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	07/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40488 Based on observation, review of the North Dakota Long Term Care Ombudsman Program Guide to Resident Rights, and resident interview, the facility failed to provide care for 2 of 10 sampled residents (Resident #1 and #2) in a manner that promotes, maintains, or enhances their quality of life. Failure to cover a urinary catheter bag (Resident #1) and failure to provide care in a dignified manner (Resident #2) does not preserve the resident's personal dignity and/or enhance their quality of life and has the potential to affect the resident's psychosocial well-being. Findings include: The North Dakota Long Term Care Ombudsman Program's Guide to Resident Rights, updated 03/21/23, page 16, stated, . The facility must treat you courteously, fairly and with dignity. - Review of Resident #2's medical record occurred on all days of survey and identified assistance of one to two staff for toileting and total assistance with dressing. Observation on 07/30/24 at 3:59 p.m. showed a certified nurse aide (CNA) (#4) entered Resident #2's room to provide incontinence cares. The CNA removed the blankets and revealed the resident's pants pulled down below the brief. When asked why and how often staff leave his/her pants pulled down, Resident #2 stated, They [facility staff] didn't want to pull them up because they are going to have to come back and change me. The resident verified it happened frequently and stated, It would be nice to be dressed. - Review of Resident #1's medical record occurred on 07/31/24 and identified assistance of one to two staff with dressing, personal hygiene, and catheter cares. Observation on 07/31/24 at 1:55 p.m. showed Resident #1 independently propelled in the hallways in a powered wheelchair with an uncovered urinary catheter bag attached to the back of the wheelchair and exposed to residents and visitors.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 40488 Based on observation, review of facility policy, and resident interview, the facility failed to ensure reasonable accommodation of needs regarding call lights for 5 of 10 sampled residents (Residents #2, #3, #4, #5, #6). Failure to place call lights within a resident's reach may result in an inability to call for help, increased falls, discomfort and/or incontinence. Findings include: Review of the facility policy titled Call Lights occurred on 07/31/24. This policy, dated 07/29/24, stated, . PURPOSE To ensure resident always has a method of calling for assistance . PROCEDURE . When leaving the room, place call light within easy reach of the resident. Random observations on 07/30/24 showed the following: * At 3:25 p.m. and 6:15 p.m., Resident #3 rested in bed with the call light located on the overbed table and out of reach. * At 3:25 p.m., Resident #4 asleep in bed. The call light hung from the bottom rung of the bed rail and out of reach. * At 3:26 p.m. and 6:16 p.m., Resident #5 asleep in bed with the call light located on the bedside table out of reach. * At 3:26 p.m. and 6:18 p.m., Resident #6 seated in a recliner in her room watching television with the call light located across the room wrapped around the bed rail and covered with the bedding. Observation on 07/31/24 at 8:41 a.m. showed Resident #2 seated in a wheelchair in her room watching television with the call light wrapped around the bed rail behind her. When asked how she notified staff for assistance, the resident looked around her wheelchair, then back to her bed, and stated, I guess I don't have a call light. Observations at 10:45 a.m. and 11:15 a.m. showed Resident #2 remained in her wheelchair with the call light out of reach.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40488 Based on observation, record review, professional reference review, resident interview, and staff interview, the facility failed to provide appropriate toileting for 1 of 4 sampled residents (Resident #2) observed for toileting. Failure to provide toileting assistance as care planned may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, and urinary tract infections. Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis [skin] more easily eroded and susceptible to injury. Page 1221 stated, . scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . Review of Resident #2's medical record occurred on all days of survey. The care plan stated, . TOILET USE: Resident requires check and change. Resident is unaware of when she is wet/soiled. BRIEF USE: Resident uses incontinence products for heavy incontinence. Check every 2-3 hours and prn [as needed]. Observations of Resident #2 on 07/31/24 showed the following: * At 8:41 a.m., seated in a wheelchair in her room watching television. * At 10:54 a.m., remained in the wheelchair in the same position watching television. When asked, Resident #2 reported she has not been toileted since she got up this morning for breakfast. * At 11:15 a.m., remained in the wheelchair in the same position watching television. An unidentified certified nurse aide (CNA) entered the room, and without toileting, assisted the resident to the dining room for lunch. * At 12:54 p.m., returned to her room and remained seated in the wheelchair and watching television. When asked if staff had toileted her since she got up this morning, the resident stated, No and reported My pants are wet. Observation showed the resident's pants visibly wet with urine. During an interview on 07/31/24 at 4:18 p.m., when asked how staff know what cares and assistance residents require, an administrative nurse (#2) stated there are care sheets (printed directly from the resident's care plans) in all the resident bathrooms. They [the CNAs] are supposed to use the care sheets in the bathroom as those are always with the current information. Review of Resident #2's care sheet showed . TOILET USE: Resident requires check and change. Resident is unaware of when she is wet/soiled. Staff should assist resident in her bed for check and changes every 2-3 hours. Assist x1 [one staff] . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's toileting record for 07/31/24 showed staff assisted with toileting at 6:00 a.m. Further review of the toileting record, dated July 18th through July 30, 2024, identified 24 occasions where staff failed to perform the check and change/toileting every three hours. The log showed gaps of approximately 3. 5 to 7 hours between the check and changes with only two documented entries (9:00 a.m. and 1:06 p.m.) on 07/28/24. During an interview on 07/31/24 at 2:18 p.m., an administrative nurse (#1) stated she expects staff to follow what the care plans tells you.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40488 Based on observation, review of facility policy, review of the facility call light logs, resident interview, and staff interview, the facility failed to promptly respond to residents' call lights for 2 of 2 sampled residents (Resident #1 and #8) observed with prolonged call light wait times. Failure to promptly respond to calls for assistance may result in falls and residents experiencing unmet needs and may negatively affect the residents' physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled Call Light occurred on 07/31/24. This policy, dated 07/29/24, stated, . PURPOSE . To promptly answer resident's call light. PROCEDURE . When resident's call light is observed/heard, go to resident's room promptly. Respond to request as soon as possible. Turn call light off and inquire about resident's request. - Review of Resident #8's medical record occurred on all days of survey. The care plan stated, . The resident has an ADL [activities of daily living] self care performance deficit R/T [related to] deconditioning E/B [evidenced by] generalized weakness/impaired balance. AMBULATION: Assist x 1 [one staff] with FWW [front wheeled walker] . The resident is at risk for falls . E/B right side weakness. Observation on 07/30/24 at 6:21 p.m. showed Resident #8 seated in a chair in her room with a front wheeled walker placed in front of her. A certified nurse aide (CNA) (#3) entered the resident's room and asked the surveyor Did you help her back [from the bathroom]? The surveyor replied, No. Resident #3 confirmed she had her call light on, no one came, and she used her front wheeled walker to walk from the bathroom to her chair. When asked how long she typically waits for her call light to be answered, Resident #8 stated, It takes a while for them [staff to answer her call light]. I tell them if I have to go [to the bathroom] and they [staff] aren't here, I will go myself. - Observations on 07/31/24 at 12:01 p.m. showed Resident #1 and #8's call lights flashing in the hallway. An unidentified CNA answered both call lights approximately 35 minutes later. During an interview on 07/31/24 at 2:18 p.m., an administrative nurse (#1) stated she expects all staff (not just CNAs) to answer call lights and the goal is to answer the lights within 15 minutes. Review of Resident #1 and #8's call light logs occurred during this interview and identified Resident #1's call light activated at 12:01 p.m. and answered 29 minutes and 59 seconds later and Resident #8's call light activated at 11:52 a.m. and answered 33 minutes and 12 seconds later.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 3 of 3 sampled residents (Resident #2, #9, and #10) observed receiving toileting assistance. Failure to follow infection control practices regarding hand hygiene during cares has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy titled Hand Hygiene occurred on 07/31/24. This policy, dated 03/29/22, stated, . All employees in patient care areas . will adhere to the 4 Moments of Hand Hygiene. 1. Entering room [ROOM NUMBER]. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting Room . Hand hygiene should be performed after glove removal. Observations on 07/30/24 showed the following: * At 4:15 p.m., two certified nurse aides (CNAs) (#3 and #4) provided toileting cares to Resident #2 while in bed. Both CNAs donned gloves and removed the resident's soiled brief. The one CNA (#3) cleansed the perineal area, removed her gloves, and without performing hand hygiene, donned a new pair of gloves. Both CNAs applied a clean brief, pulled up the resident's pants, rolled the resident onto a lift sling, and transferred the resident to a wheelchair using a full body mechanical lift. Without removing her gloves, the CNA (#3) adjusted the resident's clothing. The CNA (#3) removed her gloves, and without performing hand hygiene, exited the room, pushed the lift down the hall, opened the door to the lift storage room, closed the storage room door without cleaning the lift, and entered another resident's room. The CNA (#3) failed to perform hand hygiene after completing tasks. * At 4:50 p.m., a CNA (#5) donned gloves and assisted Resident #9 with toileting cares in the bathroom. The CNA removed the wet brief, and after voiding, the resident performed own perineal cares. Without changing gloves, the CNA (#5) assisted the resident to stand, applied a new brief, pulled up the resident's pants, and removed her gloves. Without performing hand hygiene, the CNA exited the room, walked the resident to the dining room, and seated the resident at a table. The CNA failed to perform hand hygiene and failed to offer/provide hand hygiene to Resident #9. * At 5:02 p.m., a CNA (#5) donned gloves and assisted Resident (#10) with toileting cares in the bathroom. The CNA pulled down the resident's brief, and after voiding, the resident performed own perineal cares. Without changing gloves, the CNA (#5) assisted the resident to stand, applied a barrier cream to the perineal area, pulled up the resident's brief and pants, transferred the resident into a wheelchair, and removed her gloves. Without performing hand hygiene, the CNA combed the resident's hair, transported her to a table in the dining room, and gave the resident a glass of water. The CNA failed to perform hand hygiene and failed to offer/provide hand hygiene to Resident #10. During an interview on 07/31/24 at 2:18 p.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene per facility policy.