STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 The Standard Medicare/Medicaid recertification survey and complaint survey started 06/21/21 and concluded 06/24/21.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		7/29/21

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

Electronically Signed | 07/13/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to immediately notify the resident's representative of a psychiatric doctor appointment and new medication orders for 1 of 26 sampled residents (Resident #66). Failure to promptly notify the resident's representative limited their ability to make informed decisions regarding medical care. Findings include: Information provided by the complainant indicated the facility failed to notify the resident's representative of a psychiatric doctor appointment and new medication orders. Review of the facility policy titled "Notification of Change - Rehab/Skilled" dated 05/27/21, stated ". . . A facility must immediately inform . . . the	F 580	It is the intent of this facility to notify residents and/or responsible parties of changes in compliance with the regulation. The facility policy titled Notification of change- Rehab/Skilled has been reviewed and remains in place. Education will be completed the week of 7/15/21 for Leadership staff and the week of 7/19/21 for all staff. The following was covered: 1. Review of policy entitled Notification of change- Rehab/Skilled. 2. Emphasis on documentation of notifications of changes of condition which will include medication changes and consultant appointments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 580	Continued From page 2 resident representative(s) when there is: . . . 2. A significant change in the resident's physical, mental or psychosocial status . . . 3. A need to alter treatment significantly - a need to discontinue or change an existing form of treatment or to commence a new form of treatment. . . ." Review of Resident #66's medical record occurred on all days of survey. Diagnoses included vascular dementia and depression. - Physician/physician assistant orders included: * Zoloft (antidepressant medication) 25 milligrams (mg) by mouth (PO) daily. Diagnosis (Dx) depression. Start 10/15/20, discontinue 11/06/20. * Zoloft 50 mg PO one time a day for depression. Start 11/07/20, discontinue 01/13/21. * Zoloft 25 mg PO one time a day for depression. Discontinue 01/27/21. * Psychiatric consult when arranged DX: dementia with behavioral changes. 03/30/21. - A psychiatric consult note dated 04/01/21 stated, ". . . REASON FOR CONSULTATION: Evaluation and management of behavior disturbance . . . " The facility failed to notify the resident's representative of the psychiatric doctor appointment and the above medication orders/changes. During an interview on 06/24/21 at 10:53 a.m., an administrative nurse (#1) confirmed staff failed to notify/document family notification.	F 580	The notification of change process has the potential to affect all residents. QI Monitoring for all changes of condition with emphasis on medication changes/consultant appointments will begin the week of 7/26/21 using the QI worksheet entitled CQI Worksheet-F-580: Notification of Changes. QI monitoring will be completed by the QI coordinator and/or her designee for 14 medication changes/consults weekly X 4 weeks and then monthly X 5 for a total of 6 months. QI Monitoring will include resident #66 if appropriate. 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 689	Free of Accident Hazards/Supervision/Devices	F 689		7/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 689 SS=D	Continued From page 3 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to ensure a safe environment as possible for 2 of 3 residents (Resident #23 and #89) who utilized wheelchairs to leave the facility campus on their own to smoke. Failure to assess residents for risk hazards and safety when leaving the campus on their own to smoke has the potential to result in an accident or adverse event. Findings include: During an interview on the morning of 06/21/21, an administrative staff member (#1) stated the facility is a tobacco-free campus and they have three residents who sign themselves out and smoke independently in a designated area off campus. The staff member (#1) stated facility staff inform residents prior to admission they are not allowed to smoke on the facility campus and if they wish to smoke, they can go out with family or they would need to be able to independently smoke in a designated area off campus. During an interview on the afternoon of 06/22/21, an administrative staff member (#1) stated staff	F 689	It is the intent of this facility to remain in compliance with F-689 and provide care in an environment that remains free of accident hazards as evidenced by the following: A New procedure for Tobacco Use User Defined Assessments has been created and implemented including recurring schedule of assessments. Education will be held with Nursing Leadership and Minimum Data Set staff the week of 7/15/2021 and with all staff the week of 7/19/21 to review the following: 1. Procedure to assess all residents upon admission on smoking preferences using the Tobacco Use User Defined Assessment if indicated. 2. Procedure to assess residents who wish to initiate smoking after admission on a PRN basis. 3. Procedure to Assess Residents who smoke in accordance 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 _____	C 06/24/2021

