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 _____	11/16/2017

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 For the standard Medicare/Medicaid recertification survey, started on 11/13/17 and completed on 11/16/17, the sample included 5 residents for complete review, 13 residents for focused review, and 3 closed records for review. The sample included 5 additional residents to verify specific concerns during the survey.	F 000		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available	F 167		12/21/17

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

Electronically Signed | 12/11/2017

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 _____	11/16/2017

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 167	Continued From page 1 identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, the facility failed to ensure residents understood the availability and location of prior survey results for 11 of 11 residents (Resident A, B, C, D, E, F, G, H, I, J, and K) attending the group interview. Failure to ensure residents knew of their right to review previous survey results and their location is an infringement of residents' rights. Findings include: The group interview occurred on 11/13/17 at 1:00 p.m., with eleven residents attending. When asked, the group were unaware of their right to review previous survey results or the location of the Health and Life Safety Code surveys. Observation on November 13-16, 2017 showed the Health and Life Safety Code surveys placed in one location on the wall by the main lobby.	F 167	It is the intent of this facility to remain in compliance with F-167 and provide residents and family with easy access to survey results as evidences by: Survey results are now posted on each of the PODS as well as in the community building. This was confirmed on 12-7-17. On 12-5-17 a letter was sent to residents and their responsible parties to notify them of the new locations where survey results are posted. A Resident Council meeting was held 11-27-17 to review recent survey findings and inform residents where the results are located. Social Services will address survey results and their posted location at each resident council meeting. The QI Coordinator and/or her designee will begin monitoring resident council meeting minutes using the QI worksheet titled Survey Results for verification that the location of results is discussed. Monitoring will begin the week of 12-21-2017 and will continue monthly X6 months. Periodic resident interviews will be done to determine their knowledge of survey result postings. 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 for further monitoring will be determined based upon these results.	

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 _____	11/16/2017

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 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT CITATION FROM THE STANDARD SURVEY CONDUCTED 10/05/16 Based on record review, review of the facility's admission packet, staff interview, and family interview, the facility failed to honor the resident/family's choices for 1 of 1 sampled resident (Resident #5) with fluid and diet restrictions. Failure to educate staff and update the care plan/kardex to reflect the resident/family's choice of no fluid or diet restrictions, placed all residents at risk for losing their right to make choices. Findings include: The facility's admission packet containing the Rights of Health Care Facility Residents stated, ".	F 242	It is the intent of this facility to remain in compliance with F-242 and ensure that a resident has the right to refuse medication and treatment: Resident #5□s care plan was revised to reflect the resident and family decision to refuse the prescribed diabetic diet and fluid restriction. Education will be held with the direct staff on 12-12-17 and will include the following: 1. Review the importance of a resident□s right to refuse medication and treatment 2. Importance of accurate care planning. 3. The Care Plan P & P Education was completed with the Miller	12/21/17

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 _____	11/16/2017

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 242	Continued From page 3 . . the right to refuse medication and treatment. . . ." Review of Resident #5's physician orders, kardex and care plan occurred on all days of survey. Diagnoses include; malignant neoplasm of retroperitoneum, chronic diastolic (congestive) heart failure, diabetes (DM), and neoplasm related pain (acute.) The current physician orders stated, "consistent or controlled carbohydrate, no added sodium [CCHO NAS] diet . . . fluid restriction: 1800 mL/day fluid restriction. Dietary to give 240 mL TID with meals and nursing to give 360 mL three times daily (TID). . . ." The current care plan stated, ". . . Nutrition . . . Explain and reinforce to resident the importance of following diet as ordered. Encourage resident to limit intake of high salt items and avoid salt packets. . . . FLUID RESTRICTION: Resident is on a fluid restriction. . . . See charge nurse before giving any fluids between meals. . . ." The visual/bedside kardex stated, " . . . FLUID RESTRICTIONS: Resident is on a fluid restriction. . . ." Review of Resident #5's progress notes stated, " . . . 09/04/17 No fluid restriction, No diabetic diet per family and resident request. . . ." During a family interview on 11/14/17 at 5:30 p.m., the family members verified their wishes of no diet or fluid restrictions. During an interview on 11/16/17 at approximately 2:00 p.m., an administrative nurse (#5) verified the facility failed to update the care plan and kardex to reflect the resident's choice for diet and fluids.	F 242	Pointe management staff on 12-6-17. Residents who choose to refuse dietary and fluid recommendations have the potential to be affected by an inaccurate care plan. One residents has been identified and their care plan was reviewed for accuracy to ensure that the residents wishes are known.. QI Monitoring of care plans for those residents who choose to refuse dietary and fluid recommendations will begin the week of 12/11/2017 using the QI worksheet titled Self Determination to ensure their care plan accurately reflects the residents choice. QI monitoring will be completed by the QI coordinator and/or her designee weekly X4 and monthly X2. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 242	Continued From page 4 Refer to F366.	F 242		
F 244 SS=E	LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION CFR(s): 483.10(f)(5)(iv)(A)(B) (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, resident group interview, review of Resident Council meeting minutes, and staff interview, the facility failed to resolve or provide follow-up to resident concerns/recommendations for 11 of 11 residents who attended the group interview (Resident A, B, C, D, E, F, G, H, I, J, and K). Failure to address the residents' continued concerns regarding the palatability/quality of food has the potential to negatively impact the dining experience. Findings include: Review of the facility policy titled "Resident	F 244	It is the intent of this facility to act upon resident/family grievances and recommendations. Compliance with F-244 is maintained as evidenced by the following: The facility policy titled Resident Groups has been reviewed and remains in place. Emphasis is placed on adherence to this policy along with documentation of actions taken to resolve resident or their representatives concerns and relaying information on the action taken. Education was completed on 12-6-17 for	12/21/17

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 _____	11/16/2017

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 244	Continued From page 5 Groups" occurred on 11/16/17. This policy, revised September 2017, stated, ". . . To ensure that residents are provided a means of voicing grievances and participating in decision making . . . The location must provide a designated employee who is approved by the group to be responsible for providing assistance and responding to written requests that result from group meetings. The location must consider the views of the residents and act promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the location. . . . 7. All grievances discussed at the council meeting will be written in the minutes and filed on the Suggestion or Concern form (GSS #213). The procedure for handling the grievance will be followed. 8. Each department will respond to the resident group recommendations, concerns and grievances as requested and as appropriate, with plan of correction submitted to the administrator for final disposition. . . ." - Review of Resident Council meeting minutes occurred on 11/13/17. The minutes identified the following: * May 2017 - ". . . for the most part they (meals) are improving. . . . this morning some of the food was cold . . . One of the things that was discussed is cutting down on the items that we find lose heat quickly and look at making things that tend to retain heat better. . . . - ". . . snacks will now be handed out in a fashion that is more similar to the way it was being done prior to the move. . . ." * June 2017 - ". . . meal temps on the 100/500/600 neighborhood continue to be chilly at times. . . .	F 244	department managers and those Social Service & Activity associates who have the assigned responsibility of conducting Resident Council meetings. The following will be covered: 1. Resident Groups P & P along with Suggestion & Concerns documentation form 2. Documentation and follow-up of concerns voiced by residents or their representatives along with an expected timeline for completion. Education will be completed on 12-12-17 for direct care staff on how to report a resident concern. Action taken to address concerns about the food services at Miller Pointe was discussed with residents at a Resident Group Meeting held on 11-27-17. Follow-up will continue at monthly group meetings until concerns are resolved The Suggestion/Concern process has the potential to affect all residents. CQI monitoring will be done monthly X3 starting the week of 12-11-17 by the CQI Coordinator and/or her designee using the CQI Worksheet titled Suggestions/Concerns to ensure that suggestions/concerns voiced are resolved. Results of the CQI monitoring will be reviewed as part of the monthly facility QAPI meetings X 6-months and actions summarized at the Quarterly QAPI meetings held with the Medical Director in attendance. The need for	

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 _____	11/16/2017

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 244	Continued From page 6 eggs and toast on 500 neighborhood have been chilly. . . . milk on the 500 neighborhood was bad one day." - ". . . facility no longer utilizes snack carts, new process is that facility staff are to be offering snacks to all residents during snack times. . . . resident[s] encouraged to ask for snacks throughout the day." - ". . . Resident's also expressed concerns with being left in the dining room for too long before they are taking [sic] back to rooms. . . ." * July 2017 - ". . . Residents report that meals have gotten better, however there are a few things that could still use some improvement. Resident's did voice understanding that if the food temp is not to their liking, they are aware that staff will warm it up for them. . . ." * August 2017 - ". . . One Resident did say that at times she would like her food warmed . . . One resident voiced a concern regarding the whipped topping on her strawberries last evening. . . . - ". . . another concern voiced is that some people are waiting to go back to their rooms for too long. . . ." * September 2017 - ". . . Resident reported one instance of recent vegetable dish had frozen vegetables in it. . . . one dish that seemed burnt from being left in warmers too long. . . .: - ". . . Resident's also reported that they notice resident's continue to be left in the dining rooms for too long. . . ." - ". . . Residents from different neighborhoods agreed that supper dining experience is poor as they feel that staff do not take enough time with each resident to ensure they have what they	F 244	further monitoring will be determined based upon these results.	

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 _____	11/16/2017

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 244	Continued From page 7 such [sic] . . . Resident also commented that kitchenette's do not seem adequately stocked with snacks. . . ." * October 2017 - ". . . Resident's mentioned that the 1000 island, ranch, and Cheetos were a couple items that were not in kitchenettes when they have been requested. Resident reported that a dietary staff member would not reheat resident's plate when requested. Another resident reported that staff members have not brought items that were requested during meal times." - ". . . Resident reported that she still feels that certain residents are being left in the dining room for too long after meals. Council informed that nursing will be made aware of concern. . . ." - During the resident group interview on 11/13/17 at 1:00 p.m., the residents identified the following concerns regarding food: * Resident A, B, C, D, E, F, G, H, J, and K stated hot foods served at meals were often just warm or cold * Resident F, J, and K stated often meats were too tough to chew * Resident B, J, and K stated staff failed to offer them snacks every evening before bedtime * Resident A, F, G, and K stated at least weekly the kitchenettes run out of the food at mealtimes even when the residents had placed their menu orders the day before * Resident H stated staff were unavailable during meals to offer more coffee or make sure they were present in case residents needed any assistance When asked if the facility has responded to their concerns, the residents said "no." The residents	F 244		

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 _____	11/16/2017

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 244	Continued From page 8 voiced that they do not feel their concerns were resolved, as the concerns listed above and in the meeting minutes still happen during meal times. During an interview on 11/16/17 at 10:00 a.m., two administrative staff members (#5 and #24) stated: * No specific form required for a resident concern at Resident Council, but may use Suggestion or Concern form * Each department is at the Council meeting and writes down the issues/grievances the residents talk about * Staff do not write a new grievance note for an issue brought up at a previous meeting * Process for snacks has changed back to a cart or a certified nursing aide goes door-to-door to offer each resident a snack * Old business is reviewed each month, but not all the interventions implemented when correcting an issue are documented on the Council Minutes The facility failed to ensure the process for Resident Council concerns was consistently followed to reach resolution to resident grievances and communicate those resolutions to all residents voicing concerns/grievances. Refer to F364 for additional confidential resident interviews and observations regarding meal service issues.	F 244		
F 246 SS=E	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity,	F 246		12/21/17

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 _____	11/16/2017

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 246	Continued From page 9 including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: CALL LIGHT RESPONSE 1. Based on review of the facility's procedure, facility's call light activity report, resident group interview, confidential resident interviews, and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 3 of 11 residents (Resident B, F, and J) who attended the group interview and 6 confidential residents (Resident J, L, M, U, V, and W) interviewed. Failure to respond to call lights in a timely manner may have resulted in a decreased quality of life for Resident B, F, M, U, and W and avoidable incontinence episodes for Resident J, L, and V. Findings include: Review of the facility's procedure titled "Call Light" occurred on 11/16/17. This procedure, dated September 2012, stated, ". . . To promptly answer resident's call light . . . 1. When resident's call light is observed/heard, go to resident's room promptly. 2. Respond to request as soon as possible. Turn call light off and inquire about resident's request in a friendly manner. . . ." Random interviews identified the following information regarding call light response times:	F 246	It is the intent of this facility to remain in compliance with F-246 and maintain the resident□s right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences: A delayed response to a resident□s call light and provision of care in a timely manner has the potential to affect all residents of the facility. To accommodate the individual needs and preferences-the following will be accomplished: A resident group meeting of interviewable residents will be held on 12-20-17 to discuss call light response time. Residents will be asked to establish a goal for call light response time and the residents preferred practice when the staff person initially responding needs assistance to deliver the care requested which may result in a delay. Education will be held with the direct staff on 12-12-17 to review the following: 1. Importance of answering call lights timely and following through with resident requests. 2. Call light response is everyone□s responsibility 3. The Call Light P & P	

