

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER St Vincent's - A Prospera Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 N 26th St Bismarck, ND 58501	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39685</p> <p>Based on observation, review of facility policy and staff interview, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity and individuality for 2 of 2 supplemental residents (Resident #6 and #16) who received insulin and blood glucose checks. Failure to administer insulin and perform blood glucose checks in a private area does not preserve the resident's personal dignity, infringes upon the resident's rights to privacy, and has the potential to affect the resident's psychosocial well-being.</p> <p>Findings include:</p> <p>Review of the facility policy titled Resident Dignity occurred on 04/03/25. This policy, revised 12/11/24, stated, PURPOSE: To assist with respecting and ensuring residents rights . The interdisciplinary team will assist all staff members in maintaining the dignity of every resident . respecting resident's private space . providing the resident with privacy . confidentiality.</p> <p>Observations showed nursing procedures completed in the commons area as follows:</p> <p>* 04/01/25 at 11:43 a.m., a nurse (#20) performed a blood glucose check, pulled up Resident #6's shirt and administered insulin in the resident's abdomen as multiple residents and staff observed.</p> <p>* 04/02/25 at 8:25 a.m., a nurse (#20) performed a blood glucose check, pulled up Resident #16's shirt and administered insulin in the resident's abdomen as multiple residents and staff observed.</p> <p>During an interview on the afternoon of 04/03/25, an administrative nurse (#2) stated she expected staff to take residents to a private area to perform blood glucose checks and administer insulin.</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 355060	Facility ID: 355060 If continuation sheet Page 1 of 31

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>27221</p> <p>Based on record review, review of the facility's policy, and staff interview, the facility failed to ensure the right to participate in the development and implementation of the person-centered plan of care for 1 of 1 sampled resident (#243) reviewed for care planning. Failure to afford Resident #243 and/or a family representative the opportunity to participate in the care planning process restricted their right to make decisions/provide input regarding any potential changes to Resident #243's care, treatment, and/or interventions.</p> <p>Findings include:</p> <p>Review of the facility policy titled Advanced Care Planning occurred on 04/03/25. This policy, revised on 12/02/24, stated, . Purpose: To provide each resident the opportunity to make decisions regarding medical care . assist residents to make their choices known regarding well-being and treatment . Residents and resident surrogate or proxy decision makers have the right to make decisions concerning medical care, including the right to accept or to refuse medical . treatment.</p> <p>During an interview on 04/03/25 at 12:24 p.m., an administrative nurse (#2) reported staff conduct care conferences every quarter, after a significant change, and after a hospitalization .</p> <p>Review of Resident #243's medical record occurred on all days of survey. The progress notes lacked evidence the facility invited Resident #243 and/or a family representative to care conferences following admission/quarterly assessments on 05/06/24, 10/30/24, and 01/30/25.</p> <p>Facility staff failed to afford Resident #243 and/or his family representative the opportunity to participate in the care planning process on a quarterly basis and/or after each hospitalization and failed to inform him, in advance, of changes to the plan of care.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52000</p> <p>1. Based on record review, review of facility policy, and resident, family, and staff interviews, the facility failed to ensure residents remained free from physical and mental abuse for 1 of 1 confidential resident (Resident A) with allegations of abuse. Failure to provide services necessary to avoid mental/emotional distress and physical harm resulted in fear and an unsafe environment for Resident A and has the potential for all residents to experience psychosocial harm.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse and Neglect occurred on 04/03/25. This policy, revised 07/22/24, stated, . The resident has the right to be free from abuse . Residents must not be subjected to abuse by anyone, including, but not limited to . employees .