

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Sunset Drive - A Prospera Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477</p> <p>Based on record review, review of facility policy, and resident and staff interviews, the facility failed to ensure residents remained free from abuse from 2 of 2 sampled residents (Resident #1 and #2) who displayed sexual behaviors towards other residents. Failure to protect residents from sexual abuse may result in fear, anxiety, mental anguish, and physical injury.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse and Neglect - Rehab/Skilled occurred on 01/08/25. This policy, revised 07/22/24, stated, . Purpose . To ensure that residents are not subjected to abuse by anyone, including, but not limited to . other residents . To ensure that all identified incidents of alleged or suspected abuse/neglect . are promptly reported and investigated.</p> <p>-Review of Resident #1's medical record occurred on 01/08/25. Diagnoses included dementia. An admission Minimum Data Set (MDS), dated [DATE], identified mild cognitive impairment. The care plan, dated 01/05/25, stated, The resident has a behavior symptom R/T [related to] inappropriate sexual advances E/B [evidence by] entering vulnerable female resident room alone with inappropriate physical behaviors.</p> <p>Review of Resident #1's progress notes identified the following:</p> <p>*11/06/24 at 11:33 a.m., . It was previously reported that he was found in her [Resident #2] room, and her brief was pulled down.</p> <p>-Review of Resident #2's medical record occurred on 01/08/25. Diagnoses included dementia. A quarterly MDS, dated [DATE], identified severe cognitive impairment. The care plan, initiated on 09/10/24, stated, . The resident displays/has displayed inappropriate sexual advances towards other residents and staff.</p> <p>Review of Resident #2's progress notes identified the following:</p> <p>*10/26/24 at 2:54 p.m., It was reported that [Resident #1] was fondling this other resident's private area/groin.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*11/05/24 at 4:55 p.m., Spoke with [name] (legal guardian), regarding reported incident . CNA [certified nurse aide] reported seeing a [unidentified] male resident in [Resident #2's] room and lifting her shirt up.</p> <p>*11/06/24 at 11:34 a.m., . reported that . [Resident #1] was found in [Resident #2's] room, and [Resident #2's] brief was pulled down.</p> <p>Review of Resident #2's provider notes identified the following:</p> <p>*09/09/24 at 12:25 p.m., . She [Resident #2] also grabbed a male resident's genitalia and grabbed his [sic] CNA's buttocks.</p> <p>* 01/07/25 at unknown time, . Per nursing staff, on January 5, 2025, a male resident was found in this resident's room while she was lying in bed. His hand was under her covers, touching her.</p> <p>During an interview on 01/08/25 at 2:00 p.m., a random resident stated, one time she [Resident #2] tried touching me and I pushed her hand away. I was embarrassed because she was trying to touch down here (pointing at groin area). I try to avoid her in the dining room.</p> <p>During an interview on 01/08/25 at 4:34 p.m., a staff nurse (#5) stated, [Resident #2] is touchy/feely in the dining room. She tries to touch, blow kisses, and tries to get men to come to her.</p> <p>During an interview on 01/09/25 at 10:00 a.m., a NA [nurse aide] stated while walking toward the dining room, she saw [Resident #1] sitting in his wheelchair with his back to the doorway. The NA then walked up to the bed and observed [Resident #1] pulling his hands out from under the blankets. The NA looked at [Resident #2] and her face was red.</p> <p>During an interview on 01/09/25 at 1:20 p.m., an administrative nurse (#1) stated she was unaware of incidents between Resident #1 and #2, and incidents with other residents prior to the 01/05/25 incident and expected staff to report these behaviors.</p> <p>The facility failed to recognize Resident #1 and Resident #2's behaviors as sexual abuse and implement interventions to prevent the behaviors.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to report incidents of resident-to-resident abuse to the administrator and State Survey Agency (SSA) for 2 of 2 sampled residents (Resident #1 and #2) who exhibited sexual behaviors. Failure to report incidents of sexual abuse may result in unwanted physical and/or sexual contact and may cause all residents to experience fear, anxiety, and psychosocial harm.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse and Neglect - Rehab/Skilled occurred on 01/08/25. This policy, revised 07/22/24, stated, . Purpose . To ensure that residents are not subjected to abuse by anyone, including, but not limited to . other residents . To ensure that all identified incidents of alleged or suspected abuse/neglect . are promptly reported and investigated.</p> <p>-Review of Resident #1's medical record occurred on 01/08/25. Diagnoses included dementia. An admission MDS (Minimum Data Set), dated 11/05/24, identified mild cognitive impairment. The care plan, dated 01/05/25, states The resident has a behavior symptom R/T (related to) inappropriate sexual advances E/B (evidence by) entering vulnerable female resident room alone with inappropriate physical behaviors.</p> <p>-Review of Resident #1's progress notes identified the following:</p> <p>*11/06/24 at 11:33 a.m., . It was previously reported that he was found in her room, and her brief was pulled down.</p> <p>-Review of Resident #2's medical record occurred on 01/08/25. Diagnoses included dementia. A quarterly MDS, dated [DATE], identified severe cognitive impairment. The care plan, dated 09/10/24, stated, . The resident displays/has displayed inappropriate sexual advances towards other residents and staff.</p> <p>Review of Resident #2's progress notes identified the following:</p> <p>*10/26/24 at 2:54 p.m., It was reported that [Resident #2] was fondling this other resident's private area/groin.</p> <p>*11/05/24 at 4:55 p.m., Spoke with [name] (legal guardian), regarding reported incident . CNA [certified nurse aide] reported seeing a male resident [Resident #1's] in room and lifting her shirt up.</p> <p>*11/06/24 at 11:34 a.m., . It was also reported that this same [male] resident was found in [Resident #2's] room, and [Resident #2's] brief was pulled down.</p> <p>During an interview on 01/09/25 at 1:20 p.m., an administrative nurse (#1) stated facility staff failed to report the above incidents to the administrative staff therefore the incidents were not reported to the SSA.</p>		