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 _____	11/16/2017

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 246	Continued From page 10 * During the group interview on 11/13/17 at 1:00 p.m., 3 residents (Resident B, F, and J) stated at night staff were slow to answer call lights. * During initial tour on the morning of 11/13/17, Resident U stated he waits up to a half hour in the morning a few times a week for staff to answer his call light. * During initial tour on the morning of 11/13/17, Resident X stated she requires staff assistance for toileting and waits up to a half hour for staff to answer her call light, which has resulted in the resident experiencing incontinence while waiting. * On the morning of 11/13/17, an interviewable resident (Resident J) stated she requires assistance to ambulate to the bathroom and waits a long time, especially during the evening shift, for staff to answer call lights. She identified recently waiting over an hour and a half for staff assistance and resulted in the resident experiencing incontinence while waiting. * On the morning of 11/13/17, an interviewable resident (Resident L) stated she requires assistance for toileting and frequently waits over 30 minutes, especially at night, which has resulted in the resident experiencing incontinence while waiting. Review of Resident L's medical record identified the medication Lasix (diuretic) 20 milligrams every day. * On the morning of 11/13/17, a resident (Resident V) stated she requires assistance for toileting and has waited at least 45 minutes during the evening and/or morning hours resulting in the resident experiencing incontinence while waiting. The resident indicated after previously informing staff of the the long call light waits, she has not noticed any change in the waiting time. She stated staff come in, turn off the call light, leave the room again,	F 246	QI monitoring will begin the week of 12-11 -17 using the QI worksheet Call Light Response. Monitoring of 10 call lights on each shift during peak care delivery times will be completed by the QI Coordinator and/or her designee weekly X4 and then monthly X2. Periodic interviews with individual residents will be completed to measure resident satisfaction 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 for further monitoring will be determined based on these results. Resident #15 had a therapy evaluation completed to reestablish her transfer status and determine if resident would be able to transfer using a transfer pole and maximum assist of 1 as she does at home. The transfer status accuracy was confirmed and will continue per a full lift with help of two. Residents who request a therapy evaluation have the potential to be affected if the evaluation is not addressed. Residents who request a therapy evaluation will be identified and will be monitored to ensure that the evaluation is completed and the care plan updated to include the findings and/or interventions. QI Monitoring of the resident care plans will begin the week of 12/21/2017 using the QI worksheet titled Care Plans. QI monitoring will be completed by the QI	

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 _____	11/16/2017

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 246	Continued From page 11 and the resident must then put on the call light again to remind staff to come back to assist her. * On the morning of 11/14/17, an interviewable resident (Resident M) stated she required assistance for toileting and when activated bathroom call light, she waits up to half hour for staff to return, and states "my butt goes to sleep." * On the afternoon of 11/15/17, a resident (Resident W) stated he can wait 20 minutes before staff answer a call light. Review on 11/16/17 of a current call light activity report showed Resident J's call light activated for one hour and thirty-one minutes before staff responded. During an interview on the morning of 11/16/17, an administrative nurse (#5) indicated if a resident complains of a problem with call lights, a call light activity report is printed to review the wait time. RESIDENT REQUESTS 2. Based on record review, resident and family interview, and staff interview, the facility failed to follow-up on the request of 1 of 1 resident (Resident #15) regarding a re-evaluation for toileting transfers. Failure to follow-up on the resident/family request for an evaluation related to transfers, may not allow for Resident #15's highest independence while toileting. Findings include: Review of Resident #15's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident with left	F 246	coordinator and/or her designee. Monitoring of all resident orders r/t requested therapy evaluations will be monitored weekly X 4 weeks and monthly X 2 to ensure accuracy of the care plan when changes are made. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the Quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 246	Continued From page 12 hemiparesis/hemiplegia, hypertension, and overactive bladder. Medications included Lasix (diuretic) 20 milligrams every day. During an interview on 11/14/17 at 10:00 a.m., Resident #15 and a family member (#1) identified a previous request/interest to have therapy re-evaluate the resident's ability to transfer to/from the toilet. Review of Resident #15's progress notes identified a Care Conference note, dated 04/25/17, stated, ". . . [Family] asked that therapy re-evaluate her toileting. [Nurse manager] will speak to OT [occupational therapy] regarding this and get the necessary order. . . ." During an interview on 11/16/17 at 9:00 a.m., a nurse manager (#3) verified the OT had not conducted a re-evaluation of the resident's transfer ability.	F 246		
F 278 SS=E	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of	F 278		12/21/17

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 _____	11/16/2017

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 278	Continued From page 13 the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: ACCURATE CODING 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 18 sampled residents (Resident #8). Failure to accurately complete Section O (Special Treatments, Procedures, and Programs) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents.	F 278	It is the intent of this facility to remain in compliance with F-278 and complete a resident□s MDS accurately as evidenced by the following: The 10-1-17 MDS Significant Change for Resident #8 was modified and submitted to reflect the corrected coding in section O0100J. Inaccurate coding of Section O0100J has the potential to affect all residents receiving dialysis services. The most recent MDS□ for all current residents were checked on 12-5-17 to confirm that section O0100J was coded correctly for those receiving dialysis. Of these four residents one was coded	

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 _____	11/16/2017

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 278	Continued From page 14 Findings include: The Long-Term Care Facility RAI Manual, revised October 2017, Chapter 3, page O-1 and O-4, stated, "Check all of the following treatments, procedures, and programs that were performed during the last 14 days . . . O0100J, Dialysis, Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis." - Review of Resident #8's medical record occurred on all days of survey. A significant change MDS, dated 10/01/17, identified the resident did not receive dialysis while a resident in the facility. A physician order for dialysis, dated 09/27/17, stated, "KDU [kidney dialysis unit] every Tuesday [Tue], Thursday [Thu], and Saturday [Sat] @ [at] 0700 [7:00 a.m.] . . . one time a day every Tue, Thu, Sat." The medical record showed Resident #8 returned to the facility on 09/27/17, a Wednesday, following a hospital stay. The medical record showed Resident #8 received KDU services between 09/27/17 and 10/01/17. During an interview on 11/14/17 at 3:25 p.m., an MDS nurse (#2) confirmed O0100J should have	F 278	incorrectly at O0100J. A modification was completed on 12-5-17. Six residents were identified to have the completion date entered in Z0400 on the last day of the Assessment Reference Period which was in error. These dates cannot be corrected. Not using the entire assessment reference period has the potential to affect all residents who have an MDS completed. To correct this variance for all residents - training on the correct coding practices for section O0100J and Z0400 was completed with the interdepartmental team members responsible for MDS completion on 12-6-17. Emphasis was placed on the importance of completing all sections of the MDS accurately and to sign off Z0400 after the assessment reference date. To ensure correction is maintained QI monitoring of those residents receiving Dialysis will be completed monthly X3 by the QI Coordinator and/or her designee using the QI worksheet title MDS Accuracy to ensure coding is correct at O0100J. Monitoring will also include Z0400 for 10 MDS□ completed per week X4 and then monthly X2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 278	Continued From page 15 been coded. ATTESTATION STATEMENT 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15 and 1.14), and staff interview, the facility failed to use the entire required days of observation when completing Minimum Data Set (MDS) items on 6 of 18 sampled residents (Resident #1, #4, #5, #9, #11, and #15) with at least one completed MDS. Failure to include all the days of the look back period when completing the MDS has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2017 (previously revised October 2016), Chapter 3, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, for a MDS item with a 7-day look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period. . . ." Therefore, the earliest you can code items with a look-back period and attest to the accuracy in Z0400 would be the day after the ARD. For items that do not have a standard look-back period for collecting information (i.e. [for example] the demographic items and the scripted resident interviews in Section C, Section	F 278		

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 _____	11/16/2017

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 278	Continued From page 16 D, Section F, Section J, and Section Q), it is either not required or necessary to wait until the ARD to code the MDS and attest to the accuracy in Z0400. Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections, or portion(s) of section(s) they completed, and the date completed. . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. - Review of Resident #1's medical record occurred on all days of survey. An admission MDS, dated 08/16/17, identified Section C1310 (Signs and Symptoms of Delirium) completed with a Z0400 date the same as the ARD date. - Review of Resident #4's medical record occurred on all days of survey. An admission MDS, dated 09/13/17, identified Section C1310 (Signs and Symptoms of Delirium) completed with a Z0400 date the same as the ARD date. - Review of Resident #5's medical record occurred on all days of survey. A quarterly MDS, dated 10/25/17, and a significant change MDS, dated 08/01/17, identified Section C1310 (Signs and Symptoms of Delirium) completed with a Z0400 date the same as the ARD date for both MDSs.	F 278		

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 _____	11/16/2017

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 278	Continued From page 17 - Review of Resident #9's medical record occurred on all days of survey. A quarterly MDS, dated 10/06/17, identified Section J0100A through J0100C (Pain Management) completed with a Z0400 date the same as the ARD date. - Review of Resident #11's medical record occurred on all days of survey. A quarterly MDS, dated 09/28/17, identified Section C1310 (Signs and Symptoms of Delirium) and Section J0100A through J0100C (Pain Management) completed with a Z0400 date the same as the ARD date. - Review of Resident #15's medical record occurred on all days of survey. A quarterly MDS, dated 09/22/17, identified Section C1310 (Signs and Symptoms of Delirium) completed with a Z0400 date of 09/22/17 which is also the ARD date. An annual MDS, dated 03/29/17, identified Section C1310 (Signs and Symptoms of Delirium) and Section B (Hearing, Speech, and Vision) completed with a Z0400 date, the day before the ARD date. During an interview on the morning of 11/16/17, a nurse manager (#5) agreed staff failed to complete Z0400 correctly for certain MDS sections requiring information collected during specific look-back periods.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		12/21/17

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 _____	11/16/2017

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 280	Continued From page 18 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

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 _____	11/16/2017

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 280	Continued From page 19 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to review and revise the	F 280	It is the intent of this facility to remain in compliance with F-280 and maintain a resident□s care plan so that care needs	

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 _____	11/16/2017

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 280	Continued From page 20 comprehensive care plan to reflect the residents' current status for 2 of 18 sampled residents (Resident #7 and #11). Failure to revise the care plan limited the staff's ability to communicate needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 11/16/17. This policy, revised November 2016, stated, ". . . . . A qualified team of persons will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition. This plan of care will be modified to reflect the care currently required/provided for the resident." - Review of Resident #11's medical record occurred on all days of survey and identified diagnoses including upper extremity weakness, ocular zoster disease, and macular degeneration. The current care plan stated, ". . . Hot Liquids: The resident has impaired ability to manage hot beverages and soups R/T [related to] weakness in upper extremities and difficulty seeing d/t [due to] shingles on face/eye, macular degeneration. . . . Provide cup with lid for hot liquids. . . ." A "Hot Liquid Screen" stated, ". . . 2. Required cup with a lid due to macular degeneration . . ." The current meal card also identified ". . . Adaptive Equipment: Lid for HOT liquids. . ." Observations on 11/14/17 at 8:12 a.m. and 11/16/17 at 7:55 a.m. in the dining room showed Resident #11 had no lid on her hot beverages.	F 280	are communicated for each resident as evidenced by the following: Education was held with the Interdisciplinary team on 12-6-17 to review the following: 1. Importance of up-to-date care plans 2. The Care Plan P & P Education with the direct care staff will be completed on 12-12-17 to discuss the importance of the resident care plan and its accuracy so that care is delivered as it is intended. Specifically addressed will be the completion of the Hot Liquid Screen and importance of serving hot liquids as directed on the resident□s tray card and adherence to the toileting care plan, especially those who use a commode. Resident #11□s care plan was revised after completion of the hot liquid screen to include no longer providing a lid on hot liquids per her preference. Because serving of hot liquids has the potential to affect all residents a Hot Liquid Screen will be completed on all current residents prior to 12-21-17. The Hot Liquid Screen will be completed on all new residents upon admission, annually, with a Significant Change MDS, and PRN. The results will be used to determine how hot liquids are safely served to a resident. Resident preference will be respected. QI Monitoring will be completed by the QI Coordinator and/or her designee beginning the week of 12-11-17 using the	

