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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Drive - A Prospera Community	1011 Boundary St NW Mandan, ND 58554

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, review of facility policy, and staff interview, the facility failed to complete an assessment and obtain a physician's order for self-administration of medications for 1 of 1 sampled resident (Resident #108) observed with medications at the bedside. Failure to evaluate the resident's ability to safely self-administer medications may result in medication errors and/or harm to the resident. Findings include: Review of the facility policy titled Resident Self-Administration of Medication occurred on 05/15/25. This policy, revised 10/29/24, stated, . Complete the Resident Self-Administration of Medications UDA [user defined assessment] to determine if the resident can safely administer medications . A physician's order must be obtained prior to the resident self-administering medications. Review of Resident #108's medical record occurred on all days of survey. The record lacked a facility assessment and physician's order for self-administration of medications. Observation on 05/12/25 at 10:52 a.m. identified two paper medication cups, one cup held several pills, one cup held one pill, and a tube of nystatin (an anti-fungal) cream on the resident's bedside table. During an interview on the afternoon of 05/15/25, an administrative nurse (#1) confirmed the facility failed to complete an assessment and obtain orders for Resident #108 to self-administer medications.

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observations, record review, and staff interview, the facility failed to promote care in a manner that maintained or enhanced residents' dignity for 1 of 27 sampled residents (Resident #2) and 1 supplemental resident (Resident #32) who required assistance with personal hygiene. Failure to ensure the residents face and positioning devices are clean, and doors are closed during toileting does not promote the resident's mental well-being or dignity. Findings include: - Review of Resident #2's medical record occurred on all days of survey. The current care plan identified assistance required for dressing, repositioning, and personal hygiene. Observations of Resident #2 showed the following: * 05/12/25 at 11:21 a.m., seated in a wheelchair in the day room and a chest vest positioning device soiled with debris. * 05/13/25 at 8:04 a.m., seated in a wheelchair at the dining table and a chest vest positioning device soiled with debris. * 05/14/25 at 7:44 a.m., seated in a wheelchair at the dining table with head down, a chest vest positioning device in place soiled with debris. * 05/15/25 at 8:25 a.m., seated in a wheelchair, a white substance noted on the left side of the resident's mouth and chin, and a chest vest positioning device soiled with debris. - Observation on 05/15/25 at 8:45 a.m. showed Resident #32's room door and bathroom door open, and the resident seated on the toilet and visible from the hall with no staff present. Review of Resident #32's medical record occurred on all days of survey. The care plan identified assistance of one required with toilet use. During an interview on 05/15/25 at 2:55 p.m., an administrative nurse (#1) stated she expected staff to keep doors closed during resident cares.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, review of facility policy, and resident interview, the facility failed to ensure reasonable accommodation of needs regarding call lights for 1 of 1 sampled resident (Resident #2). Failure to place call lights within reach may result in an inability to call for help, discomfort, increased falls, and/or incontinence.Findings include:Review of the facility policy titled Call Light occurred on 07/09/25. 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 resident. Review of Resident #2's medical record occurred on all days of survey. The care plan stated, . Resident is legally blind, describe location of items at bedside. non-ambulatory . Observations on 07/07/25 at 11:37 a.m. and 07/08/25 at 11:15 a.m. showed Resident #2 in bed and the call light placed on a chair located at the foot of the bed. When asked about the call light, Resident #2 stated, Every time they [facility staff] work with me, they move it there [the chair at the foot of her bed], and they forget to give it [call light] to me.The facility failed to ensure Resident #2's call light within reach at all times.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review, review of facility policy, and staff interview, the facility failed to provide a written notice of room change for 1 of 1 sampled resident (Resident #1) reviewed with a recent room change. Failure to provide the resident and/or resident's representative a written explanation of why a move is required prevents the resident and/or representative from making informed decisions significant to the resident's care. Findings include: Review of the facility policy titled Room/Roommate Change occurred on 07/09/25. This policy, dated 12/12/24, stated, . The resident has the right to receive written notice, including the reason for the change, before the resident's room . location is changed. Social services or a designated employee will discuss any proposed change in room with the resident and/or resident representative. The resident and/or representative must be given a reason for the move and provided the opportunity to see the new location and ask questions about the move. Review of Resident #1's medical record occurred on all days of survey and identified a room change. The record also identified the resident has a guardian to help with the resident care decisions. The record lacked evidence the facility notified the resident and/or resident representative of the room change.During an interview on 07/09/25 at 11:20 a.m., two administrative staff members (#1 and #2) confirmed Resident #1's medical record lacked evidence the facility notified or provided a written notice to the resident and/or resident representative of the room change.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to honor resident choices for 2 of 2 sampled residents (Resident #55 and #99) who had personal food items stored in the resident fridge. Failure to honor the resident's choice of personal food items at meals or when requested does not respect their autonomy or right to determine what is significant to their care and well-being. Findings include: Review of the facility policy titled, Safe Food Handling of Personal Food, Outside Food-Food and Nutrition occurred on 05/16/25. This policy, dated 05/13/24, stated, . Employees assist residents in accessing and consuming personal food if the resident is unable to do so on his or her own. Personal food is stored separate from the location's food. Review of a document in the facility admission packet titled Outside Food, occurred on 05/14/25. This undated document stated, Personal fridges are not allowed in individual rooms. Refrigerated food in small amounts can be stored in resident fridge in the main kitchen. All perishable containers of food must be labeled and dated with resident name when brought in or will be discarded. All perishable containers of food will be discarded after 3 days. - During an interview on 05/13/25 at 8:49 a.m., Resident #99 stated the facility lost or threw away food her son had brought into the facility. Observation of the kitchen occurred on 05/14/25 at 9:13 a.m. A dietary supervisor (#8), confirmed a fridge labeled Resident Food is for resident foods purchased or brought in by family. Observation showed foods are separated by facility unit and labeled with the resident's name and date brought in. The Resident Food fridge contained the following items belonging to Resident #99: * Plated dinner of meatloaf, mashed potatoes, and carrots dated 05/11/25. * Chicken fajitas dated 05/11/25. * Salmon patties dated 05/11/25. * Salisbury steak dated 05/11/25. During an interview on 05/14/25 at 11:27 a.m., a dietary supervisor (#8) stated a resident must request food from the Resident Food Fridge, dietary staff will bring the food to the resident, and access to the kitchen is available 24 hours a day. During an interview the morning of 05/14/25, Resident #99 stated she requested the salisbury steak meal yesterday (05/13/25), and staff told it was missing. