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	11/05/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398 Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician of a change in condition for 1 of 2 closed record residents (Resident #6) reviewed. Failure to notify the physician of increased abdominal pain, tenderness, rigidity, and vomiting may have prevented the physician from altering the treatment/care provided to the resident. Findings include: Review of the facility policy titled Notification of Change occurred on November 5, 2024. This policy, dated 12/04/23, stated, . A facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there is: . 2. A significant change in the resident's physical, mental or psychosocial status. 3. A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. Review of Resident #6's medical record occurred on November 5, 2024. Diagnoses included gastroesophageal reflux disease, history of gastrointestinal hemorrhage (bleeding), and history of peptic ulcer. Resident #6's care plan stated, . Focus: The resident has constipation R/T [related to] Decreased mobility . Observe/monitor/document/report to health care provider PRN [as needed] s/s [signs/symptoms] of complications related to constipation: . swollen abdomen, vomiting, . abdomen tenderness, guarding, rigidity. A medical provider recertification visit occurred on 10/24/24. The provider note stated, . when visiting with nursing staff there are no issues or concerns at this point. Has no questions or concerns at this time. Code Status: DNR/Do Not Attempt Resuscitation (Allow Natural Death). Review of Systems: Gastrointestinal: Negative for constipation, diarrhea, nausea and vomiting. Physical Exam: . Abdominal: General: Bowel sounds are normal. Palpations: Abdomen is soft. Tenderness: There is no abdominal tenderness. Problem List Items Addressed This Visit: . Gastrointestinal and Abdominal: PUD (peptic ulcer disease) Continue pantoprazole [reduces stomach acid secretion] 40 mg [milligrams] twice a day. At risk for constipation: Continue colace [stool softener] 100 mg daily. The nurses' notes stated the following: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 10/25/24 at 5:11 p.m., Milk of Magnesia [laxative] Concentrate Oral Suspension 2400 MG/10ML [milliliter] Give 10 ml by mouth every 12 hours as needed for Constipation for 14 Days. constipation * 10/25/24 at 6:17 p.m., traMADol HCl [hydrochloride] [opioid] Oral Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for Pain related to PAIN, UNSPECIFIED (R52) stomach pain * 10/25/24 at 6:40 p.m., Resident continues to complain of abdominal pain, appears to be more pale than this morning. She has active bowel sounds x [times] 4 [quadrants], tender and ridid [sic] to palpation. Vitally she is hypertensive [high blood pressure], otherwise stable, rates pain 10/10. PRN tramadol given. States she feels constipated, gave milk of mag [magnesia] at supper. Resident is laying in bed now, per her request. The resident reported to the nurse that both the Milk of Magnesia and Tramadol were effective for constipation and pain at approximately 7:30 p.m. on 10/25/24. * 10/26/24 at 6:00 a.m., Milk of Magnesia Concentrate Oral Suspension 2400 MG/10ML. Give 10 ml by mouth every 12 hours as needed for Constipation for 14 Days [Note at 7:58 a.m., PRN Administration was: Ineffective] * 10/26/24 at 6:32 a.m., : Resident did not have a BM [bowel movement] on night shift. Another dose of MOM [milk of magnesia] given. active bowel sounds; fluids encouraged. Offered resident fluids again during shift change and she drank 75% [percent] of her jugged water. Upon completing her drink she requested to be put on the commode, of which she is currently on the commode and report given to day shift for onward follow-up. * 10/26/24 at 6:43 a.m., Bisacodyl [laxative] EC [enteric coated] Oral Tablet Delayed Release 5 MG. Give 2 tablet by mouth every 12 hours as needed for Constipation for 14 Days. nurse notified needed and gave prune juice [Note at 7:58 a.m., PRN Administration was: Ineffective] * 10/26/24 at 8:33 a.m., Death. Date and time vital signs ceased: 10/26/25 @ [at] 0833 [8:33 a.m.] absent heart and lung sounds . * 10/26/24 at 8:59 a.m., Resident reported to have increased abdominal pain, started Friday AM, stated she hadn't had BM [bowel movement] in 2 days. She reports to have small hard BM Friday morning. Gave scheduled colace. New order for Milk of Mag [magnesia] and bisacodyl given this AM. No results. Resident vitals stable this AM, had shower and got dressed per routine. Resident states she continues to feel unwell, begins dry heaving. Phenergan gel given. Dry heaving continues and resident spits up morning meds [Medication Aide administered medications at 7:22 a.m.]. When asked if she wants to go to ER to be checked out, she states yes. This RN [registered nurse] called on call provider [name], obtained order to send to [name] ER. This RN called [power of attorney name] x2 with no response, voicemail left stating I had urgent update. [Name] (second contact called and obtained consent to send to ER and for to hold bed). Meanwhile [POA's name] called facility- this RN updated her on status and that we would be sending her to the ER, she was in agreement. This RN continued to get paperwork in order for transfer. CNA [certified nurse aide] instructed to go and grab resident to have her ready. CNA went to resident room, came back out to nurse station stating that I needed to come check on her. This RN ran to resident room. On assessment resident is pale, dusky, warm to touch, faint heart sounds. EMS [emergency medical system] called, reported update to them. During the phone call with EMS heart sounds had ceased. Second nurse [name] called to room, confirmed no heart or lung sounds at 0833 [8:33 a.m.]. Family called immediately with updated. [name]- team lead aware, [name]- provider aware. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 5:50 p.m., an administrative nurse (#1) verified staff failed to notify Resident #6's medical provider of the change in the resident's condition on October 25, 2024.