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 _____	11/16/2017

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 280	Continued From page 21 During an interview on 11/16/17 at 9:30 a.m., Resident #11 stated, "I do not want a lid on my hot beverages, I worry more about the lid coming off more than I do about having a spill." During an interview on 11/17/17 at approximately 2:00 p.m. a nurse manager (#3) stated staff should have updated the care plan to reflect the resident's choice of no lid on hot beverages. - Review of Resident #7's medical record occurred on all days of the survey. Diagnoses included dementia, generalized weakness, and limited mobility. The current care plan and visual/bedside kardex report stated, ". . . Toilet Use: Assist of 2 with EZ Stand [a mechanical lift that supports the resident in a standing position]. Use commode [a portable toilet device] and provide written cues to 'lean forward and stand with machine' . . . prior to standing" Observations of toileting cares on 11/13/17 at 3:00 p.m. and 11/14/17 at 11:45 a.m. showed Resident #7 used the toilet and not a commode for toileting. During an interview on 11/14/17, 2:30 p.m., an administrative nurse (#3) confirmed the care plan directed staff to use the commode for toileting Resident #7. Following this interview, this nurse (#3) provided a revised care plan which identified Resident #7 uses the toilet not the commode.	F 280	QI Worksheet titled Hot Liquid. 10 Residents who trigger for needing a lid for hot liquids will be monitored weekly X4 and then monthly X2 to determine correct service and resident□s satisfaction. Resident #7□s care plan was updated to reflect that the resident is taken to the bathroom instead of using a commode for toileting. Because inaccurate toileting care plans have the potential to affect all residents who use a commode those resident s have been identified and their care plans reviewed for accuracy. QI Monitoring of the resident care planned for use of a commode will begin the week of 12/21/2017 using the QI worksheet titled Commode QI to determine continued accuracy. QI monitoring will be completed by the QI coordinator and/or her designee. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the Quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results	
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans	F 281		12/21/17

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 _____	11/16/2017

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 281	Continued From page 22 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional standards, and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 1 sampled resident, Resident #16, receiving intravenous (IV) antibiotics. Findings include: Review of the facility's policy titled "Peripherally Inserted Central Catheter [PICC Line]" occurred on 11/16/17. This policy, revised November 2017, stated, ". . . 19. Label dressing with the date, time and initials of the nurse changing the dressing. . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, page 773, states, ". . . Ten [Rights of Medication Administration]. . . Right Dose . . . Double-Check calculations . . . ." An ISMP's (Institute for Safe Medication Practices) web based publication titled "ISMP's Guidelines for Standard Order Sets," dated 2010, stated, ". . . Specific Criteria for IV medication. . . Expresses rate of infusion per hour . . . Frequency (and duration if appropriate.) . . . ." - Observation on 11/16/17 at 8:25 a.m. showed	F 281	It is the intent of this facility to remain in compliance with F-281 and provide services that meet professional standards as evidenced by the following: PICC LINES The Peripherally inserted central catheter (PICC) procedure was reviewed and remains unchanged. Emphasis is placed on adhering to this procedure. Mandatory education for all nursing staff will be held 12/12/2017 and will include the following: 1. Review of the PICC line policy with special attention to the requirement of dating & initialing the dressing when applied. A resident with a PICC line in place has the potential to be affected by this practice. QI monitoring will begin the week of 12/11/2017 using the QI worksheet titled PICC Line. Monitoring of all residents with a PICC line in place will be done weekly x 4, then monthly x 2 to ensure that dressings are dated & initialed when applied. Resident #16□s PICC line has been discontinued. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results	

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 _____	11/16/2017

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 281	Continued From page 23 Resident #16's PICC Line dressing not labeled with a date, time, or the initials of the nurse who changed the dressing. During an interview on 11/16/17 at approximately 2:00 p.m., an administrative nurse (#5) stated she did not expect staff to label dressings with a date, time, or initials but indicated it would be "best practice." Review of Resident #16's physician order on 11/16/17 at 8:35 a.m., identified, ". . . Meropenem Solution Reconstituted Use 1000 milligrams (mg) intravenously two times a day . . . until 11/20/17 23:59 every 12 hours . . ." The physician order failed to state the infusion rate of the IV medication. Observation on 11/16/17 at 8:35 a.m. showed Resident #16's IV medication bag was labeled ". . . 1 gram (GM) every (q) 12 hrs Infuse 50 milliliters (ML) over 3 hours. . . must activate 16.7 ml/hour (hr). . . ." Review of the physician's order with the staff nurse (#15) showed the order failed to identify the rate of infusion for the nurse to verify the IV rate. The nurse (#15) stated, "pharmacy labels the bag with the rate."	F 281	summarized at the quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results. IV MEDICATION Resident #16□s peripherally inserted central catheter has been discontinued and is no longer receiving intravenous medication. Mandatory education for all nursing staff is scheduled for 12/12/2017 and will include the following: 1. The infusion rate must be included in the physician order for IV medication to ensure the eMAR order entry matches the IV medication label. QI monitoring will begin the week of 12/12/2017 using the worksheet titled PICC Line. A resident receiving an IV medication has the potential to be affected by this practice. Monitoring will include residents currently receiving intravenous medications to ensure that physician orders entered into the eMAR match the label on the IV medication. Observations will be done weekly x 4, then monthly x 2 for residents receiving an IV medication. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results.	

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 _____	11/16/2017

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 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		12/21/17

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 _____	11/16/2017

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 309	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, resident interview and staff interview the facility failed to provide care and services in a manner to maintain the highest practicable physical well-being for 4 of 18 (Resident #5, #7, #8, and #13) sampled residents. Failure to assess a resident who experienced chest pain and provide medication as ordered by the physician (Resident #7), to provide diabetic care per physician orders (Resident #5), to apply splints to prevent pain (Resident #13), and to monitor weights and report discrepancies per physician orders (Resident #8) placed residents at risk for continued pain, worsening health conditions and hospitalization. Findings include: Review of the facility policy/procedure titled "Medication Administration, Including Scheduling and Medication Aides" occurred on 11/16/17. This policy, dated October 2017, stated, ". . . Purpose . . . To administer medications correctly and in a timely manner . . . Procedure . . . Follow the 'Six Rights': Right medication, right dose, right resident, right route, right time and right documentation. . . ." - Review of the medical record for Resident #7 occurred on November 13-16, 2017. Diagnoses included paroxysmal atrial fibrillation, chest pain, and dementia. A physician order, dated 07/15/15, stated, "Nitroglycerin Tablet Sublingual 0.4 MG [milligram] sublingually every 5 minutes as needed [PRN] for chest pain or other	F 309	It is the intent of this facility to remain in compliance with F-309 and ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being: Physician Orders (Nitroglycerin): Education will be held with the Nursing Staff on 12-12-17 to review with staff importance of correct follow through with physician orders and appropriate assessment r/t nitroglycerin usage. Process related to use Nitroglycerin reviewed. The Medication Administration P & P will also be reviewed at this date. Appropriate usage of nitroglycerin has the potential to affect all residents with current orders for nitroglycerin. Residents with nitroglycerine orders have been identified. QI monitoring will be done by the QI Coordinator and/or her designee beginning the week of 12-11-17 using the QI Worksheet Nitro Use for these residents when nitroglycerin is administered. QI Monitoring will be done weekly X4 and then monthly X2. Resident # 7□s nitroglycerin usage will be included in the QI monitoring when nitro is administered. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 309	Continued From page 26 signs/symptoms of acute angina Give 1 tablet sublingually as needed for chest pain under tongue every 5 minutes x3 [three times] doses max. If no relief contact MD [Medical Doctor]." Review of the Medication Administration Record (MAR) and Progress Notes for Resident #7 identified the following: * MAR, 10/17/17 at 11:41 a.m., nursing staff administered Nitroglycerin. The nurse recorded Resident #7's vitals, blood pressure 130/82, pulse 86, respirations 18, oxygen level 94, and pain zero. * MAR progress note, 10/17/17 at 12:06 p.m., the nursing staff member identified the 11:41 a.m. dose of Nitroglycerin as ineffective. * Progress Note, 10/17/17 at 12:06 p.m., "Resident c/o [complains of] chest pain, PRN Nitro [Nitroglycerin] given @ [at] 1141 [11:41 a.m.] which was ineffective so another dose given @ 1205 (12:05 p.m.) which was effective, VS [vital signs] stable and charted. Notified [family], resident now playing on I pad waiting for lunch in dining room." * MAR, 10/17/17 at 12:06 p.m., nursing staff administered a second dose of Nitroglycerin. * MAR progress note, 10/17/17 at 12:26 p.m., the nursing staff member identified the 12:06 p.m. dose of Nitroglycerin as effective. The nurse failed to follow the physician order for Nitroglycerine every five minutes as needed for chest pain, waiting 25 minutes before administering the second dose. The progress note identified Resident #7 experienced chest pain, however, the nurse charted zero for pain. Failure to administer the second dose of Nitroglycerin in five minutes may have caused	F 309	Blood Glucose Monitoring: Education will be held with the Nursing and CMA Staff on 12-12-17 to review with staff importance of correct follow through with physician orders and appropriate assessment r/t blood glucose monitoring. The process related to blood glucose monitoring will be reviewed including contacting the physician, repeating the Accucheck, and documenting the action taken. Blood glucose monitoring has the potential to affect all residents with current orders for blood glucose monitoring. Those residents requiring monitoring have been identified. QI Monitoring of the resident□s blood glucose monitoring will begin the week of 12/21/2017, using the QI worksheet titled Accucheck QI. QI monitoring will be completed by the QI coordinator and/or her designee. Random monitoring of 10 residents with orders for blood glucose monitoring will be done weekly X 4 weeks and monthly X 2. Resident # 5□s blood glucose monitoring will be included in the initial QI monitoring. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Splint/Brace Usage: Education will be held with the direct care staff on 12-12-17 to review the importance of correct follow through with	

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 _____	11/16/2017

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 309	Continued From page 27 Resident #7 to experience 20 minutes of avoidable pain, as the second dose relieved the pain. During an interview on 11/16/17 at 2:30 p.m., an administrative nurse (#3) confirmed the nurse failed to follow the physician order and administer a second Nitroglycerine in five minutes. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and Type 2 diabetes. A current physician order stated, "Accucheck before meals and at HS(QID) [bedtime(4 times per day)]. Treatment for blood glucose results < [less than] 60 or > [greater than] 400, call MD as needed . . . >400 = [equals] 12 unit recheck bgm [blood glucose measurement] in 1 hour if still >400 call MD. . . ." Review of Resident #5's blood glucose measurements and electronic Medication Administration Record from August through November 13, 2017 showed: * 08/29/17 at 7:03 a.m. and 8:05 a.m. - 425 milligrams per deciliter (mg/dl) - No recheck of bgm in 1 hour and/or physician notification documented * 09/04/17 at 11:58 a.m. - 440 mg/dl - No recheck of bgm in 1 hour and/or physician notification documented * 09/28/17 at 11:23 p.m. - 411 mg/dl - No recheck of bgm in 1 hour and/or physician notification documented * 10/12/17 at 9:15 p.m. - 586 mg/dl - No recheck of bgm in 1 hour and/or physician notification documented * 10/30/17 at 7:23 a.m. - 56 mg/dl - Sliding scale	F 309	physician orders and appropriate assessment of splint/brace usage. Appropriate usage of splints/braces has the potential to affect all residents with current orders for splints/braces to be worn. Residents with orders for a brace or splint have been identified. QI Monitoring of resident□s splint/brace usage will begin the week of 12/11/2017 using the QI worksheet titled Splint/Brace Use. QI monitoring will be completed by the QI coordinator and/or her designee. Monitoring of all residents with orders for splints/braces will be done weekly X 4 and monthly X 2. Resident # 13□s splint/brace usage was discontinued when she returned from the hospital on 12-7-17. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. Monitoring of Weights: Education will be held with the direct care staff on 12-12-17 to review the importance of correct follow through with physician orders and weight monitoring. The importance of contacting the provider with weight changes when indicated will be stressed. Monitoring of a resident□s weight has the potential to affect all residents with orders for daily weight monitoring. Those residents with orders in place have been	

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 _____	11/16/2017

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 309	Continued From page 28 insulin held. Documented "Blood sugar WNL [Within Normal Limits]" No recheck of bgm, no "AT [action taken]" documented for low blood sugar, and no physician notification documented. During an interview on the morning of 11/16/17, a nurse manager (#3) stated, on the above dates, nursing staff failed to follow the physician's order for glucose results >400 by rechecking bgm in 1 hour and if >400, notify the physician, and to notify the physician if glucose results were <60. - Review of the medical record for Resident #13 occurred on all days of the survey. Diagnoses included diabetic neuropathy, numbness and tingling left and right arms, and carpel tunnel. A physician order, dated 05/18/17, stated, "Bilateral wrist splints on in AM (morning) and off at HS (hour of sleep) two times a day." Resident #13's Care Card stated, "Resident to wear bilateral wrist splints daily. On in the AM and off in the HS. Wrist splints to be off during all meals. Remove wrist splints prior to meals and place wrist splints back on after meals." Review of the MDS (Minimum Data Set), dated 09/01/17, showed a BIMS (Brief Interview for Mental Status) score of 15, indicating Resident #13 is cognitively intact. Observation throughout all days of the survey showed Resident #13 did not wear the bilateral wrist splints. During an interview on 11/16/17 at 1:25 p.m., when asked about the bilateral wrist splints, Resident #13 stated, "They have not put my	F 309	identified. QI Monitoring of the resident□s weight monitoring will begin the week of 12/11/2017 using the QI worksheet. titled Weight QI. QI monitoring will be completed by the QI coordinator and/or her designee. Monitoring of all residents with orders for a daily weight will be done weekly X 4 weeks and monthly X 2 to ensure that the provider is notified of weight changes as ordered. Resident # 8 no longer has an order for daily weights. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 309	Continued From page 29	F 309		

braces on, I did have them on one day about a month ago." The resident stated the braces help her wrist pain. When asked if she would like a staff person to put her braces on, she replied, "Yes".