</p> <p>Review of Resident A's medical record occurred on all days of the survey. Diagnoses included vertigo and hemiplegia/hemiparesis of the left side. The annual Minimum Data Set (MDS), dated [DATE], identified intact cognition and substantial assistance required for activities of daily living. The current care plan identified assist of one with sit-to-stand lift for transfers when the resident had complaints of vertigo.</p> <p>During confidential interviews on 03/31/25 through 04/02/25, Resident A and a family member #1 reported the following:</p> <ul style="list-style-type: none"> * Some staff are rough during cares and identified certified nurse aides (CNAs) (#7 and #8). * If Resident A expressed concern regarding roughness, the CNAs would be rougher the next time. * Resident A's hands would hit the side rail and door frames when turned and transferred by staff. * Staff pulled the resident to a sitting position by the back of Resident A's neck. * Resident A expressed fear and retaliation from a CNA (#8). * Resident A expressed emotional/mental distress regarding being a burden to the facility's staff. <p>Observations on all days of survey showed a bruise to Resident A's left hand. The resident indicated the bruise occurred while staff transferred him/her about a week ago. Review of the medical record lacked documentation of the bruise.</p> <p>During an interview on 04/03/25 at 12:24 p.m., an administrative nurse (#2) confirmed she was aware of Resident A's abuse allegation but unaware of any bruises.</p> <p>Refer to 609 and 610</p> <p>27221</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from abuse for 1 of 1 sampled resident (Resident #243) who had explosive outbursts and/or inappropriate behaviors towards other residents. Failure to assess, care plan, and operationalize an effective plan of care resulted in an unsafe environment and anxiety/fear for residents residing on the same unit as Resident #243.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse and Neglect occurred on 04/03/25. This policy, revised 07/22/24, stated, . The resident has the right to be free from abuse . Residents must not be subjected to abuse by anyone, including, but not limited to . other residents . Alleged or suspected violations involving any mistreatment . or abuse . will be reported immediately to the administrator.</p> <p>Review of Resident #243's medical record occurred on all days of survey. Diagnoses included anxiety, cerebral infarction (stroke), dementia, and mental disorder requiring continuous supervision. The physician's orders, dated 03/26/25, showed the resident received Carbamazepine for aggressive behaviors and Hydroxyzine HCl and Olanzapine for anxiety and/or depression.</p> <p>The progress notes identified the following:</p> <p>* 01/10/25 at 1:19 a.m., Resident is moody, sarcastic, irritable, verbal aggression towards others with much swearing. Resident has explosive temper.</p> <p>* 01/11/25 at 9:55 p.m., Resident . Brought to commons area and he became angry . yelling obscenities . He was very inappropriate to the point of being abusive, and this took place in front of other residents.</p> <p>* 01/25/25 at 8:31, p.m., . Later on in dayroom, [Resident #243] urinated in emesis bag, and was yelling loudly . He was swearing, and urine noted to be on floor and table.</p> <p>* 01/28/25 at 9:27 a.m., Resident was in the family room spitting on the walls and floor.</p> <p>* 01/29/25 at 11:30 a.m., [Resident #243] was sitting at the nurse's station with several residents sitting around him. He . talked for several minutes on his cell phone continually using foul language in a loud voice. When he was done on phone this author informed him that if he is going to use that kind of language, he needed to go back to his room so the other people didn't have to hear it. He stated 'that they can't hear or see so what difference does it make.'</p> <p>* 01/29/25 at 3:40 p.m., resident spent most of the shift, yelling and swearing . Staff was putting other residents down that were sitting at the table he was at.</p> <p>* 01/30/25 at 9:00 p.m., [Staff] called [NAME] ER [emergency room] to talk to Dr [doctor] about resident [sic] aggressive behavior towards . other residents. Explained that resident . has made comments that [sic] with residents around that they are all here to die, they just drool and stare he was told to not say those things and resident will keep saying them. Facility expressed to hospital ER that the resident was a risk to himself and others . Resident [sic] are nervous around him. Expressed our concern for safety of others due to resident behavior and that he poses a threat.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>* 01/31/25 at 9:00 a.m., Resident sitting at nurses station eating breakfast another male resident sitting at the nurses station. The other male resident stated 'to [Resident #243] why are you giving the nurses around here a hard time.' [Resident #243] stated 'what the hell do you know about it.' The other male resident stated 'you need to show some respect were you raised that way to show no respect.' [Resident #243] stated to other male resident 'I am going to kick your [blaspheme] you mother [blaspheme].' The other male resident stated 'I'm going to bust your [blaspheme] face up.' Nurse instructed caregiver to remove other male resident from the table.