

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 02/05/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) investigation, and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopements from the facility for 1 of 1 closed resident record reviewed (Resident #1). Failure to provide adequate supervision and monitoring and respond to door alarms immediately resulted in Resident #1's elopement from the facility and may result accidents, such as hit by a car, and injury from prolonged exposure to cold temperatures. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the elopement. Findings include:Review of the initial FRI report stated, . 12/24/25 at 4:35 p.m. Resident was found at the gas station across the street. Resident was not injured and came back to the facility once found. Resident on 15-minute checks and wander guard placed on resident.Review of the final FRI investigation stated, 12/24/25 at 4:37pm Resident [#1] was seen by front desk receptionist [initials] following a non-related visitor out the front door. Receptionist [initials] stated the front door alarm beeped 2 times and the light flashed. Receptionist [initials] stated she called the nurse [nurse (#3)] on unit 2 asking if a resident was wearing orange jacket and hat. Nurse [#3] immediately walked down to the front door and went outside when another staff CNA [certified nurse aide] [initials] spotted nurse [#3] and informed nurse that she seen resident [#1] go to the gas station across the street and she was headed over to get him. When CNA [initials] arrived at gas station across street, resident was inside the gas station purchasing cigarettes, and another Travel CNA [initials] was also inside with the resident during this time.Review of Resident #1's medical record occurred on 02/05/26. The Minimum Data Set (MDS), dated [DATE], identified a Brief Interview of Mental Status (BIMS) of 13, indicating cognitively intact. The care plan, dated, 12/24/25, stated, The resident has potential for elopement R/T [related to] wandering aimlessly with no intentional reasoning of where he is going . Wander guard used to alert staff of resident's [sic] movements .Review of the facility's camera footage log for 12/24/25 identified Resident #1 followed a visitor out of the facility at 4:37 p.m. and returned at 4:48 p.m.During an interview on the afternoon of 02/05/26, a nurse (#3) stated the facility placed a wander guard on Resident #1 between 10:00 a.m. and 12:00 p.m. on 12/24/25 after he exited the secured courtyard. During an interview on the afternoon of 02/05/26, a CNA (#4) stated she saw Resident #1 walking on the street towards the gas station with a walker. The CNA pulled into the facility parking lot and the nurse (#3) flagged her down and asked her to go get the resident. The CNA (#4) drove to the gas station as Resident #1 purchased cigarettes, assisted him into her truck, and returned to the facility. During an interview on the afternoon of 02/05/26, an administrative nurse (#1) stated the facility initiated 15-minute checks for Resident #1 on 12/24/25 at 5:00 p.m. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for all residents who may be affected by the deficient practice as</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 355065
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follows:*Completed an investigation into Resident #1's elopement*Initiated 15 minutes checks for Resident #1*Ensured all wander guards alarmed and worked correctly*Educated all staff on 12/24/25 via Onshift messaging service which stated, All staff! Reminder to respond to alarms setting off the doors that everyone is responsible to respond immediately as they are there to protect our residents. Especially with the cold weather. EVERYONE IS RESPONSIBLE TO CHECK WHAT IS SETTING OFF ALARMS AND RESPOND IMMEDIATELY .		