| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355065 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunset Drive - A Prospera Community | 1011 Boundary St NW<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for timely medication administration for 7 of 7 sampled residents (Resident #1, # 2, #3, #4, #5, #6, and #7). Failure to administer medications in a timely manner may cause adverse effects for the residents. Findings include:The facility failed to provide a policy regarding timely medication administration.Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 834-835, stated, . administer the medication . at the correct time. Table 35.8 . Process of Administering Medications. NON-TIME-CRITICAL MEDICATIONS . Medications prescribed . within 1 hour before or after the scheduled time. - Review of Resident #1's medication administration record (MAR), dated May 2025 showed staff administered medications over one hour late on ten occasions.- Review of Resident #2's MAR dated May 2025 showed staff administered medications over one hour late on seven occasions.- Review of Resident #3's MAR dated May 2025 showed staff administered medications over one hour late on five occasions.- Review of Resident #4's MAR dated May 2025 showed staff administered medications over one hour late on eight occasions.- Review of Resident #5's MAR dated May 2025 showed staff administered medications over one hour late on ten occasions.- Review of Resident #6's MAR dated July 2025 showed staff administered medications over one hour late on two occasions.- Review of Resident #7's MAR dated July 2025 showed staff administered medications over one hour late on two occasions. During an interview on 07/09/25 at 11:35 a.m., an administrative nurse (#1) stated she expected staff to administer medications within one hour before and one hour after their scheduled time. |

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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