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/25 at 1:18 p.m., a dietary manager (#8) confirmed Resident #99 had requested her salisbury steak meal last night and was told it was missing. The dietary manager (#8) stated she found it this morning, sent it to the resident for the evening meal, and the resident refused. - Observation on 05/14/25 at 10:29 a.m. showed two dietary staff members (#8 and #12) spoke with Resident #55 concerning access to personally purchased flavored coffee creamer from the resident food fridge in the main kitchen. The resident told the staff members (#8 and #12) nursing staff are too busy and won't go downstairs to get it [the creamer] and asked the dietary staff member (#12) if the creamer could be stored in the fridge on the second floor. The staff member (#12) stated there is not enough room in the fridge on the second floor and suggested the resident purchase individual containers of the flavored creamers to keep in his room. The resident stated, They [individual creamers] are too expensive. During an interview on 05/14/25 at 10:54 a.m., the dietary staff member (#12) confirmed staff should store the coffee creamer in the resident food fridge and deliver to him upon request. The facility failed to honor residents' choice/preferences for personal food items stored in the resident fridge.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to ensure the code level status accurately reflected the resident's wishes for 5 of 27 sampled residents (Resident #19, #80, #108, #111, and #119) reviewed for advance directives. Failure to ensure the medical record and other forms of communication accurately reflected the resident's code status limited the facility's ability to communicate to direct care staff and emergency personnel the resident's choice in the event of a medical emergency. Findings include: Review of the facility policy titled Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) occurred on [DATE]. This policy, dated, [DATE], stated, . To define a process to make resident decisions known. Residents have the right to formulate advance directives. Review of Resident #19's medical record occurred on all days of survey and identified palliative care (comfort care). Physician's orders, dated [DATE], stated, DNR/Do Not Attempt Resuscitation (Allow Natural Death), Limited additional Interventions . Transfer to hospital if indicated. A progress note, dated [DATE] at 2:14 p.m. , stated, . Family to update POLST (Physician Orders for Life-Sustaining Treatment) to no hospital transfer. Resident #19's progress notes dated [DATE] identified the following: * 7:33 a.m., Resident (#19) transferred to the emergency department (ED). * 7:44 a.m., an administrative nurse (#2) was notified of transfer. * 7:47 a.m., family notified of transfer and family questioned the transfer to the ED. * 7:50 a.m., an administrative nurse (#2) indentified the POLST on file, it stated comfort measures only. * 7:52 a.m., an administrative nurse (#2) notified the ED that the POLST sent with the resident was incorrect and [Resident #19] is on comfort measures only. During an interview on [DATE] at 8:30 a.m., an administrative nurse (#2) confirmed comfort cares for Resident #19 per the updated POLST completed approximately three months ago. - Review of Resident #80's medical record occurred on all days of survey and identified a physician's order which stated, ADVANCE DIRECTIVE: Do Not Resuscitate (DNR). The medical record identified the resident as not capable of making own decisions and has a guardian. The medical record lacked documentation that the facility discussed code status with the resident or the resident's representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #108's medical record occurred on all days of survey and identified a physician's order which stated, ADVANCE DIRECTIVE: Resuscitate (CPR). The medical record lacked documentation the facility discussed code status with the resident or resident representative. - Review of Resident #111's medical record occurred on all days of survey and identified a physician's order which stated, ADVANCE DIRECTIVE: Do Not Resuscitate (DNR). The medical record lacked documentation the facility discussed code status with the resident or resident representative - Review of Resident #119's medical record occurred on all days of survey and identified a physician's order which stated, ADVANCE DIRECTIVE: Resuscitate (CPR). The medical record lacked documentation the facility discussed code status with the resident or resident representative. During an interview on [DATE] at 4:46 p.m. an administrative nurse (#1) stated she expected staff to discuss code status/advance directives at the time of admission, at care conferences, and document the discussion in the medical record. She confirmed the medical records lacked documentation staff discussed the resident's code status/advance directive wishes with the resident or resident representative.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, review of facility policy, and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 4 of 27 sampled residents (Resident #14, #67, #69, and #99) and 2 supplemental residents (Resident #70 and #284). Failure to maintain a safe, clean, and sanitary environment may lead to injury from unsafe equipment, does not provide a homelike living area for residents, and does not promote quality of life. Findings include: Review of the facility policy titled Preventative Maintenance-Affordable Housing occurred on 05/15/25. This policy, dated November 2024, stated, . provide a safe environment for our residents . a preventative maintenance program will be implemented to promote the maintenance of buildings and equipment in a state of good repair and condition and free from safety hazards. - Observations on 05/12/25 identified the following: *10:20 a.m., A strong urine odor in Resident # 99's room. *11:50 a.m., Resident #284's bed stripped of all linens. *10:22 a.m., A strong urine odor and a sticky bathroom floor in Resident #70's room. * 10:26 a.m. showed Resident #69's oxygen concentrator covered with dust and the air intake/filter area covered with dust and hanging dust particles. *10:34 a.m., Resident #14's floor dirty with stains and debris. *2:17 p.m., Resident #284's bed stripped of all linens. - Observations on all days of survey showed missing or torn wallpaper approximately 40 inches in length by 15 inches in height behind Resident #69's head board, and dried food particles on the floor. During an interview on 05/14/25 at 5:16 p.m., an administrative nurse (#1) stated she expected staff to immediately place maintenance requests in the maintenance binder. During an interview on 05/15/25 at 8:40 a.m., a managerial staff member (#3) confirmed the maintenance binder did not have a request to fix the wallpaper in Resident #69's room. - Observations on all days of survey showed Resident #67's overbed table had about a six inch area of cracked/raised/peeling laminate on the top and around all edges of the table and water stains on two ceiling tiles above the resident's bed. The maintenance binder failed to contain a request for the repairs. During an interview on 05/15/25 at 9:42 a.m., a staff nurse (#9) confirmed the poor condition of the overbed table and the ceiling tile stains.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of a facility reported incident (FRI), review of facility investigative reports, and staff interview, the facility failed to ensure residents remained free from abuse for 2 of 2 sampled residents (Resident #47 and #76) with impaired cognition who displayed sexual behaviors towards other residents. Failure to protect residents from sexual abuse may result in fear, anxiety, mental anguish, and physical injury. Findings include: Review of the facility policy titled Abuse and Neglect occurred on 05/15/25. This policy, dated 07/22/24, stated, . PURPOSE: To ensure . an effective system in place that . prevents mistreatment, neglect, exploitation and abuse of resident . The resident has the right to be free from abuse, neglect . and exploitation. Residents must not be subjected to abuse by anyone, including . other residents . Review of a FRI, dated 03/03/25, indicated a medication aide (MA) prepared medications near the dining room and observed Residents #47 and #76 seated at opposite ends of the dining room (approximately 25 feet apart). The MA left to administer the medications, and when she returned, Resident #76 seated next to Resident #47, and Resident #76 kissed Resident #47 on the lips. Review of an undated investigative report related to a resident-to-resident incident, stated, . 