</p> <p>* 01/31/25 at 9:18 p.m., . Resident . Urinating in dayroom in urinal and leaving on table. Reported by staff from day shift that he was swearing directly to other residents.</p> <p>* 02/03/25 at 1:40 a.m., . Resident . Requests to sit at table in commons area with other residents and as he does will frequently urinate into an emesis bag and lay the bag on the table. He becomes angry at staff when the bag is removed, he continues to do this while sitting at the table and urinates in front of other residents . and family members that pass through the commons area.</p> <p>* 02/10/25 at 10:00 a.m., . Notified hospital that due [to] safety of residents . we were not going to be able to take [Resident #243] back to [facility] and that we were going to be discharging him effective today. Explained that we are just not able to meet his needs due to his aggression and behaviors .</p> <p>* 02/10/25 at 12:43 p.m., Notified Son that facility was going to be discharging resident due to safety concerns for other residents . and we are not able to meet his needs. Explained to [daughter] why the facility was discharging resident due to not being able to meet his needs, due to safety concerns from residents .</p> <p>* 02/10/25 at 1:51 p.m., Hospital called [facility] to discuss [Resident #243's] return. [Staff] talked with the hospital social worker about [Resident #243] and his behaviors . Facility is unable to meet [Resident #243's] needs, posing safety concerns to residents .</p> <p>* 03/24/25 at 9:21 a.m., Touched based with daughter to see how residents weekend was and if there was anything new the facility would need to know. Resident was started on a new anxiety medication and seemed to have a good weekend. Stated our plans was to still admit resident Wednesday morning at 10:30 am.</p> <p>* 03/27/25 at 12:59 p.m., . from 10pm to 12:40am [Resident #243] rang his call light 14 times, asked resident what could we do to help him make his transition back, resident stated that he will call when he needs staff. I did explain that we are going to have to talk more if it starts affecting other resident . We did also talk about appropriate place to urinate, explained that we can not urinate in emesis bags that is not what they are used for and it is an infection control concern.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>* 03/30/25 at 3:25 p.m., [Resident #243] is manipulating staff's time and screams and yells when he doesn't get immediate assistance. He was noted to roam the hallways and knocks and yells on other residents doors, opening them to look for staff to help him . He opened another residents door as staff was assisting this resident with putting her bra on. It was also reported several times from other residents and family members about his inappropriate language, complaints regarding food served and his appearance in the main dining room. There has been requests to file formal complaints on this matter. It has been verbalized by other residents . of being fearful of this resident due to his explosive outbursts and behaviors. Staff have also been receiving complaints of behaviors in the commons area of urinating in emesis bags in front of other resident or family members . passing through. Educated resident about this behavior/habit but he continues with this behavior.</p> <p>Resident #243's current care plan stated, [Resident #243] has a hx [history] of behavioral symptoms such as yelling and swearing at staff. At times he can be vulgar with his choice of words and say racist comments to the staff, and refused cares. Provide a calm, quite atmosphere . Re-direct resident to not swear . The care plan failed to address Resident #243's explosive outbursts and/or inappropriate behaviors towards other residents.</p> <p>During an interview on 04/03/25 at 12:20 p.m., when asked questions regarding the incident that occurred on 01/31/25, an administrative staff member (#1) stated, I didn't know about this. I will be submitting a report today and doing an investigation.</p> <p>The facility failed to assess and monitor Resident #243's patterns of behavior in an effort to protect other residents from abuse and minimize his aggressive and/or inappropriate behaviors towards other residents. The facility failed to ensure Resident #243 did not infringe upon the rights of other residents to be free from verbal abuse.</p>		