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 689	Continued From page 4 assess residents on admission for their ability to safely smoke if they wish to leave the campus independently to smoke. The staff member (#1) stated the facility does not have a policy on smoking and does not have a policy on how often staff should re-assess residents for the ability to safely smoke. - Review of Resident #23's medical record occurred on all days of survey. An admission assessment, dated 03/16/21, identified the resident as not currently using tobacco. During an interview on the afternoon of 06/21/21, Resident #23 stated she gets her cigarettes and lighter from the nurses station and goes outside on her electric wheelchair to smoke. Resident #23's current care plan for tobacco use, dated 06/21/21, stated, "TOBACCO USE: The resident uses tobacco products . . . History of smoking. Goal: Resident will safely use tobacco products in designated area. Interventions: Resident is independent with tobacco use. Educated to sign out and back in when leaving facility to smoke. Educated the risks with smoking. Educated safety with motorized W/C [wheelchair] and areas to smoke off facility. Smoking schedule: PRN [as needed]. Store cigarettes and lighter at nurse's station. . . " During an interview on 06/22/21 at 2:30 p.m., an administrative staff member (#1) stated Resident #23 told them she did not smoke when staff admitted her to the facility, but approximately 2 weeks later wanted to start smoking again. The staff member (#1) confirmed staff failed to complete a smoking assessment for Resident	F 689	Comprehensive Minimum Data Set utilizing the Tobacco Use User Defined Assessment. Tobacco Use User Defined Assessments were completed for residents #23 and #89 on 6/23/21 and will continue on a recurring schedule with Comprehensive Minimum Data Set and PRN. Smoking safety has the potential to effect some resident□s limited to those residents who wish to smoke off premises. QI Monitoring for completion of Tobacco User Defined Assessments (UDA) for qualified residents will begin the week of 7/26/21 using the QI worksheet entitled CQI Worksheet F-689: Smoking Safety. QI monitoring will be completed by the QI coordinator and/or her designee for all admissions, Comprehensive Minimum Data Set, and PRN (as needed) will be done weekly X 4 weeks and then monthly X 5, for a total of 6 months. QI monitoring will include residents #23 and #89. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 689	Continued From page 5 #23 when she started to smoke after her admission to the facility. The facility completed Resident #23's Tobacco Use Assessment on 06/23/21, approximately three months later. - During an interview on the morning of 06/21/21, Resident #89 stated staff keep his cigarettes in the medication cart and he smokes far back off the property by a bike path. Review of Resident #89's medical record occurred on all days of survey. Resident #89's current care plan stated, "TOBACCO USE: The resident uses tobacco products . . . History of smoking. Goal: Resident will safely use tobacco products in designated area. Interventions: Resident is independent with tobacco use. Educated to sign out and back in when he leaves facility to smoke. Educated the risks with smoking. Educated safety with motorized W/C and areas to smoke off of facility. Smoking schedule: PRN. Store cigarettes and lighter in resident room." The facility failed to complete the Tobacco Use Assessment for Resident #89 upon admission in April 2020. The facility completed the Tobacco Use Assessment on 06/23/21.	F 689		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		7/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 791	Continued From page 6 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of facility incident report, record review, and	F 791	It is the intent of this facility to assist residents in obtaining routine and 24 hour	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 791	Continued From page 7 resident and staff interviews, the facility failed to refer 1 of 1 resident (Resident #10) with lost dentures for dental services within three days, document assessment of ability to eat and drink adequately, and document the extenuating circumstances that led to the delay in the referral. Failure to promptly refer for dental services and/or assess the resident's ability to eat and drink adequately without dentures may result in decreased intakes, unplanned weight loss, and choking. Findings include: Review of the facility policy titled, "Denture and Oral Care, Dental Health Assessment, Dental Services- Rehab/Skilled", occurred on 06/24/21. This policy, dated 05/26/21 stated, ". . . Referral for dental services for lost or damaged dentures must occur within three days of discovery of the lost . . . If the referral is more than three days, the location must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and document the extenuating circumstances that led to the delay. . ." During an interview on 06/21/21 at 3:18 p.m., Resident #10 stated, "I lost my dentures a while back and the facility is supposed to replace them, but I haven't heard anything further." Record review occurred on all days of survey. The record failed to identify missing dentures, dental referral, and/or what was done to ensure resident could adequately eat or drink without dentures.	F 791	emergency dental care to remain in compliance with the regulation. The facility policy titled Denture and Oral Care, Dental Health Assessment, Dental Services- Rehab/Skilled was reviewed and remains in place. Emphasis is placed on adherence to this policy including documentation of action taken, notification of appropriate personnel, assurance that the resident can still eat and drink as well as documentation of any extenuating circumstances that led to the delay in referral. Education will be completed on 7/15/21 for leadership staff and the week of 7/19/21 for all staff. The following will be covered: 1. Dentures and Oral Care, Dental Health Assessment, Dental Services Policy 2. Expectations for documentation of action taken, notification of dietary personnel, assurance that the resident can still eat and drink as well as any extenuating circumstances that led to the delay in referral. Referral has been made for Resident #10 at the dentist of their choice for the first available appointment. Resident #10 and spouse were updated with appointment date. Resident #10 assessed by licensed registered dietician for ability to eat and drink safely until bottom dentures can be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 791	Continued From page 8 Review of the facility incident report occurred on 06/24/21. The form, dated 03/16/21, identified missing dentures and no investigation until 03/30/21, and no follow up with resident and spouse until 04/05/21. During