The facility failed to assess the continued use and effectiveness of bilateral wrist splints to help manage Resident #13's pain.

- Review of the medical record for Resident #8 occurred on November 13-16, 2017. Diagnoses included congestive heart failure, and stage five chronic kidney disease requiring dialysis. A physician order, dated 10/07/17, stated, "Weigh resident on admission and then every day X1 [for one] month a. Re-weigh immediately if weight is 5# [five pounds] higher or lower than previous weight obtained b. If weight gain is 3# [three pounds] or greater in 1-day or greater than 5# in a week-contact Provider . . ."

Review of the medical record showed the following weight changes:
* 10/16/17 - 211.5 and 10/17/17 - 216.7, a 4.2-pound weight gain.
* 10/23/17 - 212.5 and 10/24/17 - 217.1, a 4.6-pound weight gain.

The medical record lacked evidence of communication between the facility and the provider when Resident #8 experienced a weight gain of more than three pounds in one day, as per the physician order. The medical record showed 38 opportunities from date order, 10/07/17, through date discontinued, 10/13/17, for staff to obtain Resident #8's weight. The staff failed to weigh the resident 16 times as ordered

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 _____	11/16/2017

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 309	Continued From page 30 by the physician. Failure to weigh Resident #7 as ordered placed the resident at risk for unidentified fluid overload that can result in pain and hospitalization. During an interview on the afternoon of 11/16/17, an administrative nurse (#3) confirmed nursing staff failed to follow the physician order for weighing Resident #8 and failed to notify the physician as identified for weight gains.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference review, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled residents (Resident #5) with a current pressure	F 314	It is the intent of this facility to remain in compliance with F-314 and provide treatment / services to prevent/heal pressure ulcers Failure to treat or provide services to heal	12/21/17

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 _____	11/16/2017

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 314	Continued From page 31 ulcer. Failure to ensure staff positioned the resident in accordance with the plan of care may result in delayed healing of the pressure ulcer. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice, " 10th ed., Pearson Education, Inc., New Jersey, page 843, states, ". . . Positioning, To promote wound healing, clients must be positioned to keep pressure off the wound . . . If the client can not move independently, . . . a turning schedule is implemented . . . ." Review of Resident #5's medical record occurred on all days of the survey. Physicians orders stated, ". . . Reposition resident side to side only every 2 hours and as needed . . . ." The current care plan stated, " . . . Pressure Ulcer: Resident has an . . . unstageable pressure ulcer to her coccyx . . . reposition every 2 hours and as needed (PRN) side to side repositioning only. . ." Review of Resident #5's electronic medication administration record from August 1 through November 15, 2017 showed staff documented Resident #5 positioned on her "back" in excess of twenty times. Observation on 11/14/17 at 8:10 a.m. showed Resident #5 asleep in her bed and positioned on her back. Observation on 11/14/17 from 8:50 a.m. to 9:40 a.m. showed Resident #5 positioned on her back during morning cares. Observation at 12:20 p.m. on 11/14/17 showed resident asleep on her back. During an interview on 11/15/17 at 4:40 p.m., an	F 314	pressure ulcers may result in delayed healing. To ensure treatment and services are provided the following has been accomplished: 1. Mandatory education will be held 12-12-2017 for licensed Nurses, Medication Aides and Certified Nurses Aides, which will include a review of pressure relieving techniques as well as adherence to specific repositioning orders and accurate documentation. QI monitoring will begin the week of 12/11/2017 using the QI worksheet titled Turning Schedules. All residents with orders for a specific turning schedule have the potential to be affected if provider orders are not followed. Those residents with orders for a specific repositioning schedule have been identified. Monitoring of those residents will be completed weekly x 4 and then monthly X2. Resident #5 will be included in monitoring done the week of 12-11-17. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the quarterly QAPII meeting with the Medical Director in Attendance. The need for further monitoring will be determined based upon these results.	

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 _____	11/16/2017

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 314	Continued From page 32 administrative nurse (#3), stated she expected staff to position Resident #5 side to side only, when in bed.	F 314		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide the adequate supervision necessary to prevent accidents for two supplemental residents (Resident #22 and #23)	F 323	It is the intent of this facility to remain in compliance with F-323 and provide care in an environment that remains free of accident hazards as evidenced by the	12/21/17

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 _____	11/16/2017

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 323	Continued From page 33 observed in 1 of 6 dining rooms. Failure to supervise residents during meals placed the residents at risk of accidents and injury. Findings include: Observation on 11/13/17 at 6:14 p.m. during the evening meal in the 400 unit showed no staff in the dining room for three minutes. Resident #22 and #23 were eating supper in this dining room. - Review of Resident #22's care plan stated, ". . . EATING . . . Line of sight supervision. . . . EATING-SWALLOWING: LINE OF SIGHT SUPERVISION . . ." - Review of Resident #23's care plan stated, ". . . EATING . . . Line of Sight Supervision . . ." Failure to ensure supervision during the evening meal placed all residents at risk of injury if an emergency occurred.	F 323	following: Education will be held with the direct care staff on 12-12-17 to review the following: 1. Importance of staff presence in the dining room during meals 2. Responsibility of the charge nurse and/or his or her designee to monitor each meal while residents are dining. Staff presence in the dining rooms during meals has the potential to affect all residents including Resident #22 and #23. QI Monitoring for supervision in the dining rooms during resident meal times will begin the week of 12/11/2017 using the QI worksheet titled Dining Supervision. QI monitoring will be completed by the QI coordinator and/or her designee for evening meals will be done weekly X 4 weeks and then monthly X 5. Random audits of the morning and noon meals will also be completed weekly X4.. 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 for further monitoring will be determined based on these results.	
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater;	F 332		12/21/17

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 _____	11/16/2017

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 332	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent during 2 of 5 observations of insulin administered via an insulin pen (11/13/17 and 11/15/17). Two medication errors occurred during administration of 25 medications, resulting in an 8% error rate. Failure to ensure staff correctly primed the insulin pens may result in an inaccurate dose administered. Findings include: Review of the facility policy titled "Insulin Pens" occurred on 11/16/17. This policy, dated March 2017, stated, " . . . Turn the dosage knob to '2' units. . . . Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. . . . " - Observation on 11/13/17 at 4:56 p.m. showed a licensed nurse (#1) prepared Resident #5's Humalog insulin pen for insulin administration. After placing the needle on the insulin pen, the nurse (#1) dialed the pen to 11 units, and administered the insulin to Resident #5. The nurse (#1) failed to prime the insulin pen. - Observation on 11/15/17 at 8:30 a.m. showed a licensed nurse (#6) prepared Resident #24's NovoLog FlexPen for insulin administration. The nurse placed the needle on the pen and, holding the pen in downward position, primed the FlexPen with one unit. The nurse failed to hold the pen in an upright position and failed to prime with two units, as per facility policy.	F 332	It is the intent of this facility to remain in compliance with F-332 and be free of medication error rates of 5% or more as evidenced by the following: Failure to properly prime an insulin pen may result in inaccurate dose administration for residents who utilize an insulin pen for administration. An error sanitizing a pen prior to attaching the needle may result in a resident infection. To reduce the chance of error affecting these residents and residents #4 and #24 the following has been accomplished: 1. Reeducation including demonstration of proper use of an Insulin Pen took place with the licensed nurses working during the survey the week of 11-27-17 2. Mandatory education for all licensed nurses is scheduled for 12-12-2017 that will include a review of the Insulin Pen Use procedure as well as a return demonstration of proper priming and insulin administration. 3. Wiping of the insulin pen with an alcohol wipe prior to the attachment of the needle (F-441) QI monitoring will begin the week of 12/11/2017 using the QI worksheet Insulin Administration. Monitoring of 5 staff nurses per week will be done x 4 weeks and then 5 staff nurses monthly X4 months. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI	

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 _____	11/16/2017

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 332	Continued From page 35 During an interview on 11/15/17 at 4:40 p.m., a nurse manager (#3) stated she expected staff to appropriately prime insulin pens prior to administration.	F 332	meeting with the medical Director in Attendance. The need for further monitoring will be determined based upon these results.	
F 362 SS=F	SUFFICIENT DIETARY SUPPORT PERSONNEL CFR(s): 483.60(a)(3)(b) (a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff training record review, resident and staff interviews, the facility failed to assure dietary support staff could safely and effectively carry out food and nutrition services for 14 of 14 dietary staff members reviewed (#14, #18, #19, #25, #27, #28, #29, #30, #31, #32, #33, #34, #35, and #36). Failure to assure adequate training of dietary support staff affected the dietary service provided to residents. Findings include: Refer to F 244, F 363, F 364, F 366, F 368, and F 371 for observations, and resident and staff interviews. Upon request the morning of 11/16/17, an administrative dietary staff member (#12) identified she would look for the training records	F 362	It is the intent of this facility to remain in compliance with F-362 and provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition services. The current dietary staff received mandatory training related to safe dietary practices on 11/27/17. Further training along with an orientation checklist (CVTC) will be completed for all current employees prior to 12-21-17. Staff meetings/training sessions will be held monthly to address staff training and competencies as they arise. Insufficient training for dietary support personnel has the potential to affect all dietary employees and facility residents. To ensure correction is maintained QI monitoring of all new hires orientation	12/21/17

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 _____	11/16/2017

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 362	Continued From page 36 for dietary staff members (#14, #18, #19, and #25) observed during dining and meal service. An administrative dietary staff member (#11) shared the "Competency Verification/Training Checklist Dietary Assistant" on the afternoon of 11/16/17. When asked about completed training records for dietary staff members #14, #18, #19, and #25, during an interview on the afternoon of 11/16/17, this administrative staff member (#11) stated "Those records do not exist." When asked about the training records for dietary staff members #27, #28, #29, #30, #31, #32, #33, #34, #35, and #36, the administrative staff member (#11) stated "Those records do not exist."	F 362	checklists and monthly staff meeting/in-service minutes will be completed by the QI Coordinator and/or her designee. This monitoring will take place monthly X6 months. A Trainer Designee position has been developed. This trainer provides a minimum of 5-days of training for each person hired in the dietary department, additional training days as needed. A Trainer Binder has been developed which contains position responsibilities, and policy and procedures approved by the LRD and Dietary Manager. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	
F 363 SS=F	MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED CFR(s): 483.60(c)(1)-(7) (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable	F 363		12/21/17

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 _____	11/16/2017

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 363	Continued From page 37 efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: REVIEW OF MENUS 1. Based on observation, resident interview, and facility policy review, the facility failed to provide a menu with varied food offerings for 7 of 7 days reviewed. Failure to offer a variety of food items and prepare food correctly may contribute to resident dissatisfaction with food served, quality of the dining experience and contribute to unplanned weight loss. Finding include: Review of the facility policy/procedure titled "Menu Requirements" occurred on 11/16/17. This policy, dated September 2017, stated, ". . . Procedure . . . Menus are written to provide the desired variety of food and drink items, to assure balanced nutritious meals and to include at least: a. The primary menu for the meal including beverages and condiments. b. Secondary options for entree and accompaniments as needed based on overall meal options. The	F 363	It is the intent of this facility to remain in compliance with F-363 and provide menus that meet the nutritional needs of residents in accordance with established national guidelines: The Menu Requirements and Society Menu Programs Policy was reviewed and will remain unchanged. The current dietary staff received training on 11/27/17 and 12/7/17 on the following: 1. Importance of serving sizes/portions and appropriate utensil usage. 2. Importance of Accurate Recipe follows through. Additional training regarding menus will be held on 12/14/17 for dietary staff. Menu selections are being reviewed by the dietary manger and LRD. Menus are being updated to improve on the variety of foods offered and serving sizes listed.	