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<p>F 0605</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489</p> <p>Based on observation, record review, and review of the North Dakota Resident's Rights Guide, the facility failed to ensure residents remained free of chemical restraints for 1 of 1 sampled resident (Resident #37) with an as needed (PRN) psychotropic medication. Failure to assess resident behaviors in an effort to determine causative/precipitating factors, develop a behavioral care plan, and implement individualized interventions in an attempt to manage behaviors resulted in the frequent utilization of psychotropic medications to control Resident #37's behavior.</p> <p>Findings include:</p> <p>Review of the North Dakota Long Term Care Ombudsman Program Resident's Rights Guide, dated 03/21/23, pages 12-13 stated, . Chemical . Restraints may not be used for the convenience of the staff or for disciplinary reasons . Chemical Restraints means a 'psychopharmacological drug that is used for discipline or convenience' .</p> <p>Review of Resident #37's medical record occurred on all days of survey. Diagnoses included vascular dementia, anxiety disorder, Alzheimer's Disease, restlessness and agitation.</p> <p>Physician's orders identified the following:</p> <p>* 12/17/24 Ativan (an antianxiety medication) 0.5 milligrams (mg) every six hours PRN for restlessness, agitation, and anxiety.</p> <p>* 01/14/25 Ativan 0.5 mg at 4:00 p.m. and continue 0.5 mg every six hours PRN for agitation, restlessness and anxiety.</p> <p>* 03/04/25 Change order to ativan 0.5 mg twice a day at 4:00 p.m. and bedtime. Continue PRN 0.5 mg every six hours as needed for agitation, restlessness and anxiety.</p> <p>Observations of Resident #37 showed the following:</p> <p>* 03/31/25 at 12:55 p.m. asleep in the recliner, curled up in a ball. A certified nurse aide (CNA) (#15) shook the resident's right shoulder and stated the resident's name several times. The resident did not respond and her eyes remained closed. Two CNAs (#14 and #15) utilized the sit to stand lift (mechanical lift) to transfer the resident from the recliner to the wheelchair and to the bathroom. The CNAs physically placed the resident's hands on the assist bars of the sit to stand lift. The resident's eyes remained closed with no response during toileting.</p> <p>* 04/01/25 at 11:35 a.m. asleep in the wheelchair with head resting on chest.</p> <p>* 04/02/25 at 10:20 a.m. asleep in the recliner and leaning to the left side. A CNA (#16) shook the resident's right shoulder and stated the resident's name several times. The resident did not respond and her eyes remained closed. Another CNA (#15) stated, We'll need to use the pal lift [sit to stand lift].</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #37's current care plan stated, . has impaired cognitive function or impaired thought processes R/T [related to] Alzheimer's Disease . AMBULATION/LOCOMOTION/TRANSFERS: [Resident's name] is able to walk with Ax1 [assist of one staff] gait belt and FWW [front wheeled walker] on the unit. Ativan for anxiety . has a mood problem r/t major depressive disorder and anxiety . (depression and anxiety): Attempt non-pharmacological interventions: loves visiting with the staff and enjoys listening to the TV.</p> <p>The care plan failed to address and specify Resident #37's behaviors and types of non-pharmacological interventions.</p> <p>An admission Minimum Data Set (MDS), dated [DATE] and a quarterly MDS, dated [DATE], showed Resident #37 did not exhibit wandering, rejection of care, verbal, physical and/or other behaviors.</p> <p>Review of Resident #37's electronic medication administration record (EMAR) from December 18th, 2024, through February 28, 2025, (approximately 73 days), identified staff administered PRN Ativan 50 times. The nursing progress notes indicated the facility staff administered PRN Ativan due to the resident's restlessness, agitation, rudeness to staff, refusing cares, aggression to the staff, and wanting to leave the facility.</p> <p>The medical record included the following progress notes:</p> <ul style="list-style-type: none"> * 01/14/25 at 11:02 a.m., . Seen by psych, [psychiatry] resident improved. * 01/19/25 at 3:09 p.m., . Mood and behavior team met for month of December [2024] she comments about going home and becomes restless at times . * 01/30/25 at 2:10 p.m., . Mood and behavior team met for the month of January [2025] her behaviors have been much. [sic] No new concerns for mood or behavior were noted at this time. * 02/26/25 at 4:43 p.m., . Mood and behavior team met for the month of February [2025]. There are no concerns with mood or behavior wise noted for the month. * 03/13/25 at 2:34 p.m., . Behavior team met for month of March [2025]. Resident less anxious and wanting to sleep more. <p>A physician's progress note dated, 03/04/25, stated, . Review of MAR does indicate PRN ativan is used often. Will schedule a bedtime dose in addition to afternoon dose and continue PRN. has PRN Ativan 0.5 mg [milligrams] every 6 hours as needed. MAR indicates that in the last month, she did use ativan 10x [times] with needing it twice on two of those days. Overall improved and not so problematic .