial causes . review the attempted alternatives and explore further alternatives . (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's initial report, dated 06/09/24, stated, Friday 6/7/24 9:45pm resident [#1] was secured in her wheelchair with a sheet by [name of a registered nurse (#2)] to prevent a fall. Resident is COVID [coronavirus infection] + [positive] and is a very high fall risk and typically sits out in the living room. It was witnessed by [name of a certified nurse aide (CNA) (#3)] and confronted the nurse about this. No changes were made. At shift report 10:30pm it was witnessed by [name of a CNA (#4)] that resident was sitting in her room with a sheet wrapped around her waist and tied to the wheelchair. At 10:45 pm [CNA (#4)] removed the sheet and put [name of Resident #1] to bed. Review of Resident #1's medical record occurred on June 19, 2024. Diagnoses included dementia. The quarterly Minimum Data Set (MDS), dated [DATE], indicated severely impaired cognition, dependent on staff for all activities of daily living (ADLs), and bed and chair alarms used daily. The record lacked documentation of observations suggesting the need for a restraint, an assessment regarding the use of a sheet tied around the resident to the wheelchair as a possible restraint, less restrictive devices attempted, monitoring of the restraint, and an order for a physical restraint. The current care plan failed to address the use of a restraint. During an interview on 06/19/24 at 10:45 a.m., an administrative nurse (#1) stated they placed the nurse (#2) on administrative leave as soon as they found out about the incident with Resident #1 and terminated the nurse's contract after completion of the investigation. They provided education to the two CNAs who witnessed the restraint and required all staff to read a Restraint PowerPoint and sign a roster after completed. Also, staff were required to complete the Abuse module. The administrative nurse (#1) stated all new hires are required to complete both modules. They planned an all-staff meeting next week to review expectations. Based on the following information, non-compliance at F604 is considered past non-compliance. The facility implemented corrective action for the resident affected by the deficient practice by: * Completing an investigation following the incident, and * Determining the nurse failed to follow policy in implementing a restraint. The facility implemented measures to ensure the deficient practice does not recur as follows: *Placed the nurse (#2) on administrative leave on 06/09/24 to protect all residents during the investigation. The nurse (#2) terminated from her employment on 06/17/24 after completion of the investigation. * Provided the CNAs (#3 and #4) with re-education related to Abuse and Neglect during their interviews on 06/09/24, to include reporting of incidents such as the above to the on-call nurse or Director of Nursing in a timely manner. Additionally, the CNAs were required to review the Proper Use of Restraints PowerPoint by 6/14/2024. * Disseminated the Proper Use of Restraints PowerPoint on 06/14/24 to all units and required all staff to read and acknowledge. * Reassigned all staff the Abuse and Neglect of the Vulnerable Adult module, with a due date of July 15, 2024. Additionally, staff are expected to continue to complete this module annually. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* All new hires expected to complete the Abuse and Neglect of the Vulnerable Adult module in the Success Center (online learning program), and review and acknowledge the Proper Use of Restraints PowerPoint. * Review the Abuse and Neglect policy and expectations at an all-staff meeting planned for 06/25/24 at 7:00 a.m. and 2:30 p.m. This surveyor determined a deficient practice existed on 06/07/24. The facility implemented corrective action by 06/14/24 and continues with staff education and monitoring for restraint use.