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 _____	11/16/2017

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 363	Continued From page 38 secondary option does not contain all food groups in the primary menu; residents can choose from the available options. c. Ala carte options available based on location practice and updated periodically to prevent menu fatigue. . . ." Review of the facility policy/procedure titled "Society Menu Program" occurred on 11/16/17. This policy, dated October 2017, stated, ". . . Procedure . . . 1. Society menus are provided prior to the start of each menu cycle. Also included will be recipes, production reports/worksheets and order guides/worksheets. . . . 3. Society menus are written in advance for both regular and therapeutic diets, are approved . . . and are followed. Portion sizes are identified for each menu item. . . . 8. Post menu documents at the location. This includes at least the following: a. Dining areas - Diet by the week (daily regular diet menu) report. b. Preparation and service areas - spreadsheet menu. The Menu Quick Reference Guide (spreadsheet) report is customizable for diets available at the location if desired. . . ." For resident concerns of food temperature, palatability, quality, consideration of resident preference, and avoiding resident allergies refer to F 244; F 364; and F 366. Review of the facility menu for the week of November 12-18, 2017 showed the following repetitions: * Seasoned Carrots or a vegetable blend containing carrots served on six days. On one of the six days the facility served seasoned carrots at lunch and a vegetable blend with carrots at	F 363	Menu updates will be completed prior t0 12/21/17. Appropriate serving sizes and following of recipes has the potential to affect all residents. To ensure compliance the following QI monitoring will be completed by the QI Coordinator and/or her designee using the QI worksheet titled Menus and Preparation: 1. QI monitoring r/t serving sizes will be completed by monitoring random meals, each unit weekly X4, then monthly X 2. 2. QI monitoring of recipe follow through will be done a minimum of weekly X4 in the main kitchen and then a minimum of monthly X2. 3. QI monitoring of menus will be done weekly X 4 and then monthly X 2 ensure listing of serving size and a variety of options. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 363	Continued From page 39 supper. * The same meal of egg salad, Italian Lasagna, and peas mixed with another vegetable served on 11/15/17 for lunch and on 11/17/17 for supper. * Peas served as half a mixed vegetable on three days. * The menu identified a sandwich for both meal options at supper on 11/18/17. The facility identified individualized portion sizes on the resident tray cards. The tray cards for residents with altered consistency requirements (pureed, ground, or chopped) identified a half serving or full serving and directed staff to use a dipper for serving. The resident tray card failed to identify the dipper size for the indicated portions. Observations of food service occurred on 11/13/17 at supper, 11/14/17 at breakfast and lunch, 11/15/17 at breakfast and lunch, and 11/16/17 at breakfast. The menu spreadsheets were not posted for staff to reference as identified by the policy. Failure to post the menu spreadsheets to identify the portion sizes for the pureed, ground, and chopped diets does not provide serving staff the information needed to provide proper portion sizes for residents on altered textured diets. Observation of the preparation of the egg salad for egg salad croissants occurred on 11/15/17 at 9:25 a.m. The cook (#21) stated she did not believe the facility had a recipe for the egg salad and she needed to make 58 sandwiches. The cook (#21) used seven dozen (84) precooked hard boiled eggs, made the salad and then scooped a third of a cup of egg salad onto each	F 363		

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 _____	11/16/2017

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 363	Continued From page 40 croissant. When asked, the cook (#12) identified she normally checks the temperature of the egg salad after making the sandwiches, the cook (#21) made 57 sandwiches and ran out of egg salad. The cook (#21) stated she would make more egg salad and make a sandwich on regular bread for a resident who does not like croissants. An interview occurred on the morning of 11/16/17 with two administrative dietary staff members (#11 and #12). The printed facility recipe for egg salad identified two eggs per sandwich. Failure to follow the menu and provide two eggs per sandwich (116 eggs) decreased the protein serving for the residents who received the egg salad croissant for lunch on 11/15/17. TRAY LINE OBSERVATIONS 2. Based on observation, review of facility menus, and staff interview, the facility failed to ensure staff provided the appropriate serving sizes indicated on the menu during observation of meals and tray line on 6 of 6 resident care units (100, 200, 300, 400, 500, and 600 Units). Failure to ensure staff provided the appropriate serving size placed residents at risk for decreased intake and may result in unplanned weight loss. Findings include: - Observation of tray line for Unit 100 occurred on 11/13/17 beginning at 5:02 p.m. The ladle handle used to serve the tomato soup identified it held two ounces (oz.). As the dietary staff member (#10) served the meal, she gave each resident	F 363		

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 _____	11/16/2017

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 363	Continued From page 41 receiving soup two ladles of soup (four oz.). - Observation of tray line for Unit 200 occurred on 11/13/17 beginning at 5:30 p.m. A dietary staff member (#10) prepared to serve the meal. When asked what size ladle she would use to serve the tomato soup, the staff member stated she did not know the size. Observation of the ladle handle identified it held two oz. As the staff member served the meal, she gave each resident receiving soup two ladles of soup (four oz.). - Observation of tray line for Unit 100, 200, 300, 400, 500, and 600 occurred for the supper meal on 11/13/17. Observation of the units showed an inconsistency in the serving of chicken tenders to residents, Units 100 and 200 served one chicken tender, Units 300 and 400 served one or two chicken tenders and Units 500 and 600 served three chicken tenders. Review of the facility menu for the evening meal on 11/13/17 occurred on 11/14/17 and identified the serving size for the tomato soup as six oz., two oz. more than the amount served on 11/13/17. The menu identified a two ounce portion of chicken tenders, with the inconsistent serving sizes observed it increases the chance a unit could run out of a food as resident concerns identified. Refer to F 244. During an interview on 11/14/17 at 8:15 a.m. a facility dietician (#11) confirmed staff should have served each resident 6 oz. of tomato soup for the evening meal on 11/13/17.	F 363		
F 364 SS=F	NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP CFR(s): 483.60(d)(1)(2)	F 364		12/21/17

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 _____	11/16/2017

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 364	Continued From page 42 (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, review of Resident Council Meeting minutes, review of facility policy/procedure, and staff and resident interview, the facility failed to provide food and drinks at palatable and appetizing temperatures on 2 of 2 days of food service observations (November 13 and 14, 2017), affecting all residents consuming foods served at those meals. Failure to serve food at palatable and appetizing temperatures may result in decreased intake and weight loss. Findings include: - During the initial tour of the facility, on the morning of 11/13/17, the following residents expressed concerns regarding food service: * Observation showed Resident M's meal tray on the overbed table beside the bed and showed the resident consumed none of the egg. The resident stated the egg was "cool." * When asked about food, Resident F stated, "A lot of it's cold. The eggs are always cold." * Resident N stated he/she had to send the oatmeal back today because it was cold. He/she stated the eggs are usually cold.	F 364	It is the intent of this facility to remain in compliance with F-364 and prepare food by methods that conserve nutritive value, flavor, and appearance and provide food and drink that is palatable, attractive, and at a safe and appetizing temperature as evidenced by: The Food Temp Monitoring Policy was reviewed and will remain unchanged. The current dietary staff received training on 11/27/17 and 12/7/17 on the following: 1. The importance of monitoring food items for appropriate food temperature at the start and end of tray service. 2. Food temperature monitoring when reheating in the microwave. New lids for the steam table have been purchased and put into use to improve on keeping hot foods at the desired temperature. Cooling containers have also been purchased to improve on keeping beverages cold. Cold food items are to be stored in the unit refrigerators until service.	

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 _____	11/16/2017

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 364	Continued From page 43 * Resident L stated issues of hot foods served during meals were cold. * Resident Y stated meal temperatures vary. Food is cold alot of the time when brought to the room, and cold in the dining room, but not as often. * Residents A,O, P, Q, R, S, T, AA, and BB complained of cold food served during meals. *Observation showed Resident Z sitting next to her meal tray on the overbed table, the resident pointed to the omelet on her plate and stated she could not eat it as it was too dry. Resident Z also stated the meats served here are tough to chew and food is not very tasty. - Review of the facility's Resident Council Meeting Minutes from May through October 2017 identified each of the six months residents complained of hot food being served cold at meals. - During the group interview on 11/13/17 at 1:00 p.m., 10 of the 11 residents (Resident A, B, C, D, E, F, G, H, J, and K) indicated ongoing issues with hot food temperatures being cold at meal service. - Observation of the kitchenette on Unit 200 on 11/13/17 at 1:23, an unidentified dietary staff member dished Resident #8's plate of hot food, covered it with another plate. The staff member stated the kitchnette was out of the correct food covers. During an interview at 1:25 p.m., Resident #8 stated "The soup is warm, the meat ain't." - Observation of the kitchenette on Unit 300 on 11/13/17 at 5:15 p.m. showed an unidentified	F 364	Food temperature and palatability has the potential to affect all residents. To ensure compliance the following QI monitoring will be completed by the QI Coordinator and/or her designee using the QI Worksheet titled Temperature Logs: 1. QI monitoring of food temperature compliance will include monitoring of pre and post meal food temperatures and completion of food temperature logs a minimum of week1y X4 on all six units and then a minimum of monthly X2. This will include temperatures when re-heating food items in the microwave. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 364	Continued From page 44	F 364		

staff member brought Resident #25's meal tray back to the kitchenette and asked the dietary staff member (#18) to cut the chicken strips. A staff member delivered the tray to Resident #25 at 5:24 p.m. (9 minutes later). The staff member returned with the meal tray at 5:26 p.m. and stated Resident #25 complained of cold food. The dietary staff member (#18) then served a new meal tray to Resident #25.

- Observation of the kitchenette on Unit 500 on 11/14/17 at 8:30 a.m. showed a dietary staff member (#18) served hot food from the kitchenette's steam table. An unidentified staff member brought a bowl of blended meat to the serving area, informed the dietary staff member (#18) it was cold, and asked the dietary staff member (#18) to prepare a new serving of blended meat and make sure it is hot. The staff member failed to identify the resident who sent the blended meat back. The dietary staff member (#18) obtained a ham patty from the steam table, blended it, and put it on the counter with a cover over it. When dietary staff members working in the kitchen asked who the blended ham was for and the dietary staff member (#18) responded he did not know.

Observation of the dining area on Unit 500 at 8:55 a.m. showed Resident #10 eating the blended ham observed above. He had consumed about half of it. The resident stated his ham is cold.

- Dietary staff prepared a test tray beginning at 9:17 a.m., after providing breakfast to all residents on Unit 500. The test tray consisted of scrambled eggs, a ham patty, and a glass of

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 _____	11/16/2017

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 364	Continued From page 45 milk. The ham patty was dished from the steam table put on a small room temperature plate and covered. The milk was poured from the milk container on the counter. The eggs finished cooking and were plated on a small room temperature plate and covered. At 9:25 dietary staff delivered the tray to the resident dining room. Food temperatures obtained as follows: * Scrambled eggs 156.7 * Ham patty 101.3 * Milk 52.8	F 364		
F 366 SS=E	SUBSTITUTES OF SIMILAR NUTRITIVE VALUE CFR(s): 483.60(d)(4)-(6) (d)(4) Food that accommodates resident allergies, intolerances, and preferences; (d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and (d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, record review, facility policy review, and staff interview, the facility failed to ensure each resident received meals which honored individual food preferences for 4 of 18 sampled residents (Resident #3, #8, #13, and #17) and 3 confidential residents (Resident N, P and U). Failure to provide residents with their desired food preferences negatively impacts the quality of the dining	F 366	It is the intent of this facility to remain in compliance with F-366 and to accommodate resident allergies, intolerances, and preferences and supply residents with appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice as evidenced by the following:	12/21/17

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 _____	11/16/2017

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 366	Continued From page 46 experience and placed residents at risk of weight loss (Resident #3, #8, #17, N, P, and U). Failure to respect a resident's food allergies (Resident #13) placed the resident at for risk allergic reactions. Findings include: Review of the facility policy/procedure titled "Resident Choice Dining" occurred on 11/16/17. This policy, dated September 2017, stated, "Purpose: To ensure resident choice in dining and meal times. To provide residents with dining services that take into consideration their cultural, ethnic and religious food preferences . . . Procedure: . . . Create a diet plan for each resident that takes into consideration their physician-ordered diet, allergies and preferences. . . . Communicate individual diet plans clearly (e.g., diet/tray cards . . .). Make individual tray card or diet plan adjustments as needed to guide employees in providing dining service to the resident. . . . When a resident has a standing request for substitute food and drink options, his/her diet plan will be adjusted and approved by the dietitian to ensure nutritional adequacy of the resident-specific diet plan to the extent possible . . ." During the initial tour on the morning of 11/13/17, interviews with the following residents showed: * Resident N expressed concerns that the menu choices he circled on his tray card for the next day's meals are not what he received at those meals. The resident stated this situation has been going on "for weeks." * Resident P stated she does not always get to fill out a tray card for the next day's meals, instead,	F 366	The Resident Choice Dining Policy was reviewed and remains unchanged. The current dietary staff received training on 11/27/17 and the direct care staff will receive training on 12/12/17 on the following: 1. Importance of completing the resident□s dietary tray cards at noon each day to ensure options and choices are made available to all residents. This will be started on 12-11-17. 2. Importance of following dietary restrictions-not serving resident□s food they should not have. 3. Make every attempt to honor food requests of a resident within reason (example pureed or slurried toast) Additional training regarding dietary restrictions and resident choice will be held on 12/14/17 for dietary staff. Providing choices and following dietary restrictions has the potential to affect all residents. We will ensure all residents have the opportunity to choose their menu selections by having the dietary cook review that all menus have been received daily and are filled out. A double check by the dietary aid serving will be done to compare the number of meals served and the unit census to make sure that all residents have been served. To ensure compliance the following QI monitoring will be completed by the QI Coordinator and/or her designee: 1. QI monitoring for tray card completion	