4/20/25 at 2200 [10:00 p.m.] [nurses name] reported: taff [sic] saw [Resident #76] coming out of [a] females [Resident #47's] room on his hands and knees. When he [sic] asked him 'what are you doing?' He replied 'oh just getting some exercise I guess.' When staff looked in on [the] female resident [Resident #47] her knees were elevated and she was wide awake. When asked [Resident #76] what was he doing in [the] females [sic] resident [sic] room, he stated, 'I just went to go say hi to her.' Asked 'why would he go into a females [sic] room late at night when she was already asleep when he could say hi in the morning.' He stated, 'oh I suppose I could have.' . When asked [Resident #76] if he kissed [the] female resident and where it was he stated, 'yes on the lips.' When asked if he touched [the] female resident and where, he stated, 'yes I only held her hand.' . When asked [the] female resident [Resident #47] if [Resident #76] touched her . kissed her she mouthed 'no' and shook her head back and forth. When asked what was [Resident #76] doing in her room she mouthed, 'I don't know.' When asked 'was he just crawling on your floor?' she mouthed 'yes' and shook her head up and down. - Review of Resident #47's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. A quarterly Minimum Data Set (MDS), dated [DATE], identified severely impaired cognition. The care plan stated, . MOOD/BEHAVIOR . sexual behavior toward others including grabbing . BEHAVIOR: The resident displays/has displayed inappropriate sexual advances towards other residents and staff including crude gestures and grabbing others' private areas. Per guardian: resident to not [sic] alone with males in her room due to cognition and lack of safety awareness. Monitor the involved residents and know their whereabouts. Provide involved residents with opportunities for socialization in supervised areas. Ensure alarm on door is working, door open and stop sign is in place over door when resident is in her room alone. No male residents to be left alone with resident within 5 feet without supervision. Check every 15 minutes to ensure resident not alone with a male resident. Staff to redirect any sexually inappropriate advances by resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 04/23/25 at 9:20 a.m., stated, . [Resident #47] and I discussed an incident that was reported the night of 4/20 [2025]. When asked if the incident happened, resident could not remember. - Review of Resident #76's medical record occurred on all days of survey. Diagnoses included dementia. A quarterly MDS, dated [DATE], identified moderately impaired cognition. The care plan stated, . SEXUAL BEHAVIOR: The resident may display physical affection toward female peers such as being close to one another or touching or kissing. Resident has history of wandering into female rooms. Behavior contract in affect [sic]. Contract was gone over, approved my [sic] resident and signed. Monitor the involved residents and know their whereabouts. Door alarm to resident room to monitor wandering . Redirect resident if in female resident [sic] room. Resident not to be left alone with female resident in unsupervised areas. Provide involved residents with opportunities for socialization in supervised areas.' Resident #76's progress notes included the following: * 04/23/25 at 9:04 a.m., . [Resident #76] and I discussed an incent [sic] that occurred the night of 4/20. He admitted to crawling under the door alarm and 'stop' sign outside a female resident's room, holding her had [sic], and kissing her . * 05/04/25 at 1:37 p.m., . New dietary staff unaware of res [Resident #76] not being close to female residents. CNA [certified nurse aide] saw res [Resident #76] sitting next to a resident [Resident #47] in dining room and that his hand was on [Resident #47's] knee area. When [sic] CNA told [sic] dietary staff that res wasn't allowed within 5 feet of a male, [Resident #76] stood up and went back to his room. The facility failed to ensure Residents #47 and #76 and all other residents remained free from potential sexual abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and review of facility policy, the facility failed to report incidents of potential abuse to the State Survey Agency (SSA) for 2 of 2 sampled residents (Resident #47 and #76) who displayed sexual behaviors towards other residents. Failure to report events of potential sexual abuse to the SSA placed Resident's #47 and #76 and all other residents at risk for possible abuse, mental and emotional distress, and/or physical injury. Findings include: Review of the facility policy titled Abuse and Neglect occurred on 05/15/25. This policy, dated 07/22/24, stated, . Residents must not be subjected to abuse by anyone, including . other residents . Results of all investigations will be reported . to the state survey and certification agency within five working days of the incident, or sooner as designated by state law . - Review of Resident #47' medical record occurred on all days of survey. A progress note, dated 04/23/25 at 9:20 a.m., stated . [Resident #47] and I discussed an incident that was reported the night of 4/20 [2025]. When asked if the incident happened, resident could not remember. - Review of Resident #76's medical record occurred on all days of survey. A progress noted, dated 04/23/25 at 9:04 a.m., stated, . [Resident #76] and I discussed an incent [sic] that occurred the night of 4/20. He admitted to crawling under the door alarm and 'stop' sign outside a female resident's [Resident #47's] room, holding her had [sic], and kissing her . The facility failed to report the incident between Resident #47 and #76 as potential abuse to the SSA.

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Sunset Drive - A Prospera Community	1011 Boundary St NW Mandan, ND 58554

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and review of facility policy, the facility failed to provide the resident or their representative and the State Long Term Care Ombudsman a written notice of transfer and bed-hold notice for 1 of 5 sampled residents (Resident #37) reviewed for hospitalizations. Failure to provide a notice of transfer and a bed-hold notice does not allow the resident and/or their representative to make informed decisions regarding their rights, or inform the Ombudsman of the transfer. Findings include: Review of the facility policy titled Discharge And Transfer occurred on 05/15/25. This policy, dated 03/28/25, stated, . Before a location transfers . the location must: 1. Notify the resident and the resident's representative of the transfer . in writing . the location must send a copy . to a representative of the Office of the State Long-Term Care Ombudsman . Review of the facility policy titled Bed-Hold occurred on 05/15/25. This policy, dated 12/19/24, stated, . PURPOSE: To ensure that the resident/resident representative is made aware of the facility's bed hold and reserve bed payment policy before and upon transfer to a hospital . To determine if resident/resident representative wants to hold the bed. POLICY: At the time of . transfer . the location will provide written information to the resident or resident representative . of the state bed-hold policy . Review of Resident #37's medical record occurred on all days of survey. The record identified a hospitalization on January 30, 2025 through February 2, 2025. The facility failed to complete and/or provide the resident/resident representative with a written notice of transfer and a written bed-hold notice and failed to provide the State Ombudsman a copy of the transfer notice.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and review of the federal database for Long-Term Care Survey, the facility failed to ensure timely electronic data submission of required Minimum Data Set (MDS) assessments for 1 of 27 sampled residents (Resident #281). Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.19), page 2-33 and 2-34, stated, Non-Comprehensive assessments and Entry and Discharge Reporting Discharge Assessment - Return Anticipated . The MDS must be transmitted . electronically no later than 14 calendar days after the MDS completion date . Page 2-38 stated, Entry Tracking Records . Must be submitted no later than the 14th calendar day after the entry . Page 5-1 stated, . All Medicare and/or Medicaid-certified nursing homes . must transmit required MDS data records to CMS' [Center for Medicare and Medicaid Services] Internet Quality Improvement and Evaluation System (iQIES) Assessment Submission and Processing (ASAP) system. Page 5-2 stated, . Comprehensive [admission, annual, and significant change in status] assessments must be transmitted electronically within 14 days of the Care Plan Completion Date . Review of Resident #281's medical record occurred on all days of survey and identified the following: * A discharge return anticipated MDS with a completion date of 03/14/25 and transmitted to iQIES 04/01/25 (4 days late). * A discharge return anticipated MDS with a completion date of 04/07/25 and transmitted to iQIES 04/24/25 (3 days late). * An entry tracking MDS dated [DATE] and transmitted to iQIES 05/09/25 (18 days late). *A significant change in status MDS with a care plan completion date of 04/25/25 and transmitted to iQIES 05/12/25 (3 days late). During an interview on 05/14/25 at 3:26 p.m., an administrative nurse (#11) confirmed the facility transmitted Resident #281's MDSs late.