</p> <p>Failure to assess and implement behavioral and non-pharmacological interventions before utilization of PRN Ativan may have contributed to the resident's increased sleeping, and decreased responsiveness to staff.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27221</p> <p>Based on record review, review of the facility's policy, and resident, family, and staff interviews, the facility failed to ensure all alleged violations involving abuse were reported immediately to the administrator of the facility and to other officials (including the State Survey Agency) for 1 of 1 sampled resident (Resident #243) and 1 confidential resident (Resident A). Failure to report Resident A's allegation of abuse to the state agency, and an incident involving Resident #243 and another resident to the administrator and State agency placed all residents at risk of mistreatment, verbal abuse, and/or experiencing anxiety/fear.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse and Neglect occurred on 04/03/25. This policy, revised on 07/22/24, stated, . suspected violations involving any mistreatment . or abuse . will be reported immediately to the administrator. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency .</p> <p>- Review of Resident A's medical record occurred on all days of the survey. The annual Minimum Data Set (MDS), dated [DATE], identified intact cognition and required substantial assistance for activities of daily living.</p> <p>During confidential interviews on 03/31/25 through 04/02/25, Resident A and a family member #1 reported the following:</p> <ul style="list-style-type: none"> * Staff are rough during cares. * When assisted to a seated position, staff grab the resident by the back of his/her neck. * Indicated a bruise to his/her left hand occurred when Resident A's hand hit the side rail while staff transferred him/her. * Staff disregard requests when answering the his/her call light. <p>During an interview on 04/03/25 at 12:24 p.m., an administrative nurse (#2) confirmed the facility failed to report Resident A's allegations to the state agency.</p> <p>- Review of Resident #243's medical record occurred on all days of survey. Diagnoses included anxiety, cerebral infarction (stroke), dementia, and mental disorder requiring continuous supervision.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 01/31/25 at 9:00 a.m., stated, Resident [#243] sitting at nurses station eating breakfast another male resident sitting at the nurses station. The other male resident stated to [sic] [Resident #243] 'why are you giving the nurses around here a hard time.' [Resident #243] stated 'what the hell do you know about it.' The other male resident stated 'you need to show some respect were you raised that way to show no respect.' [Resident #243] stated to other male resident 'I am going to kick your [blaspheme] you mother [blaspheme].' The other male resident stated 'I'm going to bust your [blaspheme] face up.' Nurse instructed caregiver to remove other male resident from the table.</p> <p>During an interview on 04/03/25 at 12:20 p.m., when asked what steps the facility took when Resident #243 threatened another resident on 01/31/25, an administrative staff member (#1) stated, I didn't know about this.</p> <p>Facility staff failed to identify Resident #243's explosive outbursts and/or inappropriate behaviors as abusive and failed to report the incident that occurred on 01/31/25 to the administrator and State agency.</p> <p>52000</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27221</p> <p>Based on record review, review of facility policy, and resident, family, and staff interviews, the facility failed to thoroughly investigate alleged violations of abuse for 1 of 1 sampled resident (Resident #243) and 1 confidential resident (Resident A). Failure to thoroughly investigate Resident #243's incidents of abusive behavior and Resident A's allegations of abuse, ensure the protection of other residents during the investigation, implement corrective actions, and evaluate the effectiveness of the actions, placed all residents at risk for mistreatment, verbal abuse, and/or experiencing anxiety/fear.</p> <p>Findings include:</p> <p>Review of the facility policy titled Abuse and Neglect occurred on 04/03/25. This policy, revised on 07/22/24, stated, . The location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in process. If the alleged or suspected violation is verified, appropriate corrective action will be taken.