STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a complaint was completed on 01/18/23. The concerns identified by the complainant were partially substantiated.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		2/22/23

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

Electronically Signed | 02/16/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 1 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, and review of facility policy, the facility failed to provide appropriate toileting assistance for 1 of 2 sampled residents (Resident #2) careplanned to be check-and-changed every two-to-three hours. Failure to provide incontinence cares may result in a loss of dignity and place residents at risk of skin breakdown. Findings include: Information provided by the complainant indicated staff failed to toilet residents as scheduled. The complainant indicated he/she observed a resident sitting in his/her wheelchair, "soaked in urine." Review of the facility policy titled "Bowel and Bladder: Incontinence Program" occurred on 01/18/23. This policy, revised 01/10/23, stated, ". . . Resident will be checked for dryness/incontinence every two hours unless otherwise ordered by the physician and/or written in the plan of care. Resident should be kept clean, dry, odor free, with skin integrity maintained . . . " - Review of Resident #2's medical record occurred on 01/18/23. The quarterly Minimum Data Set (MDS), dated 12/18/22, identified the resident as frequently incontinent of urine, always	F 690	F690- Bowel/Bladder Incontinence, Catheter, UTI It is the intent of this facility to remain in compliance with F690 and ensure residents with incontinence receive appropriate treatment and services to prevent infection and restore continence to the extent possible. • All Residents were reviewed for appropriate documentation time frames for toileting of bowel and bladder. Education was provided to CNA staff on 2/16/23 reviewing policy “Bowel and Bladder: Incontinence Program” and POC documentation requirements. Education was provided to Admission Nurses regarding requirement to edit the task for toileting in the electronic medical record on 2/16/23. Random audits will be completed weekly x 4 and monthly x2 to ensure toileting assistance is occurring at correct intervals and being documented appropriately. Audits will include Resident #2 as appropriate. Audits will be completed by the QAPI Coordinator, Director of Nursing, and/or their designee. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meeting with the Medical Director in attendance. The need	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 2 incontinent of bowel, and at risk for pressure ulcers. The current care plan stated, ". . . The Resident has bladder incontinence . . . Assist of 2 [staff members] for . . . check and change. Offer ever 2-3 hours . . . Resident is at risk for alterations to skin integrity . . . Keep skin clean and dry . . . Reposition every 2 hours and PRN [as needed] . . ." Resident #2's toileting record, dated December 18, 2022-January 17, 2023, identified the following timespans between check and change and incontinence cares: * greater than (>) 3.5 hours: 23 occasions * > 4 hours: 20 occasions * > 5 hours: 9 occasions * > 6 hours: 6 occasions * > 9 hours: 2 occasions * > 10 hours: 1 occasion * > 11 hours: 3 occasions The toileting records showed facility staff failed to check and change Resident #2 as careplanned 64 times in one month.	F 690	for further monitoring will be determined based on these results.	