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 6 of 27 sampled residents (Resident #2, #27, #55, #66, #67, and #119) and 1 supplemental resident (#59). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled Care Plan-R/S, LTC, Therapy & Rehab occurred on 05/15/25. This policy, dated December 2024, stated, Each resident will have an individualized, person-centered, comprehensive plan of care . The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. - Review of Residents #2, #27, #55, #59, #66, #67, and #119 medical records occurred on all days of survey and identified diagnoses of diabetes, and physician's orders for insulin. These residents' care plans lacked signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) to be monitored and interventions to treat hypoglycemia and hyperglycemia. Resident #67's diagnoses also included a foot ulcer with enhanced barrier precautions (EBP) in place. The resident's care plan failed to include a problem, goals, and interventions for EBP. During an interview on 05/15/25 at 12:44 p.m., an administrative nurse (#1) confirmed staff failed to update the residents' care plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 1. Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 1 supplemental resident (Resident #284) observed during insulin preparation. Failure to properly prime insulin pens may result in the resident receiving an inaccurate dose of insulin. Findings include: Review of the facility policy titled Medication: Insulin Administration, Insulin Pens, Insulin Pumps occurred on 05/14/25. This policy, dated 09/05/24, stated, . Insulin Pen: . Turn the dosage knob to '2' units to prime the pen. Observation on 05/13/25 at 12:16 p.m. showed a facility nurse (#10) prepare an insulin pen for Resident #284. After placing a new cap on the pen, the nurse (#10) dialed the insulin pen to the prescribed dose without priming the pen. When asked if she had primed the pen, the facility nurse (#10) stated she never primes an insulin pen. During an interview on 05/13/24 at 12:20 p.m., an administrative nurse (#2) confirmed staff should prime insulin pens before dialing to the prescribed insulin dose. 2. Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 27 sampled residents (Resident #27 and #281). Failure to obtain, follow, and transcribe provider's orders may result in adverse health effects. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, Nurses are expected to analyze procedures . ordered by the physician or primary care provider. If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. Review of the facility policy titled Physician/Practitioner Orders-Rehab/Skilled occurred on 05/15/25. This policy, revised 04/16/25, stated, . Transcribing/Processing Orders. Orders are processed and transcribed into PCC [PointClickCare]. immediately upon receipt of an order. - Review of Resident #27's medical record occurred on all days of survey. Provider's orders, dated 05/02/25 and 05/06/25, stated, . continue to utilize . Dexcom G7 CGM [Continuous Glucose Monitoring] system to monitor glucose continuously. ensure . phone/receiver is within 20 feet of . sensor at all times to ensure integration of the system. If readings are significantly different than symptoms . then a fingerstick glucose reading should be performed . If Dexcom CGM is reading above 300 mg/dl [milligrams per deciliter] or below 70 mg/dl, a fingerstick glucose reading should be performed . to make sure the appropriate treatment is administered. The medical record lacked evidence facility staff transcribed the orders into electronic health record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 2:55 p.m., an administrative staff member (#1) confirmed staff failed to transcribe the orders to Resident #27's electronic health record (orders, medication administration record, and care plan). - Review of Resident #281's medical record occurred on all days of survey. Diagnoses included anxiety disorder. A physician's order, dated 07/02/24, identified lorazepam (anti-anxiety medication) 0.5 milligrams (mg) every six hours as needed (PRN) for anxiety and 0.25 mg as needed for anxiety 30 minutes prior to therapy for 90 days. The order identified a stop date of 09/03/24. A nurse's note, dated 10/07/24 at 1:40 p.m., stated, . Resident was given a dose of PRN Lorazepam 0.25mg [sic] following a catheter exchange due to increased anxiety. After administered this writer . noticed that this medication was no longer listed in the TAR [treatment administration record]. After verifying orders it was discovered that the current order for the medication had endedon [sic] 9/30/24. During an interview on 05/15/25 at 9:29 a.m., an administrative nurse (#1) confirmed the nurse administered the medication without an active order.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and resident and staff interview, the facility failed to ensure residents received the necessary services to maintain personal hygiene for 4 of 27 sampled residents (Resident #2, #29, #55, and #76) and 2 supplemental residents (Resident #88 and #120) who required staff assistance for bathing. Failure to aid residents who cannot perform the bathing and nail care task independently may result in poor hygiene, skin related issues, and decreased self-esteem. Findings include: The facility failed to provide a policy. - Random observations of Resident #2 on all days of survey showed Resident #2's fingernails extended approximately one fourth inch beyond the finger with dark debris under the nails. Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, . The resident has an ADL [activities of daily living] self care performance deficit . BATHING: Resident requires assist x 1 [times one staff] will receive a minimum of one bed bath/shower/bath per week . PERSONAL HYGIENE: Resident requires assist x 2 [times two staff] . Review of the Resident #2's spa/bathing schedule identified showers scheduled twice per week on Monday and Thursdays. The May 1-15, 2025 bathing record identified the resident received one of four scheduled showers and one bed bath. - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included seborrheic dermatitis (scaly patches/dandruff). The care plan stated . Resident will receive a minimum of 1 bath choice, complete bed bath or shower, per week . Review of Resident #29's spa/bathing schedule identified baths scheduled twice per week on Mondays and Fridays. The April 1-30, 2025 bathing record identified the resident received three of eight scheduled baths. The May 1-15, 2025 bathing record showed the resident received two of four scheduled baths. During an interview on 05/12/25 at 1:49 p.m., Resident #29 identified the following: - No bath in over a week. - Always the last to be bathed because of 2 assist with a full body mechanical lift. - Facility short staffed. - Scalp dandruff gets worse and itches due to lack of showering and hair scrubbed. - Feels left behind and forgotten because of not bathing. Observation during the resident interview showed the resident's hair was greasy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #55's medical record occurred on all days of survey. Diagnoses included candidiasis (fungal infection) of the skin, eczema (inflamed skin), and xerosis cutis (severe dry skin). A physician's order, dated 10/23/24, stated, Resident to receive shower on Mondays and Fridays . at 1330 [1:30 p.m.] . The care plan stated, BATHING: Resident requires 2 staff assist with total lift to get onto shower bariatric shower chair. Requires 2 staff at all times. During an interview on 05/12/25 at 3:50 p.m., Resident #55 stated the following: * Just this morning they [nursing staff] came in [my room]. I asked about my shower today [Monday]. I was told I was given a shower on Friday and she only had to sponge bath me. * She [staff member] said there wasn't a shower aide here today. I did not get a shower today at all. * According to [nurse manager's name], the facility is only required to give a shower once a week. * If I don't accept [the sponge bath on scheduled showered days] I am basically refusing. I say no, I need a shower. * I do not feel clean with a sponge bath. Review of Resident #55's spa/bathing schedule identified showers scheduled twice per week on Mondays and Fridays. The May 1-15, 2025 bathing record showed the resident received 2 of the 4 physician ordered showers, no bed baths, and no refusals. - Review of Resident #76's medical record occurred on all days of survey. The care plan stated, . BATHING: Requires assist x 1 for shower. Independent