</p> <p>- Review of Resident A's medical record occurred on all days of the survey. The annual Minimum Data Set (MDS), dated [DATE], identified intact cognition and required substantial assistance for activities of daily living.</p> <p>During confidential interviews on 03/31/25 through 04/02/25, Resident A and a family member #1 reported the following:</p> <ul style="list-style-type: none"> * Staff are rough during cares. * When assisted to a seated position, staff grab the resident by the back of his/her neck. * Indicated a bruise to his/her left hand occurred when Resident A's hand hit the side rail while staff transferred him/her. * Staff disregard requests when answering the his/her call light. <p>An administrative staff member (#1) provided a document regarding CNA (#7's) performance. An excerpt, dated 12/04/24 stated, . [administrative staff member name] sent [administrative staff member name] and I an e-mail letting us know that she talked to [name of CNA (#7)] this morning about the abuse allegation and sent her home for administrative leave. The document failed to show any information about the allegation/investigation.</p> <p>During an interview on 04/03/25 at 12:24 p.m., an administrative nurse (#2) confirmed she was aware of Resident A's allegations.</p> <p>- Review of Resident #243's medical record occurred on all days of survey. Diagnoses included anxiety, cerebral infarction (stroke), dementia, and mental disorder requiring continuous supervision.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 01/31/25 at 9:00 a.m., stated, Resident [#243] sitting at nurses station eating breakfast another male resident sitting at the nurses station. The other male resident stated to[Resident #243] 'why are you giving the nurses around here a hard time.' [Resident #243] stated 'what the hell do you know about it.' The other male resident stated 'you need to show some respect were you raised that way to show no respect.' [Resident #243] stated to other male resident 'I am going to kick your [blaspheme] you mother [blaspheme].' The other male resident stated 'I'm going to bust your [blaspheme] face up.' Nurse instructed caregiver to remove other male resident from the table.</p> <p>During an interview on 04/03/25 at 12:20 p.m., when asked what steps the facility took when Resident #243 threatened another resident on 01/31/25, an administrative staff member (#1) stated, I didn't know about this.</p> <p>The facility failed to thoroughly investigate the incident that occurred on 01/31/25 between Resident #243 and another resident and the allegations by Resident A, prevent further potential verbal abuse and mistreatment while the investigation is in process, and implement appropriate corrective actions.</p> <p>52000</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489</p> <p>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual and staff interview, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 3 sampled residents (Resident #37) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability to accurately assess the resident's status and identity and implement appropriate care approaches.</p> <p>Findings include:</p> <p>The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.18.11), dated October 2023, page 2-24 stated, . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. and Page 2-27 stated, A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. Any decline in an ADL [activities of daily functioning] physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning.</p> <p>Review of Resident #37's medical record occurred on all days of survey. An admission Minimum Data Set (MDS), dated [DATE], identified supervision required with oral hygiene and moderate/partial assistance required with taking on/off socks and shoes. A quarterly MDS, dated [DATE], identified as moderate/partial assistance required with oral hygiene, maximum/substantial assistance required with taking on/off shoes and socks and a weight loss.</p> <p>The record lacked evidence facility staff identified and/or completed a SCSA following Resident #37's decline in activities of daily living and weight loss.</p> <p>During an interview on 04/03/25 at 11:16 a.m., an administrative staff nurse (#13) verified Resident #37 declined with oral hygiene, taking on/off shoes and socks, and had a weight loss.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19410</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 5 of 23 sampled residents (Residents #37, #76, #243, and #443). Failure to update care plans limited the staffs' ability to communicate needs and ensure continuity of care.</p> <p>Findings include:</p> <p>Review of the facility policy titled Care Plan occurred on 04/03/25. This policy, dated 12/02/24, stated, . POLICY: Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care . The plan of care will be modified to reflect the care currently required/provided for the resident.