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 _____	11/16/2017

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 366	Continued From page 47 staff fill out her tray card. - During an observation of the main kitchen on 11/15/17 at 9:25 a.m., a dietary staff member (#26) sorted the tray cards for supper. Four or more cards were blank for Units 100, 300, 400, 500, 600, and all the tray cards for Unit 200 were blank. During an interview on 11/15/17 at 9:40 a.m., two dietary staff members (#12 and #26) identified it has been a problem to get the tray cards completed. - During an interview on 11/13/17 at 1:25 p.m., Resident #8 stated he is not supposed to eat potatoes or bread, and dietary sends them every day. The tray delivered to the resident's room had a serving of red potatoes, a hamburger on a bun, and an eight ounce can of cola. The resident's tray card stated: "Renal Diet Considerations) Limit Dairy To 1 Cup Total Per Day. Recommend Avoidance/Limiting The Following: Orange/Orange Juice, Potatoes, Banana, Colas, Tomato/Tomato Juice, High Salt Food/Beverages." During an interview on 11/14/17 at 2:05 p.m., Resident #8 stated he ate the meatloaf and broccoli for lunch. He reported he did not eat the mashed potatoes and gravy served. An eight-ounce cola sat on the table beside his chair. He said it was from the day before, and he does not drink cola. Observation of Resident #8 at supper on 11/14/17 at 6:00 p.m., showed he had not received his meal yet, nor had half the residents	F 366	and delivery will take place on each unit weekly X 4, and then monthly X 2 using the QI worksheet titled Diet Card Completion. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 366	Continued From page 48	F 366		

in the dining room. Identified meal service time for their unit is 5:30 p.m. Review of Resident #8's tray card, at the kitchenette showed his tray card had not been filled out.

During an interview on 11/15/17 at 4:50 p.m., Resident #8 stated he ordered lasagna and received an egg salad croissant for lunch. He stated he cannot eat bread.

Observation of Resident #8's tray cards on the morning of 11/15/15 and 11/16/17 for the days evening meals showed blank tray cards. Based on observations and statements by Resident #8, when the tray card is not filled out, staff provide the main menu item for those meals, without considering the renal diet limitations.

An interview occurred on the morning of 11/16/17 with two administrative dietary staff members (#11 and #12). A dietician (#11) stated potatoes and milk should be limited for Resident #8.

- Observation of the tray line for Unit 200 occurred on 11/13/17 beginning at 5:30 p.m. A dietary staff member (#10) prepared Resident #17's meal tray and a Certified Nursing Assistant (CNA) (#13) delivered the tray to the dining room. A few minutes later, the CNA (#13) returned and stated Resident #17 would like a piece of bread. A licensed nurse (#3) assisting with meal service, indicated Resident #17 required pureed bread. The CNA (#13) then asked the dietary staff member (#10) to puree some bread for Resident #17. The staff member stated "no," she could not puree the bread for Resident #17. The staff member failed to honor Resident #17's request for bread.

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 _____	11/16/2017

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 366	Continued From page 49 An interview with the facility dietician (#11) occurred on 11/14/17 at 8:15 a.m. When asked about the above interaction, the dietician stated the kitchens on each unit have blenders, she said the dietary staff member (#10) could have pureed bread for Resident #17 or she could have given the resident bread slurry, which the kitchen has on hand. - Observation of breakfast on 11/16/17 at 8:45 a.m. showed Resident #17 received hot cereal and sausage. Review of the resident's tray card showed she had chosen pancakes and sausage for breakfast. Failure to provide the resident's food choices may result in decreased intake and weight loss. - Observation of the tray line for Unit 600 occurred on 11/13/17 at 5:15 p.m., an unidentified CNA returned Resident #13's supper tray including the tomato soup. The unidentifeid CNA notified the dietary aide that Resident #13 is allergic to tomatoes. - Observation on 11/14/17 at 5:22 p.m., showed Resident #3 received barbeque pork ribette for the evening meal and crispy fish fillet was circled on her tray card. - During a confidential interview, on 11/15/17 at 1:00 p.m., Resident U stated he fills out his tray card for the next day's meals, and the tray card often gets lost. On the day of the meal, Resident U receives a blank tray card and has to fill it out again.	F 366		
F 368 SS=D	FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		12/21/17

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 _____	11/16/2017

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 368	Continued From page 50 CFR(s): 483.60(f)(1)-(3) (f) Frequency of Meals (f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. (f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. (f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to provide three meals a day for 1 of 18 sampled residents (Resident #4) who did not receive breakfast. Failure to provide breakfast on 11/07/17 and 11/12/17 resulted in greater than 14 hours between meals for Resident #4 and has the potential to result in weight loss. Findings include: During an interview on 11/13/17 at 6:15 p.m. Resident #4 stated he did not get breakfast	F 368	It is the intent of this facility to remain in compliance with F-368 and provide each resident with at least 3 meals daily, at regular times comparable to normal mealtimes as evidenced by the following: The Frequency of Meals and Snacks Policy and Procedure was reviewed and remains in place. Emphasis will be on following this P & P. The current dietary staff received training on 11/27/17 that included the following:	

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 _____	11/16/2017

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 368	Continued From page 51 yesterday (11/12/17) or last Tuesday (11/07/17). During an interview on 11/14/17 at 8:30 a.m. Resident #4 expressed concerns that he is forgotten at meals. Review of Resident #4's meal intake documentation showed no intake documented for breakfast on 11/07/17 and 11/12/17. During an interview on 11/16/17 at 8:15 a.m., a dietician (#21) stated she was unaware Resident #4 did not receive his meals and stated that was unacceptable.	F 368	1. Importance of providing 3-regularly scheduled meals/day and no more than 14 hours between meals unless a substantial snack is served in the PM. 2. Dietary cooks are responsible to check the unit census and compare to the tray cards to ensure that all residents are accounted for and have had the opportunity to select their meal choices for the following day. 3. The Dietary Aide is responsible for double checking the diet cards during the meal service to ensure all residents are served at meal time or accounted for if away from the building for an appointment, etc. Education will be held with direct care staff on 12/12/17 on the importance of adhering to the meal schedule and meal delivery to all residents. Because frequency of meals has the potential to affect all residents, random meals on all three shifts will be audited to ensure residents are served on each unit. Resident #4 will be included in the initial auditing. QI monitoring will be take place on each unit weekly X 4 and then monthly X5 using the QI Worksheet titled Meal Service. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to serve, prepare, and store food and dishware in a sanitary manner in 1 of 1 facility kitchen and 6 of 6 facility kitchenettes (Unit 100, 200, 300, 400, 500, and 600). Failure to serve food at safe holding temperatures, prepare food in a clean and sanitary manner, and store food and	F 371	It is the intent of this facility to remain in compliance with F-371 and store, prepare and serve food in accordance with professional standards as evidenced by the following: The Food Temp Monitoring Policy was reviewed and will remain unchanged.	12/21/17

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 _____	11/16/2017

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 371	Continued From page 53 dishware sanitarily placed residents, visitors, and staff at risk for foodborne illness. Findings include: REHEATING FOODS Review of the facility policy/procedure titled "Food Temperature Monitoring" occurred on 11/16/17. This policy, dated September 2017, stated, ". . . Minimal Internal Cooking Temperatures . . . Reheated cooked foods (microwave) . . . 165 degrees F . . . Allow to stand for two minutes . . ." - During meal service on 11/13/17 at 5:25 p.m. Resident #16 requested staff heat knoephla soup brought by the resident's family. The dietary staff member (#10) heated the soup in the microwave in plastic container and a staff member delivered it to the resident. Staff brought the soup back because the resident requested it be heated in a glass bowl. The dietary staff member (#10) poured the soup into a glass bowl, heated it in the microwave, and placed it on a tray for staff to deliver to the resident. The dietary staff member (#10) failed to take the soup's temperature after microwaving and before serving to the resident, to ensure it reached 165 degrees, as stated in the facility policy. FOOD TEMPERATURES Review of the facility policy/procedure titled "Food Temperature Monitoring" occurred on 11/16/17. This policy, dated September 2017, stated, ". . . Proper holding temperature - Temperature required for food safety (cold food <	F 371	The current dietary staff received training on 11/27/17 on the following: 1. Sanitation, storage, and preparation of food, along with importance of monitoring for appropriate food temperature at the start and end of tray service. 2. Food temperature monitoring when reheating in the microwave 3. Sanitation strip testing of the dishwasher. 4. Apron usage with dishwashing. Additional training for the Cooks was held on 12-7-17. Training included use of aprons, menu plan and tray cards, recipe compliance, handy hygiene, and appropriate use of ladles for portion size. Additional training r/t dishwashing and proper sanitation of food prep areas and equipment will be held on 12/14/17 for dietary staff. Specific instructions include: 1. Dietary aides are instructed to set-up steam tables on the units and transfer hot foods into the hot wells immediately upon entering the unit to maintain proper food temperatures. New lids for the steam table have been purchased and put into use to improve on keeping hot foods at the desired temperature. Cooling containers have also been purchased to improve on keeping beverages cold. Cold food items are to be stored in the unit refrigerators until services. Cooks are instructed to retain hot foods in the main kitchen ovens	

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 _____	11/16/2017

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 371	Continued From page 54 [less than] 41 degrees Fahrenheit, hot food > [greater than] 135 degrees Fahrenheit [F] . . . Food temperatures are taken and recorded before each meal service. Periodically, temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges. . . . Before meal service, the cook/designee takes the "cook-to" and "serve" temperatures of all Time/temperature Control for Safety (TCS) menu items and records on the Food Temperature Record . . . - Observation of the kitchenette on Unit 100 on 11/13/17 at 5:35 p.m. showed the following: * Chicken strips on the steam table = 101 degrees Fahrenheit (F) at the top of the pan and 140.2 degrees F at the bottom of the pan * Potato salad on the ice pack = 45 degrees F During an interview at the end of meal service, the dietary aide (#10) stated she never checked food temperatures before, during, or after any meal service. - Observation of the kitchenette on Unit 200 on 11/13/17 at 5:07 p.m. showed a steam table with the individual partitions covered with foil and a deep metal container of potato salad on the counter with an ice pack under the container. Observation showed two refrigerators in the kitchenette and no staff present in the kitchenette. At 5:30 p.m. a dietary staff member (#10) arrived, began serving food, and finished at 5:57 p.m. At the conclusion of service, when asked to take temperatures of the foods, the dietary staff	F 371	as long as possible before moving food into the hot cart for transfer to the units for service improve on keeping hot foods at the desired temperature. Food service sanitation has the potential to affect all residents. To ensure compliance the following QI monitoring will be completed by the QI Coordinator and/or her designee using the QI worksheet titled Food Procedure: 1. QI monitoring r/t food temperature compliance will include monitoring of pre and post meal temping and completion of food temperature forms a minimum of week1y X4 on all six unit and then a minimum of monthly X2. This will include temperatures when re-heating food in the microwave. 2. QI monitoring of the dishwashing process including hand hygiene when moving from soiled to clean tasks, checking the sanitizer strips once per meal, and use of aprons will be done a minimum of weekly X4 on all 6 units and then a minimum of monthly X2. 3. Use of chemical sanitation will be monitored weekly X4 and then monthly X2 to ensure that dietary staff is using chemicals at the correct concentration (150-400 ppm) to clean counters etc. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meetings with the Medical Director in attendance. The need for further monitoring will be determined	

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 _____	11/16/2017

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 371	Continued From page 55 member (#10) indicated she did not have a thermometer. Temperatures obtained using the surveyor's food thermometer showed the following: * chicken strips on the steam table = 131.1 degrees F * potato salad on the ice pack = 47.5 degrees F - Observation of the kitchenette on Unit 400 on 11/13/17 at 5:36 p.m. during the evening meal showed a dietary staff member (#18) serving meals from the kitchenette's steam table, from a deep metal container of potato salad sitting on a metal cart and not on ice, and milk from a carton sitting on an ice pack on the counter. A dietary staff member (#19) checked the temperatures of the food at 5:53 p.m. after the surveyor asked what the temperatures were and after the dietary manager (#12) retrieved a thermometer from the main kitchen. The dietary staff member (#19) stated she was not trained to take the temperature of food. The temperatures showed the following: * Grilled cheese on the steam table: 112 degrees F * Chicken strips on the steam table: 120 degrees F At 6:07 p.m., a dietary aide (#19) checked the temperature of the milk and it was 50 degrees F. - Review of the "DIETARY FOOD TEMPERATURES" form for the kitchenette on Unit 300 and Unit 400 failed to include November 2017. The October 2017 form on Unit 300 showed staff documented food temperatures for 25/93 meals. The October 2017 form on Unit 400	F 371	based on these results.	