with sponge bathing. A care plan intervention, dated 03/19/25, stated, Will receive a minimum of one bed bath or shower per week . During an interview on 05/13/25 at 9:24 a.m., Resident #76 stated, I am supposed to have showers on Tuesday and Thursday. Sometimes I go a week or so without a shower. Review of Resident #76's spa/bathing schedule identified showers scheduled twice per week on Tuesdays and Fridays. The May 1-15, 2025 bathing record showed the resident received 2 of 4 scheduled showers, no bed baths, and no resident refusals. - Review of Resident #88's medical record occurred on all days of survey. The care plan stated, . BATHING: Resident requires assist x 1 for all bathing. A care plan intervention, dated 02/13/25, stated, Minimum one shower or bed bath each week. During an interview on 05/12/25 at 12:13 p.m., Resident #88 stated, One week they didn't shower me for 10 days. They said I denied it. That is not true. I never deny my showers. Smelling like [slang words for bowel and urine] during therapy is no good. Review of Resident #88's spa/bathing schedule identified showers scheduled twice per week on Wednesdays and Saturdays. The May 1-15, 2025 bathing record showed the resident received 3 of 4 scheduled showers. The resident indicated he did not receive one of the three documented showers. The spa record showed no baths or refusals. The charting conflicts with the resident's statement. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of Resident #120's medical record occurred on all days of survey. The nursing assistant care card (Kardex) stated, . Resident requires assist x 1. The care plan stated, . Resident requires one bed bath/whirlpool/shower per week . Review of Resident #120's spa/bathing schedule identified baths scheduled twice per week on Wednesdays and Saturdays. The May 1-15, 2025 bathing record showed the resident received one of four scheduled baths. During an interview on 05/12/25 at 11:24 a.m., Resident #120 stated baths are on Wednesdays and Saturdays and he/she has had no bath in over a week due to the facility's lack of staff. The resident's daughter came to the facility and provided the shower on 05/11/25. The resident voiced concerns regarding the next scheduled bath on 05/14/25 as he/she had a planned outing with family and did not want to smell. During an interview on 05/14/25 at 7:44 a.m., a staff member (#24) stated bath aides are scheduled Monday, Wednesday, and Friday and the spa/bathing schedule identifies which days the bath aids complete resident baths/showers, which baths/showers completed by the floor staff, and which baths/showers completed on the evening shift. During an interview on 05/14/25 at 1:49 p.m., when asked the difference between a sponge bath and bed bath, the certified nurse aide (CNA) (#21) stated, Oh there is a big difference between them. A sponge bath is when we [CNAs] provide the resident a washcloth to wash their face, eyes, and arm pits. A bed bath is when we [CNAs] have a basin of water, and we [CNAs] do the entire body. During an interview on 05/15/25 at 11:15 a.m., a nursing staff member (#10) confirmed resident baths or showers were not completed on 05/14/25 due to lack of staff, and today (05/15/25) the facility could not guarantee residents would receive a bath or shower because of a lack of a bath aide.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and resident and staff interviews, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and preferences for 1 of 27 sampled residents (Resident #76) and 1 confidential resident (Resident I). Failure to provide meaningful activities for residents limits their ability to reach their highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled Activity Services Calendar occurred on 05/15/25. This policy, dated 12/30/24, stated, . The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities . to meet the interests of and support the physical, mental, and psychosocial well-being of each resident . The activity services calendar of events will be based on resident interests and abilities as well as the care plan goals and interventions . - Review of Resident #76's medical record occurred on all days of survey. A comprehensive Minimum Data Set (MDS), dated [DATE], identified doing favorite activities and group activities are very important. The care plan stated, . Resident's preferred activities are . Games in the evening with other residents, such as cards, dice games. During an interview on 05/13/25 at 9:24 a.m., Resident #76 stated, I wish there were more organized evening activities like Yahtzee and cards. The resident stated evening card games must be self-initiated with other residents on the unit. - Review of Resident I's medical record occurred on all days of survey. A comprehensive MDS, dated [DATE], identified doing favorite activities, group activities, and going outside are very important. The care plan stated, . Resident likes: Watching TV, visiting peers, Puzzles, visiting with staff, newspaper. During an interview on 05/12/25 at 11:25 a.m., when asked about evening activities, Resident I stated, [There's] Nothing. Review of the March 1, 2025 through May 31, 2025 activity calendars showed no scheduled evening activities. During an interview on 05/14/25 at 11:49 a.m., an activity staff member (#17) confirmed there were no scheduled evening activities over the past three months unless resident initiated.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure 1 of 2 sampled residents (Resident #6) reviewed for limited range of motion received restorative services as per care plan. Failure to consistently provide restorative nursing/therapy services may adversely affect the resident's ability to maintain their range of motion (ROM). Findings include: Review of Resident #6's medical record occurred on all days of survey. Diagnosis included Parkinsons's disease and abnormal posture. A quarterly Minimum Data Set (MDS), dated [DATE], identified impairment to upper and lower extremities (arms and legs) bilaterally. The current care plan stated, . Resident has a need for restorative intervention R/T [related to] contractures from Parkinsons. Arm and leg exercises both sides. Range of motion [ROM] exercises provided weekly or bath/shower days as available. Stuffed animal to be placed in hands for contractures. Observation of Resident #6 occurred on all days of survey and identified the resident's hands severely contracted in a gripping position, arms tight to chest, and feet pointed downward bilaterally. Observation showed no adaptive devices/stuffed animals in place to the resident's hands or feet. During an interview on 05/15/25 at 8:30 a.m., a certified nurse aide (CNA) (#13) stated the bath aid is to do any ROM that is noted in the white binder in the bath house, and confirmed she is not aware of a ROM program for Resident #6. Review of the white binder in the bath house on 05/25/25 confirmed no documentation for ROM for Resident #6. During an interview on 05/15/25 at 10:26 a.m., a CNA (#14) stated she is unable to open Resident #6's hands to clean them related to contracture and confirmed arm mobility is very limited bilaterally. During an interview on 05/15/25 at 10:30 a.m., a CNA (#15) stated it is very difficult to clean Resident #6's inner hands related to contractures, and stated there is a good chance the resident has skin breakdown to her inner hands. Staff failed to implement interventions for contractures (ROM exercises and the use of staffed animals) as care planned.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility reported incident (FRI) and investigation, and resident and staff interviews, the facility failed to provide appropriate supervision and/or assistance to prevent an accident for 1 of 1 sampled resident (Resident #55) injured during a facility van transport. Failure to ensure the power control to the motorized scooter (wheelchair) is turned off during transport resulted in an injury to Resident #55's foot and placed all residents with motorized wheelchairs at risk for injury during transports. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings include: The surveyor determined a deficient practice existed on 02/28/25. The facility implemented and completed corrective action on 03/05/25. Review of Resident #55's medical record occurred on all days of survey. Diagnoses included quadriplegia, immobility, and right foot fracture. The care plan stated, . AMBULATION: Does not ambulate at this time. Resident has proven sufficient in steering his motorized wheelchair independently. Review of the FRI, dated 02/28/25 at 2:20 p.m., stated, Van driver [name] stated that while transferring resident in [the] transportation van, resident was seated in a motorized scooter, in locked position and strapped/seat belted appropriately. The motorized scooter power was not shut off. While van was in motion, the van slowed down, the chair was propelled forward by resident accidentally hitting the forward button causing the chair to move slightly forward. The motorized scooter foot board hit the chair in front of the resident and slightly lifted up toward the resident causing it to hit the resident's right foot. The resident then moved his foot off the foot board and rested it on the van wall ledge. When the resident arrived to his scheduled appointment at the clinic he stated to them his pain of his right foot and what had occurred. The clinic ordered an xray [sic] to be completed and was completed on 02/28/27 [sic]. The xray [sic] finalized 3/4/25 and released with findings inconclusive stating unable to tell if non-displaced [foot bones remain in place] fracture vs [versus] advance bone demineralization. and would require further testing. Provider [name] notified and has no additional orders on 3/4/25. [Provider name] stated she would see resident on 3/5/25 for further evaluation. Review of the x-ray results, completed on 03/09/25, identified a healing change to the first metatarsal head [foot bones] fracture, fracture line remains visible. The facility final report investigation stated, Staff [van driver's name] failed to ensure that the motorized wheelchair power was turned off after she securely buckled/hooked the motorized scooter in place before she put the van in motion. [Van driver's name] was educated immediately after this was reported to administration when she returned to the facility after dropping [Resident #55's name] off for his appointment. All Staff who operate the van were immediately educated and weekly audits will be performed. Resident is able to turn on and off his motorized scooter and utilize his scooter independently . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/12/25 at 3:50 p.m., Resident #55 stated, She [van driver] did nothing negligent. It was an accident. The facility failed to ensure Resident #55's motorized wheelchair control was in the off position prior to transporting the resident. Based on the following information, non-compliance is considered past non-compliance. The facility implemented corrective actions for other residents who may be affected by the deficient practice as follows: * Completed an investigation in Resident's #55's incident and injury. * Provided immediate education to van driver (#27) involved in the incident on 02/28/25. * Educated all van drivers, either in person or by telephone, prior to operation of the van. Last person educated on 03/05/25. * Competency for all van drivers reviewed and in place, dated 07/30/24 through 01/02/25. * Implemented audits for van transports with motorized wheelchairs.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and resident interview, the facility failed develop an effective pain management regimen and schedule routine pain medications to meet residents' needs for 1 of 3 sampled residents (Resident #67) reviewed for pain management. Failure to develop and implement an acceptable and manageable pain management plan resulted in unresolved pain and discomfort. Findings include: Review of the facility policy titled Pain Management occurred on 05/15/25. This policy, dated 01/31/25, stated, . The licensed nurse will review response to medication intervention and work closely with the physician to assist in the individualized pain management plan. The nurses working directly with residents must continually monitor and observe the resident for success of the pain management plan and report to the nurse manager and prescriber as necessary to keep the resident comfortable. a pain management plan should be person centered . The interdisciplinary team and nurses must have ongoing communication with the resident and monitor and evaluate the pain management plan. Include the resident's goal for control of his or her pain. Review of Resident #67's medical record occurred on all days of survey. Diagnoses included neuropathy [nerve pain], above the knee amputation, and chronic foot ulcers. Medications included acetaminophen 650 milligrams (mg) every 6 hours as needed (PRN) for mild pain, oxycodone (a narcotic) 5 mg PRN every 4 hours for moderate to severe pain, and scheduled gabapentin (treats nerve pain) 300 mg in the morning and 600 mg at bedtime. The care plan stated, . The resident has acute pain/discomfort R/T [related to] RAKA [right above the knee amputation] E/B [evidenced by] resident complaints of pain . Goal. Resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain . During an interview on 05/12/25 at 11:47 a.m., Resident #67 stated pain pretty much all over and I have to ask for it [pain medication] and on 05/14/25 at 9:38 a.m., stated hurting all over. The resident identified acetaminophen does not work as well as oxycodone and wishes the medication was scheduled so she would not have to ask for it all the time. Observation during a dressing change to Resident #67's left foot occurred on 05/15/25 at 9:23 a.m. The resident reported right stump phantom pains. Observation throughout the dressing change showed the resident continually moved the stump up, down, and in circles with facial grimacing. When finished, the resident requested a pain pill and rated the pain an 8 out of ten. The record showed the resident received an oxycodone. Review of a significant change Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition and a pain rating of 10 of 10, with pain almost constantly which frequently affected sleep, interfered with therapy activities, and limited day to day activities. Review of Resident #67's progress notes showed the following: * 03/12/25 at 2:32 p.m., . MDS interview completed . Resident confirmed pain in bilateral [both] legs 10/10 [10 of 10] almost constantly. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 04/08/25 at 10:08 a.m., . MDS interview completed . Resident confirms pain almost constantly in lower back 10/10 . Review of Resident #67's April 2025 and May 01-12, 2025 Medication Administration Record (MARs) identified PRN oxycodone administered 67 times and acetaminophen administered eight times. The facility failed to evaluate the resident's pain, notify the provider of the frequent use of PRN pain medications, and consider scheduled pain medications.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of resident council meeting minutes, confidential resident interviews, and staff interviews, the facility failed to ensure sufficient nursing staff and related services are available at all times to meet the residents' needs for 7 of 27 confidential residents (Resident A, B, E, H, I, J, and K) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights, physical, mental, and psychosocial well-being, and/or provide a safe environment for the residents. Findings include: Review of the Resident Council meeting minutes, dated 01/13/25 through 04/24/25 identified the following: * 02/23/25, . Staff turning off call lights without meeting the residents needs continue to be addressed as well as call light times. * 02/27/25, . There were several complaints about CNAs [certified nurse aides] turning off lights and not coming back. Residents feel that the call light times are lengthy nursing will look into this issue and report back. * 03/31/25, . There were several complaints about CNAs turning off lights and not coming back. Residents feel that the call light times are a little better but are still lengthy at times. Nursing is looking into call light times. * 04/24/25, . There remain complaints about CNAs turning off calls [sic] lights and not coming back. Confidential interviews conducted during the survey identified the following: * Resident A stated, Staffing is terrible, they are short CNAs and dining servers all the time. * Resident B stated, I was not offered to shower due to being short staffed. I'm supposed to shower on Wednesday & Saturday and have not had one for over a week. My daughter came in and showered me. They are also short on dining room servers. * Resident E stated, There wasn't a shower aide here today. There is constantly not enough help. * Resident H stated the facility is always short staff. He waited approximately 40 minutes for his call light to be answered and I [slang word for bowel] myself twice because they didn't come for almost an hour. That was humiliating for me to ever experience that. That depressed me. After a fall, I laid there for probably 20 minutes on the floor for help. * Resident I stated he feels concerns addressed with staff and during resident council meetings go in one ear and out the other. I don't say nothing [sic] anymore. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Resident J identified long call light times and stated It took an hour yesterday. They come in to see what I need and then will be gone 30 minutes to an hour before they come back. * Resident K stated, My last shower was over a week ago, I know it is because they are short staffed, but I still feel forgotten, and it makes the dandruff on my head worse when I do not shower and get my head scrubbed. I wish they would get enough staff so I could get my showers. * A confidential staff member (A) stated the activity department is short staffed. * A confidential staff member (B) stated, Right now, bath aids are always pulled to the floor to work so residents are not getting scheduled baths. During resident council it comes up that staff are always turning off call lights, not helping, and not getting baths. The kitchen serves one or two units from the main kitchen because of short staffing so when the food gets to the residents it is cold, and the residents are complaining. Refer to citations F557, F561, F578, F640, F677, F679, F688, and F804.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 1 of 1 sampled resident (Resident #67) with a medication not held prior to scheduled surgery. Failure to accurately transcribe and follow physician's orders may result in adverse health consequences and/or delayed treatment for the resident. Findings include: Review of the facility policy titled Medication Errors occurred on 05/15/25. This policy, dated 04/08/25, stated, Definitions . Significant Medication Error: One which causes the resident discomfort or jeopardizes his or her health and safety . Medication Error Types . Transcription Error: Inaccurate transcription of an order. Review of Resident #67's medical record occurred on all days of survey. A physician's order, dated 05/09/25, stated, preop [preoperative {before surgery}] instructions for surgery on 5/16/25. hold . ASA [aspirin] . 5 days before surgery. Review of Resident #67's May 2025 medication administration record (MAR) identified the facility failed to hold the aspirin on May 11th, 12th, and 13th, 2025 per physician's orders (until the surveyor brought the medication error to the attention of nursing). During an interview on 05/13/25 at 4:49 p.m., a nurse manager (#26) confirmed staff failed to accurately transcribe and hold the aspirin starting on 05/11/25.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, review of resident council meeting minutes, and resident and staff interviews, the facility failed to serve foods at palatable temperatures in 4 of 4 units (Sunset, Edgewater, Grandview, and [NAME]). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled Food Temperature Monitoring - Food and Nutrition Services occurred on 05/15/25. This policy, revised 12/16/24, stated, . Proper serving temperature - a temperature that is . appetizing to the resident . this is the temperature when the food reaches the resident. Test tray monitoring occurs as part of quality assurance monitoring to ensure temperatures are acceptable when the location uses room trays or satellite dining rooms. Test tray is checked after all residents have been served. Confidential resident interviews conducted during the survey identified the following: * Resident A identified staff set trays down before the residents are able to sit down to eat and the food gets cold. * Resident B identified the food is not always good. Sometimes the food is cold. They are short on servers, I don't want to ask them to warm my food, I don't want to be a problem. * Resident C stated, The food is terrible. It's always the same thing. The food is never hot. * Resident D stated, The food is not hot when you get it. * Resident E stated, The infection control [staff] says they cannot take my plate from my room to heat it up again. * Resident F stated, Food is cold and it takes awhile. * Resident G stated, Food is awful. Ice cold. Review of resident council meeting minutes, dated 01/13/25 through 03/31/25 occurred on the afternoon of 05/12/25 and identified the following: * 01/13/25 . they [residents] still sometimes get cold food. [dietary manager] will continue education and make sure staff is temping [taking food temperatures]. * 02/27/25 . Food is coming out cold . * 03/31/25 . The food is coming cold more often than not. Residents asked about hot plates for food. The dietary manager will provide education to staff and look into how food can be served warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/13/25 at 4:32 p.m. showed a dietary aide (#23) transferred the evening meal, covered with foil from the main kitchen to the Grandview dining room on an open cart. The dietary aide failed to obtain food temperatures before placing food on the steam table. The dietary aide indicated no education on or knowledge of when to take the food temperatures. When asked how room trays are delivered, the dietary aide stated, I just load up the cart with whatever fits and then they [staff] take them to the [resident] rooms. During an interview on 05/13/25 at 5:03 p.m., two dietary managers (#8 and #22) stated they expected staff to obtain food temperatures at the beginning and end of the meal service. During an interview on 05/14/25 at 8:44 a.m., a dietary manager (#8) indicated staff had not completed a test tray quality assurance regarding palatability/temperatures. The dietary manager identified she expected staff to place three room trays on a cart, wrap the food with foil, and utilize a plate cover when staff delivered resident room trays.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility policy, and staff interview, the facility failed to store and serve food properly in 1 of 4 units (Grandview) observed during/after meal service. Failure to ensure food is stored at proper temperatures and served in a sanitary manner may result in foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled Food Temperature Monitoring occurred on 05/14/25. This policy, dated 12/16/24, stated, . Proper holding temperature - Temperature required for food safety (cold food < [less than] 41 degrees Fahrenheit [F].) - Observation on 05/14/25 at 3:09 p.m. in the Grandview Unit Kitchenette showed the following items in a cold well (open refrigerated area built into the counter) * A half gallon of milk measured 46.8 degrees F * A side salad containing lettuce, egg, and tomato * Containers of grape, cranberry and prune juice. The cranberry juice measured 46.8 degrees F. The cold well had approximately one half inch of frost build up on all four of the inner sides. A facility refrigerator thermometer placed in the cold well showed a temperature of 52 degrees F. During an interview on 05/14/25 at 3:19 p.m., a dietary manager (#8) stated she expected staff to return all the items from the cold well to the refrigerator after meal service and these food items will be discarded. During an interview on 05/14/25 at 3:21 p.m., a dietary aide (#23) stated the juice and milk are located in the cold well when the aide arrives for the evening meal. The dietary aide indicated she did not receive education regarding returning the items to the refrigerator after meal service. - Observation on 05/15/25 at 12:44 p.m. during the Sunset Unit meal service showed a certified nurse aide (CNA) (#15) thumb accidentally touched a resident's jelly sandwich. The CNA cleaned the partial food debris from her thumb onto her pants and proceeded to deliver the resident's sandwich. A survey team member stopped and informed the CNA (#15) of the observed food contact incident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 9 of 10 sampled residents (Resident #2, #3, #6, #19, #26, #29, #67, #107, and #281) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), catheter care, dressing changes, glove use, hand hygiene, and disinfecting of shared equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Catheter: Care, Insertion & [and] Removal, Drainage Bags, Irrigation, Specimen occurred on 05/15/25. This policy, revised 04/05/25, stated, . Connecting Leg Bag. Following insertion of an indwelling urinary catheter, it is recommended to maintain a closed urinary drainage system. 4. Swab attachment site of catheter with alcohol pad. 5. clamp catheter. 6. After wiping cap with alcohol pad, disconnect catheter and drainage tubing and do not allow ends to touch anything. Review of the facility policy titled Hand Hygiene occurred on 05/15/25. This policy, revised 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 . Gloves are a protective barrier . 