an interview on 06/22/21 at 2:14 p.m., an administrative nurse (#1) confirmed the facility failed to make dental referral and/or document assessment of resident's ability to eat or drink adequately. During an interview on 6/23/21 at 11:02 a.m., a social services staff member (#6) confirmed the facility failed to investigate the lost dentures until 03/30/21 (fourteen days after the report of the lost dentures), failed to notify dietitian and/or speech therapist for evaluation of ability to eat or drink, and/or refer to dentist until 04/05/21. When asked, he/she acknowledged awareness of the need for referral and/or documentation to occur within three days. During an interview on 6/23/21 at 11:34 a.m., a licensed nutrition professional (#2) confirmed the facility failed to notify nutrition services Resident #10 lost his/her dentures. He/she reported the facility process is for nursing and/or social services to notify nutrition services to assess the residents ability to eat/drink on the current texture when dental issues occur.	F 791	obtained. Licensed Registered Dietician deemed resident safe to eat and drink as prior. Resident #10□s care plan was reviewed and remains unchanged. Documentation now in place regarding any extenuating circumstances that lead to the delay in referral. Dentures and Oral Health Assessments have the potential to affect most residents CQI monitoring for Denture Care Follow up with begin the week of 7/26/21 using the QI worksheet entitled CQI Worksheet F791: Denture Follow Up. QI Monitoring will be completed by the QI coordinator and/or her designee for all missing dentures weekly x 4 and monthly x 5 for a total of 6 months. QI monitoring may include resident #10 Results of the CQI monitoring will be reviewed as part of the monthly facility QAPI meetings and then summarized at the Quarterly QAPI meetings held with the Medical Director in attendance. The need for further monitoring will be determined based upon these results.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed	F 805		7/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 805	Continued From page 9 to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference review, and staff interview, the facility failed to ensure each resident received food in a form designed to meet the individual resident needs for 1 of 4 sampled residents (Resident #43) with physician's orders for a texture modified diet. Failure to serve food according to physician's orders placed the resident at risk for reduced meal intake, choking, and aspiration pneumonia. Findings include: Review of the Academy of Nutrition and Dietetics Diet Manual NDD (National Dysphagia Diet) Level 2: Mechanically Altered Nutrition Therapy, showed ". . . This diet consists of foods that are easy to swallow because they are blended, chopped, grinded, or mashed so that they are easy to chew and swallow. . . . Foods you eat should be cut into 1/4-inch pieces . . ." Review of Resident #43 medical record occurred on all days of survey. Diagnoses included dementia, dysphagia, and a history of aspiration pneumonia. The current orders, dated 03/08/21 stated, . . . "Regular diet Level 2-Mechanical texture, (texture modified diet) Mildly Thick consistency, minced and moist for Diet." The care plan stated, . . ."Regular diet, NDD2 . . . minced & moist food textures, Level-2 Mildly Thick (NECTAR) fluid consistency (texture modified diet with thicken liquids). The resident's tray card identified on 06/21/21 spice cake slurried (softened with liquid to form puree	F 805	It is the intent of this facility to remain in compliance with F-805 and provide food in the form to meet the resident□s individual needs Education will be completed the week of 7/15/21 for Leadership staff and the week of 7/19/21 for all staff. The following will be covered: 1. Review of Process 2. Physician ordered Texture modified therapeutic diets/liquids Following physicians orders for a texture modified diet has the potential to affect most residents. A list of all residents currently on texture modified therapeutic diet has been reviewed including resident #43. QI Monitoring for texture modified diet compliance will Begin the week of 7/26/21 using the QI worksheet entitled CQI Worksheet F805: Texture Modified Diets. QI Monitoring will be completed by the QI coordinator and/or her designee beginning the week of 7/26/21 on all residents on texture modified diets weekly X 4 and then monthly X 5 for a total of 6 months to ensure that physician□s orders for texture modified diets are followed. Monitoring will include resident #43 for as long as they meet criteria.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 06/24/2021

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 805	Continued From page 10 consistency), and 6/22/21 cheesy green beans chopped and thickened to mildly thickened for all fluids." Observation on 06/21/21 at 5:33 p.m. showed Resident #43 seated at the dining room table. An unidentified dietary assistant served Resident #43 a piece of spice cake. The dietary assistant failed to serve slurried cake. Observation of 06/22/21 at 5:40 p.m., showed Resident #43 received ground meat with mashed potatoes and gravy, and green beans in a cheese sauce. The green beans were approximately one inch in length. The dietary assistant (#4) reported she smashed the green beans using a serving spoon. A licensed nurse (#3) confirmed the green beans were not chopped or smashed, she stated, "maybe cut in half." The resident received a glass of water and apple juice. Before the resident drank the liquids, a licensed nurse (#5) confirmed staff had not thinkened the liquids. An unidentified certified nursing assistant stated, "I put thickener in them" and after stirring the water and apple juice the fluids became thickened liquids. The facility staff failed to serve chopped green beans and thickened liquids as ordered. During an interview on 06/24/21 at 9:10 a.m., a dietary manager (#2) confirmed she expected Resident #43 to receive a diet as ordered including slurried spice cake, chopped green beans, and thickened liquids.	F 805	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.	