</p> <p>- Review of Resident #37's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. A physician's order, dated 12/17/24, stated ativan (an antianxiety medication) 0.5 milligrams (mg) every six hours PRN for restlessness, agitation, and anxiety.</p> <p>Resident #37's current care plan stated, . has impaired cognitive function or impaired thought processes R/T [related to] . Alzheimer's Disease . document/report to health care provider any changes in cognitive function, specifically</p> <p>changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. DEMENTIA / IMPAIRED THOUGHTS: Attempt non-pharmacological interventions: Reduce any distractions- turn off TV [television], radio, close door etc. [ec cetera] . Ativan for anxiety . has a mood problem r/t . major depressive disorder and anxiety . (depression and anxiety): Attempt nonpharmacological interventions: loves visiting with staff and enjoys listening to TV.</p> <p>Review of Resident #37's electronic medication administration record (EMAR) from December 18th, 2024, through February 28, 2025, (approximately 73 days), identified staff administered PRN Ativan 50 times. The nursing progress notes indicated the facility staff administered PRN Ativan due to the resident's restlessness, agitation, rudeness to staff, refusing cares, aggression to the staff, and wanting to leave the facility.</p> <p>Resident #37's care plan failed to address and specify the resident's behaviors and types of non-pharmacological interventions.</p> <p>- Review of Resident #76's medical record occurred on all days of survey. The record identified a lesion/boil to the resident's inner thigh on 03/16/25 and to the back of the head on 03/19/25. The provider ordered Bacitracin (topical antibiotic) and a warm compress to the area on 03/16/15 and Doxycycline (an antibiotic medication) on 03/19/25.</p> <p>Resident #76's care plan failed to address the skin issues and antibiotic use.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Review of Resident #243's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, anxiety, dementia, depression, and mental disorder. Staff indicated the resident posed a serious threat to other residents and described him as having an explosive temper and indicated he put other residents down, yelled obscenities at/in front of other residents, threatened other residents, roamed the halls knocking on/opening the doors to other residents' rooms while looking for staff, spit on the walls and floor in the family room, and urinated in emesis bags in front of other residents/their family members in the commons area.</p> <p>Resident #243's care plan failed to address his behaviors towards other residents residing in the facility.</p> <p>Resident 243's medical record also showed a diagnosis of diabetes mellitus. The current physician's orders included 100 units/milliliter Insulin Lispro Injection Solution per sliding scale four times a day for diabetes.</p> <p>Resident #243's care plan failed to address symptoms of diabetes and/or the possible complications that may occur.</p> <p>- Review of Resident #443's medical record occurred on all days of survey. Diagnoses included quadriplegia and an abdominal wound. A quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #443 is at risk for developing pressure ulcers.</p> <p>Resident #443's care plan lacked a problem, goal, and interventions related to the resident's abdominal wound and high risk for developing pressure ulcers.</p> <p>40489</p> <p>27221</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>51999</p> <p>Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #1) with high blood glucose readings. Failure to notify the provider of high blood glucose levels as ordered may result in adverse outcomes for the resident.</p> <p>Findings include:</p> <p>Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText 2021, Pearson, Boston, Massachusetts, page 63, stated, Carrying Out a Physician's: Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out.</p> <p>Review of Resident #1's medical record occurred on all days of survey and included a diagnosis of type 2 diabetes mellitus. A physician's order, dated 10/10/24 stated, ACCU-CHECKS [blood glucose monitoring] before meals. Call PCP [Primary Care Provider] if BS [blood sugar] is < [less than] 60 or > [greater than] 400.</p> <p>Review of Resident #1's Blood Sugar Summary, dated January 1 - March 31, 2025, showed the following blood glucose readings:</p> <p>* 01/24/25 at 12:22 p.m. - 567.0 mg/dL [milligrams per deciliter]</p> <p>* 01/26/25 at 5:21 p.m. - 404.0 mg/dL</p> <p>The medical record lacked documentation the facility notified Resident #1's provider of the elevated blood glucose levels.