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 _____	11/16/2017

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 371	Continued From page 56	F 371		

showed staff documented food temperatures for 42/93 meals.

- Observation of the kitchenette on Unit 500 on 11/13/17 at 5:30 p.m. showed a clear heavy plastic container of potato salad sitting on ice packets and a box of ice cream cups not on ice packets, on the counter of the serving area.

When asked, dietary staff member (#25) obtained to following end of tray line temperatures:
* Potato salad 50 degrees F
* Tomato soup 100 degrees F, taken while in the steam table.
* Chicken tenders 100 degrees F, taken while in the steam table.
* Peas and carrots 125 degrees F, taken while in the steam table.

- Observation of the kitchenette on Unit 500 on 11/14/17 at 8:30 a.m. showed a dietary staff member (#18) served hot food from the kitchenette's steam table, milk from a half gallon carton and juices in cartons which all sat on ice packets on the counter.

Dietary staff prepared a test tray beginning at 9:17, after providing breakfast to all residents on Unit 500. The test tray consisted of scrambled eggs, a ham patty, and a glass of milk. The ham patty was dished from the steam table, put on a small plate, and covered. The milk was poured from the milk container on the counter. Staff finished cooking the eggs, placed them on a small plate, and covered. At 9:25 dietary staff delivered the tray to the resident dining room. Food temperatures obtained as follows:

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 _____	11/16/2017

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 371	Continued From page 57 * Ham patty 101.3 degrees F * Milk 52.8 degrees F - Observation of the kitchenette on Unit 100 on 11/14/17 at 12:15 p.m. showed a dietary staff member (#14) serving milk from a large carton sitting on an ice pack on the counter. * Milk = 47.8 degrees F - Observation of the kitchenette on Unit 200 on 11/14/17 at 1:00 p.m. showed the following: * Ham salad sandwiches = 57 degrees F * A metal container of ham salad covered with foil = 55.9 degrees F - Observation of the delivery of food to the kitchenettes on Unit 100 and 200 on 11/14/17 at 4:52 p.m., showed a dietary staff member (#19) rolled the heated carts to the end of the hall. The dietary staff member (#19) left the 200 Unit cart at the side of the hall and took the 100 Unit cart to the kitchenette. At the kitchenette, the dietary staff member placed the hot foods in the steam table and left the cold foods in the bottom of the cart, with an identified holding temperature of 77 degrees F. The dietary staff member (#19) returned to the 200 Unit cart and pushed it to the 200 Unit kitchenette. She plugged the cart into a wall outlet leaving the hot and cold food in the cart. The cart displayed a hot temperature of 141 degrees F and a cold temperature of 77.5 degrees F. The dietary staff member (#19) identified the cold food as sliced tomatoes. Review of the food temperature records for November 12-15, 2017 showed staff failed to check food temperatures as follow: * 11/12/17, the kitchen and all six kitchenettes	F 371		

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 _____	11/16/2017

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 371	Continued From page 58 for all three meals. * 11/13/17, the kitchen for breakfast. All six kitchenettes for all thee meals. * 11/14/17, Unit 100 kitchenette for the noon and evening meals. Unit 200, 300, 400, 500, and 600 kitchenettes for the evening meal. * 11/15/17, the kitchen for the noon meal. Unit 600 kitchenette for all three meals. Unit 200 and 500 kitchenettes for the noon and evening meals. Unit 100, 300, and 400 for the evening meal. Failure to serve food at safe holding temperatures placed residents, visitors, and staff at risk for foodborne illness. SANITATION DURING FOOD SERVICE - Observation of the kitchenette on Unit 300 on 11/13/17 at 4:33 p.m. showed a dietary staff member (#19) removed an airpot's drip-through assembly and placed her bare hand on the down tube. The dietary staff member (#19) then filled the airpot with coffee and placed the down tube back in the airpot. The dietary staff member (#19) failed to utilize gloves. - Observation of the kitchenette on Unit 300 on 11/13/17 at 5:10 p.m. during the evening meal showed a dietary staff member (#18) serving meals from the kitchenette. The dietary staff member (#18) placed his bare hand inside the mouth of the milk carton as her opened it and served the residents' milk. The dietary staff member (#18) failed to utilize gloves. - Observation of the kitchenette on Unit 100 on 11/14/17 at 12:15 p.m. showed: * Three opened sacks of bread beside the	F 371		

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 _____	11/16/2017

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 371	Continued From page 59 handwashing sink - Observation of food preparation in the main kitchen on 11/15/17 at 9:25 a.m. showed a cook (#21) making egg salad for croissant sandwiches for lunch. After making a portion of sandwiches, the cook (#21) moved the egg salad to the cooler as the egg salad tempted at 44 degrees F. The cook (#21) cleaned the work space by obtaining a cloth from the sanitation bucket and wiping the counter covered with egg pieces and croissant crumbs. When asked, the cook (#21) checked the level of quaternary ammonium chemical sanitization, and identified a reading of 50 to 100 ppm (parts per million). The cook (#21) and administrative dietary staff member (#12) identified the chemical concentration should be 150 to 400 ppm. The cook (#21) did not re-sanitize the counter after removing the food debris. The cook (#21) continued to prepare lunch on the improperly sanitized food preparation surface. - During the kitchen observation on 11/16/17 at 10:32 a.m., staff were asked to check the sanitization solution prepared for use. An administrative dietary staff member (#12) checked the sanitization of the prepared solution and obtained a reading of 50 to 100 ppm. A cook (#21) identified the bucket was due to be changed. When staff obtained a fresh sanitation solution, and used the correct test strips, per dietary staff (#12), the solution measured 200 ppm. Failure to prepare foods in a clean and sanitary manner placed residents, visitors, and staff at risk for foodborne illness.	F 371		

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 _____	11/16/2017

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 371	Continued From page 60 DISHWARE During the full dietary tour on 11/16/17 beginning at 9:00 a.m., the following observations occurred: * 100/200 Unit. A dietary staff member (#14) washing dishes failed to wear an apron, which allowed her uniform to become wet/soiled while washing dirty dishes. The dietary staff member (#14) failed to wash her hands when moving from soiled to clean dishes. An administrative staff member (#12) reminded the staff member to wash her hands. The dietary staff member (#14) then washed her hands in the dish sink rather than the hand washing sink and the administrative staff member (#12) told her to use the hand sink not the dish sink. While moving clean dishes from the drying area to the service area, the staff member (#14) held the rack of dishes against her wet uniform. * 300/400 Unit. Observation of a dietary staff member (#27) washing dishes showed the staff member failed to wear an apron to prevent his uniform from becoming wet/soiled while washing dirty dishes. * 500/600 Unit. Observation of a dietary staff member (#30) washing dishes showed the staff member failed to wear an apron to prevent his uniform from becoming wet/soiled while washing dirty dishes. The dietary staff member moved clean dishware from the drying area to the serving area using a cart, and while placing the rack of dishware on the cart, the rack and cart came into contact with the staff member's (#30) wet uniform. * Main Kitchen. Observation of a dietary staff member (#26) washing dishes showed the staff member failed to wear an apron to prevent	F 371		

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 _____	11/16/2017

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 371	Continued From page 61 soiling of her uniform. The dietary staff member (#26) moved from the soiled area to handling clean dishes without washing her hands. Failure to clean and store dishware in a sanitary manner placed residents, visitors, and staff at risk for foodborne illness.	F 371		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 441		12/21/17

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 _____	11/16/2017

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 441	Continued From page 62 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 441		

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 _____	11/16/2017

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 441	Continued From page 63 Based on observation, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to follow infection control practices during observations of cares and medication administration for 5 of 18 sampled residents (Resident #3, #5, #12, #14 and #16) and 1 supplemental resident (#26). Failure to follow infection control practices related to hand hygiene, glove use, intravenous equipment, insulin pens, and isolation signage has the potential to spread infection within the facility. Findings include: HAND HYGIENE Review of the facility policy and procedure "Hand Hygiene and Handwashing" occurred on 11/16/17. The policy and procedure, revised March 2016, stated, "Procedure . . . Wash hands with plain soap and water or with anti-microbial soap and water: * If hands are visibly soiled (dirty) * If hands are visibly contaminated with blood or body fluids . . . If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: * Before having direct contact with residents . . . * After having direct contact with another person's skin * After having contact with body fluids, wounds or broken skin * After touching equipment or furniture near the resident/patient * After removing gloves . . ." - Observation on 11/13/17 at 2:30 p.m. showed two Certified Nursing Assistants (CNAs) (#20 and #22) assisted Resident #3 to the bathroom. One CNA (#20) performed perineal cares, changed	F 441	It is the intent of this facility to remain in compliance with F-441 as evidenced by: HANDWASHING: The Hand Hygiene P & P was reviewed. Education and QI monitoring will focus on adherence to the policy and preventing the spread of infection by proper hand hygiene for both staff and residents. Education, including policy review, was provided at the nursing staff meetings held on 11/27/17 and will again be discussed at staff meetings on 12/12/17. This education included proper Hand Hygiene for both residents and staff, with special attention to hand hygiene during the completion of perineal care and dressing changes. Improperly performed hand hygiene has the potential to affect all residents. Beginning the week of 12/11/17 the QI coordinator and/or her designee will complete QI monitoring of 10 direct care opportunities weekly X 2 and monthly X 5 to ensure that appropriate hand hygiene is performed using the QI worksheet titled Hand Hygiene.. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and then summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. FLEX PEN: Please see the POC for F-332 to note education, re-demonstration, and QI monitoring plan for correction of the Infection Control Portion of the Flex Pen	

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 _____	11/16/2017

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 441	Continued From page 64 her gloves, ambulated the resident to her recliner, removed the gaitbelt, adjusted the recliner, hung up Resident #3's jacket, gave the resident a pillow and blanket, moved the bedside table closer to the resident, and washed her hands. The CNA (#20) failed to perform hand hygiene after providing perineal cares and prior to completing other tasks. - Observation of cares for Resident #12 occurred on 11/13/17 at 3:10 p.m. and showed two CNAs (#16 and #17) donned gloves and assisted Resident #12 to the bathroom utilizing a sit-to-stand lift. Observation revealed the resident incontinent of a large loose bowel movement. One CNA (#17) removed the soiled brief, placed it in a garbage can, and changed her gloves. The resident complained of nausea and the CNA (#17) removed her gloves, and without performing hand hygiene, left the room and returned with an emesis container. The same CNA then performed other tasks including giving the resident a cool cloth for her forehead, providing perineal care using perineal wipes to remove large amounts of bowel movement, cleaning the toilet seat (soiled with bowel movement), providing additional perineal care with a wet wash cloth, applying cream to the resident's perineal area, and assisting the resident back to her chair using the sit-to-stand lift. During these tasks, the CNA (#17) changed her gloves multiple times, but failed to perform hand hygiene until after assisting Resident #12 back to her chair. - Observation on 11/14/17 at 8:10 showed staff nurse (#1) failed to perform hand hygiene before exiting Resident (#5's) room after performing	F 441	Use. IV/PICC LINE The peripherally inserter Central Catheter (PICC) policy was reviewed and remains unchanged. Resident #16□s peripherally inserted central catheter has been discontinued. Mandatory education for all nursing staff will be held on 12/12/2017 and will included the following: 1. Expectation of sterile capping the IV tubing after being discontinued and 2. Dating and initialing the PICC line dressing when applied QI monitoring will begin the week of 12/11/17 using the QI worksheet titled PICC Line and will include all residents currently receiving intravenous medications via a PICC line. Monitoring will be done weekly X 4, then monthly X 2. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results. ISOLATION: Education and QI monitoring will focus on placement of isolation signage on both sides of the hall door to alert staff and visitors of current transmission based precautions. Education will be provided at staff meetings scheduled for 12/12/17. The absence of signage when transmission based precautions are in place has the potential to affect all	

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 _____	11/16/2017

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 441	Continued From page 65 cares. - Observation on 11/14/17 at 9:35 a.m. showed the staff nurse (#1) failed to perform hand hygiene before donning gloves to perform Resident (#5's) pressure ulcer dressing change and between glove changes when going from dirty to applying the clean dressing. During an interview on the afternoon of 11/16/17, an administrative nurse (#3) confirmed the CNA (#17) should have performed hand hygiene prior to leaving Resident #12's room to obtain supplies and after removing her gloves. She further stated she expected staff to perform hand hygiene before cares, when changing gloves, and after completing resident cares. INTRAVENOUS EQUIPMENT A P&T (Pharmacy and Therapeutics) web based publication titled "Capping Intravenous Tubing and Disinfecting Intravenous Ports Reduce Risks of Infection," dated February 2011, stated ". . . failure to place a sterile cap on the end of a reusable intravenous (IV) administration set that has been removed from a primary administration set, saline lock, or IV catheter hub, with the tubing left hanging between uses. Result: The tip of the set is exposed to potential contaminants; this can lead to infection if the non-sterile IV set is reconnected to the patient's IV access. . . ." - Observation on 11/13/17 at approximately 9:30 a.m. and on 11/16/17 at 9:30 a.m. showed an IV administration set hanging on an IV pole in Resident #16's room. The administration set lacked a sterile cap on the end.	F 441	residents requiring precautions. Beginning the week of 12/11/17 the QI coordinator and/or her designee will complete QI monitoring using the QI Worksheet titled Isolation of all residents currently in transmission based precautions weekly X 4 and then monthly X 2 to ensure that signage is on both sides of the door to alert staff and/or visitors. Results of the QI monitoring will be reviewed as part of the monthly facility QI meetings and the results summarized at the Quarterly QI meeting with the Medical Director in attendance. The need for further monitoring will be determined based on these results.	