2. Hand hygiene should be performed after glove removal. After removing gloves regardless of task completed . After contact with a patient's non-intact skin, wound dressings, secretions, excretions, mucous membranes . when moving from contaminated body site to a clean body site during patient care . When entering healthcare zone (supply drawers, linen drawers or cupboards) . When exiting the patient room . Review of the facility policy titled Safe Resident Handling Program (SRHP) Resource Packet occurred on 05/15/25. This policy, revised 12/23/24, stated, . All Nursing Department employee's responsibilities include: . Follows infection control practice to clean lifts after each use. Review of the facility policy titled Standard, Enhanced Barrier and Transmission-Based Precautions occurred on 05/15/25. This policy, revised 04/06/25, stated, . Enhanced barrier precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. used for resident who are infected or colonized with a . MDRO . also used for residents with chronic wounds (i.e., pressure ulcers, diabetic foot ulcers .) and residents with indwelling medical devices (i.e., central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes .) . High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, . device care or use . and wound care . - Review of Resident #3's medical record occurred on 05/12/25. The current care plan stated, . The resident needs Enhanced Barrier Precautions (EBP) related to left plantar foot wound and suprapubic [situated above the pubic bone] catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/12/25 at 4:21 p.m. showed an EBP sign on Resident #3's door frame and two certified nurse aides (CNAs) (#5 and #6) entered the room. The CNAs performed hand hygiene, applied gloves but failed to apply a gown. The CNA (#5) completed suprapubic catheter cares, removed a soiled brief and without removing the soiled gloves, placed a new brief and sling under the resident and adjusted the resident's shirt. The CNA (#5) removed the soiled gloves and without completing hand hygiene, applied new gloves. The CNAs (#5 and #6) transferred the resident from the bed to the wheelchair with a full body mechanical lift. The CNA (#5) combed Resident #3's hair, adjusted the resident's clothing, and cleaned the resident's bedside table. Without sanitizing the mechanical lift, the CNA (#6) placed it in the hallway outside of the resident's room. - Review of Resident #29's medical record occurred on all days of survey. An annual MDS, dated [DATE], identified an indwelling catheter. The current care plan stated, . resident has indwelling suprapubic catheter . Observation on 05/13/25 at 8:48 a.m. showed an EBP sign on Resident #29's door frame. A CNA (#7) entered Resident 29's room, performed hand hygiene, applied gloves, and failed to apply a gown. The CNA (#7) emptied the catheter, removed the soiled gloves, and without performing hand hygiene applied new gloves, arranged the resident's blankets, moved the bedside table, and gave the resident a soda. The CNA (#7) failed to follow EBP by not applying a gown prior to completing high-contact resident cares, and failed to perform hand hygiene after completing catheter cares. - Review of Resident #19's medical record occurred on all days of survey. Observation on 05/13/25 at 4:42 p.m. showed a CNA (#4) entered Resident #19's room and transferred Resident #19 from the bed to the toilet using a sit to stand mechanical lift., removed her gloves, completed hand hygiene and applied new gloves. After providing cares, the CNA (#4) exited the room with the mechanical lift, placed it outside the resident's room, and failed to disinfect the lift. - Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, . The resident requires Enhanced Barrier Precautions . R/T [related to] history of MRSA [methicillin resistant staph aureus] in nasal, and VRE [vancomycin resistant enterococcus] in urine . Observation on 05/13/25 at 9:01 a.m. showed Resident #26 seated in a wheelchair. A CNA (#19) applied a gown and gloves and transferred the resident from a wheelchair to the toilet. After providing incontinence cares, the CNA (#19) assisted Resident #26 to the wheelchair. The CNA (#19) removed the soiled gloves, applied clean gloves, and assisted the resident to bed. The CNA (#19) removed the gown and gloves, and without performing hand hygiene, removed the breakfast tray and garbage from the room, placed the garbage in the soiled utility room and the dishes in the kitchen, and then the CNA (#19) performed hand hygiene. - Review of Resident #281's medical record occurred on all days of survey. The current care plan stated, . The resident needs Enhanced Barrier Precautions related to . indwelling catheter, and CRE [Carbapenem-resistant Enterobacterales] . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/13/25 at 10:53 a.m. showed two CNAs (#18 and #20) performed hand hygiene, applied gowns and gloves. The CNA (#18) applied the gown over the gloves and applied a second pair of gloves on top of the gown and gloves. The CNA (#20) provided incontinence care and emptied Resident #281's catheter bag. During this observation, the clamp of the catheter bag broke. After completing cares, the CNA changed her gloves without performing hand hygiene, and placed a new catheter bag and tubing on the resident's bed. The CNA connected the new tubing to the resident's catheter and failed to clean the connection site with alcohol. - Review of Resident #107's medical record occurred on all days of survey. The current care plan stated, Resident should be toileted . check and change per resident preference. Total lift x2 [full body mechanical lift with two staff] with medium sized sling. - Observation on 05/13/25 at 12:34 p.m. showed a CNA (#16) entered Resident #107's room, performed hand hygiene, and applied gloves. The CNA removed the resident's soiled brief and completed perineal care. Without removing her gloves or completing hand hygiene, the CNA applied a clean brief and adjusted the resident's clothing. A second CNA (#7) entered Resident #107's room to assist with a full body mechanical lift transfer. After the transfer, the CNA (#7) moved the lift to the hallway without sanitizing it. - Review of Resident #2's medical record occurred on all days of survey. The current care plan stated, . requires Enhanced Barrier Precautions . R/T [related to] indwelling catheter . Observation on 05/14/25 at 12:43 p.m. showed Resident #2 seated in a wheelchair next to the bed. Two CNAs (#4 and #19) applied gowns and gloves and transferred the resident from the wheelchair to bed with a mechanical lift. The CNA (#4) performed catheter and incontinence cares. After the cares, the CNA (#4) changed her gloves and failed to perform hand hygiene. The other CNA (#19) left the room to obtain new linens and failed to perform hand hygiene prior to leaving the room. Upon return, the CNA (#19) applied a new gown and gloves and changed the linen on the bed, failing to perform hand hygiene between the handling of soiled linen and clean linen. - Review of Resident #67's medical record occurred on all days of survey and identified a left foot wound and orders for insulin. Observation on 05/15/25 at 9:23 a.m. showed a sign on Resident #67's door indicating EBP. The nurse (#9) brought wound care supplies and an insulin pen into Resident #67's room and placed them on an overbed table. The nurse applied gloves and a gown and removed the soiled dressing. Without changing her gloves or performing hand hygiene, the nurse cleansed the wound and placed a clean dressing. After removing her PPE and performing hand hygiene, the nurse exited the room and placed the supplies on the medication cart. The nurse sanitized the scissors but failed to sanitize the Dakins (wound cleanser) bottle or insulin pen prior to placing them back in the cart. At 9:42 a.m., the nurse (#9) entered Resident #67's room again, performed hand hygiene, applied PPE, dated the dressing with a marker, and placed the sock and the padded boot to the left foot. With the same gloves, the nurse touched the outside of a juice glass, and the straw, assisted the resident with a drink, and rearranged the resident's personal items on the table. - Review of Resident #6's medical record occurred on all days of survey. The current care plan stated,. The resident needs enhanced barrier precautions related to pegtube. (continued on next page)

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	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Drive - A Prospera Community	1011 Boundary St NW Mandan, ND 58554

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/25 at 10:26 a.m. showed a CNA (#14) entered Resident #6's room to complete incontinent care and failed to wear a gown. During an interview on 05/15/25 at 1:40 p.m., an administrative nurse (#9) confirmed she expected staff to perform hand hygiene before applying gloves, after glove removal, disinfect lifts after use, wear proper PPE in rooms, and clean catheter connection sites.