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 08/10/2021

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 An unannounced onsite complaint investigation survey was completed on August 10, 2021. The concerns identified by the complainant were partially substantiated. The sample included three (3) sampled residents.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide necessary care and services for 1 of 1 sampled resident (Resident #1) who received a burn after a coffee spill. Failure to assess Resident #1's inner thigh in a timely manner may have resulted in delayed treatment and physical discomfort. Findings include: Review of the facility policy titled "Notification Of Change- Rehab/Skilled" occurred on 08/10/21. This policy Reviewed/Revised May 2021, stated, ". . . A facility must immediately . . . consult with the resident's physician . . . when there is: 1. An accident involving the resident which results in injury and has the potential for requiring physician intervention . . ."	F 684	It is the intent of this facility to remain in compliance with F684 and provide care of the upmost quality to our residents as evidenced by the following: Burns- Rehab/Skilled Policy was reviewed and remains in place unchanged. Education and emphasis is placed on adherence to this policy as it is written. Resident #1 was assessed by their provider and received orders for treatment. By 8/18/21, patient's burn was determined to be resolved and treatment was stopped by their provider. All residents were evaluated and the facility determined burns have the potential to affect all residents. Mandatory education for all nurses will be	9/14/21

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

Electronically Signed | 09/08/2021

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F 684	Continued From page 1 Review of Resident #1's medical record occurred on 08/10/21. Diagnoses included dementia with behavioral symptoms and unspecified anxiety disorder. The current physician's orders identified the following: * 08/03/21 at 9:00 p.m., ". . . Cleanse right inner thigh skin burn with NS (normal saline), apply silvadene ointment, and cover with non-stick telfa dressing until healed . . ." A wound assessment, dated 08/06/21, identified, ". . . Traumatic wound . . . Full thickness . . . Continue with current plan of treatment . . ." The Progress Notes Identified: * 08/01/21 at 2:42 p.m. ". . . Late Entry: . . . Resident came rushing to me stating he had spilled his coffee down his front. I was in the middle of a task unable to stop so I said, Go [sic] to your room, remove your pants and put a sheet over you to cool the area. I would be in shortly to see him. He said 'I'm gonna find a real nurse' and sped off. Within 10 minutes I seen him going to his room, entered shortly after and asked how he was. He wanted to know if I would put salve on his burn area. I said no I needed the area to cool and I would assess and take the correct action . . . I again asked what he wanted from me and he just said 'Nothing!' and waved me out. I left anticipating no action was needed . . ." * 08/02/21 at 4:25 p.m., ". . . Resident came to nurse to assess right inner thigh from hot liquid burn. Nurse assessed and noticed a blister that had popped. Nurse notified nurse manager and wrote note for provider to assess tomorrow.	F 684	completed by September 13th, 2021 and will include a review of the Burns policy, review of the Wound Data Collection User Defined Assessment and review of the physician notification process as it relates to burns. To ensure compliance the following QI monitoring will be completed by the QI coordinator and or her designee using the QI worksheet entitled: CQI Worksheet-F684: Quality of Care- Burns. QI monitoring will be completed on all burns that occur beginning the week of September 15th, 2021. Compliance will be monitored weekly x 4 and then monthly x 5. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI committee meetings and the results will be summarized at the quarterly QAPI meeting with the medical director in attendance. The need for further monitoring will be determined based on these results.	

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F 684	Continued From page 2 Nurse cleansed wound with NS and left it to air dry. Wound nurse suggested Silvadene to wound . . ." * 08/02/21 at 8:00 p.m., ". . . At [7:30 p.m.] Resident was very upset he said 'I am hurting and no one cares, maybe it is just time for me to die, since no one wants to take care of me any way'. I asked him if he would like a pain pill and he said 'no I want something for on [sic] this pointing to his right inner thigh were he had redness. I told him I would call the on call provider. On call provider, [Physician], was updated, order received to applied Bacitracin to redness . . . every 4 hours PRN [PRN] for pain and comfort . . ." * 08/03/21 at 11:36 p.m., ". . . son . . . Stated that [Resident #1] has called him reporting pain to his thigh. Informed him about the new order for Silvadene cream to be delivered from pharmacy today . . ." * 08/06/21 at 3:31 p.m., ". . . Resident was seen today for weekly wound measurements . . . He continues with a burn to the right inner thigh. Wound care completed as ordered . . ." The facility failed to: * Assess Resident #1's burn immediately following the coffee spill on 8/01/21 at 2:42 p.m. * Describe/measure the injury after staff noted a popped blister on 8/02/21 at 4:25 p.m. * Obtain a physician order for the burn injury until 08/03/21 at 9:00 p.m., approximately 54 hours after Resident #1 received a burn after a coffee spill. During an interview on 08/10/21 at 5:30 p.m., an administrative nurse (#2) acknowledged the facility failed to assess Resident #1's burn injury	F 684		

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F 684	Continued From page 3 and notify the physician in a timely manner.	F 684		