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 _____	11/16/2017

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 441	Continued From page 66 During an interview on 11/17/17 at approximately 2:00 p.m., an administrative nurse (#5) indicated she did not expect staff to place a sterile cap on the IV tubing but stated it would be "best practice." This failed to meet the professional standard stated above. Review of the facility's policy titled "Insulin Pens" occurred on 11/15/17. This policy, dated March 2017, stated, ". . . 6. Wipe the tip of the pen where the needle will attach with an alcohol swab or cotton ball moistened with alcohol. . . ." - Observation on 11/13/17 at 4:56 p.m. showed a staff nurse (#1) failed to cleanse the Humalog insulin pen tip with an alcohol swab prior to applying the needle for Resident #5's insulin administration. - Observation on 11/14/17 at 4:57 p.m. showed a staff nurse (#37) failed to cleanse the NovoLog insulin pen tip with an alcohol swab prior to applying the needle for Resident #26's insulin administration. During an interview on 11/15/17 at 4:40 p.m., an administrative nurse (Resident #3) stated she expected staff to clean an insulin pen tip with an alcohol swab prior to applying the needle. ISOLATION - Observations during the afternoon of 11/13/17 and the morning of 11/14/17 showed personal protective equipment hanging on Resident #14's closed room door. with no isolation signage on the door to alert staff and visitors before entering	F 441		

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 _____	11/16/2017

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 441	Continued From page 67 the room. During an interview on 11/16/17 at 10:00 a.m., an administrative nurse (#23) stated when residents are on isolation, a sign alerting staff and visitors to first visit with the nurse before entering the room is placed on the back of the door. She stated residents' doors are usually open and when open the back of the door faces the hall.	F 441		
F 493 SS=D	GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN CFR(s): 483.70(d)(1)(2) (d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and (2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the Minimum Data Set (MDS) for 3 of 18 sampled residents (Resident #9, #13, and #17). Failure to have a process in	F 493	It is the intent of this facility to continue to remain in compliance with F-493 and continue to adhere to MDS completion guidelines.	12/21/17

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 _____	11/16/2017

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 493	Continued From page 68 place to ensure completion of all portions of the MDS resulted in an incomplete assessment of the residents' status and needs. Findings include: - Review of Resident #13's Admission Assessment, dated 12/07/16, identified staff placed dashes, rather than completing the assessment for Section F - Resident Daily Preferences, Activity Preferences, and Preferences for Customary Routine and Activities. - Review of Resident #17's Significant Change in Status Assessment, dated 06/19/17, identified staff placed dashes, rather than completing the assessment for Sections C - Cognitive Patterns and D - Mood. - Review of Resident #9's Significant Change in Status Assessment, dated 08/30/17, and the Quarterly Assessment, dated 10/06/17, identified staff placed dashes, rather than completing the assessment for Sections C - Cognitive Patterns and D - Mood. During an interview, on 11/16/17 at 2:15 p.m., two MDS nurses (#8 and #9) confirmed staff did not complete Sections C and D for Resident #17's 06/19/17 assessment. The nurses stated Social Services staff complete those sections, and the nurses (#8 and #9) did not know why staff placed dashes in those sections. When interviewed, on 11/16/17 at 2:30 p.m., a social worker (#7) stated staff "dashed" Sections C and D of Resident #17's assessment because	F 493	The MDS 3.0 RAI Procedure was reviewed and remains in place with an emphasis on compliance with these requirements. Training was completed on 12-6-17 with administrative staff and members of the interdisciplinary team responsible for MDS completion on the following: 1. MDS completion guidelines and the importance of completing all sections (specifically Section F, Section C, and Section D) of the MDS within the timeline required by CMS. 2. Importance of communication between team members to ensure adherence to the MDS schedule and timely completion of assigned sections. 3. Process development that alerts MDS Coordinators when a section of the MDS has not been completed prior to the completion deadline. MDS Coordinators will continue to establish the MDS schedule and will email updates to staff members as changes occur. Prior to the ARD date, the MDS Coordinator will contact staff members responsible for the sections that must be done prior to the ARD date to ensure completion. The MDS Coordinator will audit the MDS prior to signing off at ZO500 to ensure all areas are complete. The MDS□ of Resident #9, #13, and 17 have been reviewed. The areas noted to	

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 _____	11/16/2017

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 493	Continued From page 69 Social Service staff were gone that week, and therefore, did not complete the sections. During an interview, on 11/16/17 at 2:35 p.m., a management staff member (#38) stated, staff "dashed" Sections C & D for Resident # 9, and Section F for Resident #13 because Social Service staff were gone that week. The facility's failure to develop and implement a process to ensure completion of the Social Services portions of the MDS when Social Services staff were not available resulted in the MDSs lacking information for Sections C, D, and F and may have impact the care planning process.	F 493	be incomplete are areas that cannot be modified or corrected at this time. Incomplete MDS□ have the potential to affect all residents of the facility when information is incomplete. To ensure completion QI monitoring will be done by the QAPI Coordinator and/or her designee beginning the week of 12-11-17 using the QI worksheet titled MDS Completion. All MDS□ completed will be monitored weekly X4 and then 15 per month will be monitored monthly X2. Results of the QI Monitoring will be reviewed as part of the monthly QAPI meetings and the results summarized at the quarterly QAPI meeting with the Medical Director in attendance. The need for further monitoring will be determined based upon these results.	
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514		12/21/17

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 _____	11/16/2017

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 514	Continued From page 70 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure a complete and accurately documented medical record for 3 of 18 sampled residents (Resident #5, #8, and #13). Failure to have a complete and accurate medical record limited staff's access to the most recent medical information regarding the residents. Findings include: - Observation on 11/14/17 at 9:00 a.m. showed a staff nurse (#1) entered Resident #5's room and found emesis on the resident's gown, bedding, and in an emesis bag.	F 514	It is the intent of this facility to remain in compliance with F-514 and maintain medical records on each resident that are complete, accurate, accessible, and systematically organized as evidenced by the following: Education will be held with the nursing staff on 12-12-17 and will include the following: 1. Review of Documentation Policy 2. Importance of complete and accurate documentation in the medical record of resident events that occur (exception based charting) 3. Importance of monitoring residents	

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 _____	11/16/2017

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 514	Continued From page 71 Review of Resident #5's medical record occurred on the morning of 11/15/17. The medical record lacked progress notes related to the emesis. - Review of Resident #8's medical record occurred on November 13-16, 2017. A physician order, dated 10/07/17, stated, "Weigh resident on admission and then every day X1 [for one] month." The medical record showed 38 opportunities from date order, 10/07/17, through date discontinued, 10/13/17, for staff to obtain Resident #8's weight. The Medication Administration Record (MAR) showed nursing staff signed off obtaining Resident #8's weight on 16 occasions, and failed to document the resident's numerical weight in the medical record. During an interview on the afternoon of 11/16/17, an administrative nurse (#3) confirmed the medical record lacked documented numerical weights for Resident #8. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included diabetic neuropathy, numbness and tingling left and right arms, and carpel tunnel. A physician order, dated 05/18/17, stated, "Bilateral wrist splints on in AM (morning) and off at HS (hour of sleep) two times a day." Resident #13's Care Card stated, "Resident to wear bilateral wrist splints daily. On in the AM and off in the HS. Wrist splints to be off during all meals. Remove wrist splints prior to meals and place wrist splints back on after meals."	F 514	with daily weights ordered, requesting a re-weigh if 3-5# weight difference and contacting provider. 4. Importance of applying splints per orders Resident #5□s chart was updated to reflect correct information describing the situation noted on 11/14/17. Resident #8 is no longer receiving ordered daily weights. Because weight monitoring has the potential to affect those residents with daily weights ordered-monitoring will be completed as per POC for F-309. Resident # 13□s splints were discontinued upon her return from the hospital. Splint usage has the potential to affect those residents with orders for splint use. Please See POC for F-309 for splint QI. The accuracy of resident medical records has the potential to affect all residents. Resident charts will be audited for a progress note or UDA 5 days per week X4 weeks and then 1 week per month monthly X2 for events reported during morning report to ensure accuracy. QI Monitoring will be completed by the QI Coordinator and/or her designee beginning the week of 12-13-17 using the QI worksheet titled Complete Medical Records, 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 _____	11/16/2017

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 514	Continued From page 72 The November MAR (Medication Administration Record) stated, "Bilateral wrist splints on in AM and off at HS, two times a day." The MAR indicated 0600 and 2045 for the times of the day to be signed off by the nursing staff. Observation throughout all days of the survey showed Resident #13 did not wear bilateral wrist splints. Review of the November MAR on 11/16/17, showed the nursing staff signed the MAR indicating Resident #13's wrist splints were on and removed on, November 1-16, 2017. During an interview on 11/16/17 at 2:35 pm, an administrative nurse (#39) said Resident #13 no longer wore the wrist splints, and staff should not have signed off the November MAR.	F 514	for further monitoring will be determined based on these results.	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		12/21/17

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 _____	11/16/2017

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 520	Continued From page 73 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to implement corrective measures to address resident concerns with dietary services. Failure to implement interventions to correct known dietary concerns resulted in missed meals, unresolved resident grievances, food not prepared according to professional standards, at palatable temperatures, or in a manner to meet residents' individual needs including accommodating allergies, intolerances, and preferences. Findings include:	F 520	It is the intent of this facility to remain in compliance with F-520 and continue to implement corrective measures to address resident concerns related to the dietary services provided at Miller Pointe as evidenced by the following: The Quality Assurance and Performance Improvement Policy was reviewed and remains in place. This policy serves as the framework for the quality improvement program at Miller Pointe.	

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 _____	11/16/2017

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 520	Continued From page 74 An interview with Quality Assurance staff members (#23 and #38) occurred on 11/15/17 at 5:00 p.m. The staff members stated the facility became aware of residents' dietary concerns in late May or early June 2017 and attempted several interventions to resolve those concerns. The facility failed to attempt additional interventions to correct the residents' on-going food concerns resulting in citations at: F 244 - Grievances of the group F 364 - Food and drink that is palatable, attractive, and at a a safe and appetizing temperature F365 - Food prepared in a form designed to meet individual needs F366 - Food that accommodates resident allergies, intolerances, and preferences F368 - There must be no more than 14 hours between a substantial evening meal and breakfast the following day F371 - Store, prepare, distribute and serve food in accordance with professional standards for food service safety	F 520	Staff education is planned for 12-12-17 and will include corrective action necessary to address the following: 1. Quality Assurance and Performance Improvement Policy, committee function, and staff responsibility 2. F-244: Grievances of the group 3. F-364: Food and drink that is palatable, attractive, and at a safe and appetizing temperature 4. F-365: Food prepared in a form designed to meet individual needs 5. F-366: Food that accommodates resident allergies, intolerances, and preferences 6. F-368: There must be no more than 14 hours between a substantial evening meal and breakfast the following day 7. F-371: Store, prepare, distribute and serve food in accordance with professional standards for food service safety Specific education covering dietary services was and will be provided on the following dates: 1. 11-27-17: 2. 12-7-17: 3. 12-14-17 The Performance Improvement Project addressing dietary services has been revised to address each of the areas cited during the recent survey. QI monitoring for each of these citations will begin the week of 12-11-17 after staff education has taken place. Results of this monitoring will be addressed at each monthly QAPI	

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 _____	11/16/2017

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 520	Continued From page 75	F 520	meeting with members of the interdisciplinary team present. Action will be taken to address remaining concerns and the project revised along with monitoring needs based on the results QI audits. Results and the action taken will be summarized at the Quarterly QAPI Meeting with the medical director in attendance. The Dietary Services Performance Improvement Project (PIP) will remain active until such time as all concerns noted have been resolved. Surveillance monitoring will then be initiated to ensure that improvements are sustained.	