</p> <p>During an interview on 04/03/25 at 2:47 p.m., an administrative staff member (#1) confirmed staff failed to notify the physician of Resident #1's high blood sugar levels on the above dates.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>39685</p> <p>Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide appropriate toileting and perineal care for 1 of 4 sampled residents (Resident #293) observed for toileting who required staff assistance. Failure to provide toileting assistance as care planned and proper perineal care may result in a loss of dignity and placed the resident at risk for skin breakdown, decreased self-esteem, and urinary tract infections (UTI).</p> <p>Findings include:</p> <p>Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis [skin] more easily eroded and susceptible to injury . Page 1221 stated, . scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry .</p> <p>- Review of Resident #293's medical record occurred on all days of survey. The care plan stated, . TOILET USE: Resident requires check and change. Resident can be unaware of when he is wet/soiled. BRIEF USE: Resident uses incontinence products for heavy incontinence. Check every 2-3 hours and prn [as needed].</p> <p>Observations of Resident #293 on 03/31/25 showed the following:</p> <p>* At 2:12 p.m., seated in a wheelchair in the activity room attempted to self-propel and stated to staff, I have to go, let me go. A CNA (#11) told the resident to stay there and sit down.</p> <p>* At 3:50 p.m., seated in a wheelchair and stated, I have to go and attempted to self-propel the wheelchair down the hallway. Two CNAs (#11 and #12) told the resident to stay there and did not assist the resident to the bathroom.</p> <p>* At 4:21 p.m., urine ran down Resident #293's wheelchair and on to the floor in the activity room.</p> <p>Review of Resident #293 toileting chart on the afternoon of 3/31/2025 showed staff toileted the resident at 01:33 p.m. and 05:00 p.m. (39 minutes after the incontinent episode observed in the activity room).</p> <p>During an interview on 03/31/25 at 5:18 p.m., an administrative nurse (#10) stated he/she expected staff to toilet residents as care planned and as needed.</p> <p>The facility staff failed to toilet Resident #293 as care planned.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40489</p> <p>1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate assessment and/or assistive devices necessary to prevent accidents for 2 of 7 sampled residents (Resident #25 and #37) who required assistance with transfers. Failure to provide appropriate assessment and use assistive devices during transfers placed the residents at risk of accidents and injury.</p> <p>Findings include:</p> <p>Review of the facility policy titled Gait-Transfer Belt occurred on 04/02/25. This policy, revised 05/02/24, stated, . a device used for stability and/or support for a short time during the actual transfer .</p> <p>Review of the facility policy titled Safe Resident Handling occurred on 04/03/25. This policy, stated, . Skilled . Licensed Nurses . Responds timely to caregivers reports of changes in the resident mobility and . The following documentation is used: To identify the resident's most appropriate method of transfer: Sit-Stand-Walk Data Collection Tool . used to identify resident needs for appropriate method of transfer .</p> <p>- Review of Resident #25's medical record occurred on all days of the survey. The care plan stated, . AMBULATION/TRANSFERS/MOBILITY: Assist of 1, gait belt .</p> <p>Observation on 04/01/25 at 11:05 a.m. showed a certified nurse aide (CNA) (#3) transferred Resident #25 from the bed to the wheelchair. The CNA reached under Resident #25's buttocks, assisted her to stand and stabilized her at the waist/arm to pivot to the wheelchair. The resident verbalized weakness in her legs during the pivot. The CNA (#3) reached under Resident #25's arm to boost and stabilize the resident, then transferred Resident #25 from the toilet back to the wheelchair. The CNA (#3) failed to use a gait belt during the transfers.</p> <p>- Review of Resident #37's medical record occurred on all days of survey. The care plan stated, . [Resident's name] has an ADL [activities of daily living] self care performance deficit . is able to walk with Ax1 [staff assistance of 1] gaitbelt and FWW [front wheeled walker] on the unit. WC [wheelchair] if needed for distances. Nurse to assess for changes in transfer.</p> <p>Observation on 03/31/25 at 12:55 p.m. showed Resident #37 asleep in the recliner. A (CNA) (#15) shook the resident's right shoulder and called her name several times as she attempted to wake the resident. The resident did not respond, and her eyes remained closed. Two CNAs (#14 and #15) used the sit to stand lift (mechanical lift) to transfer the resident from the recliner to the wheelchair, assisted the resident to the bathroom, and again used the sit to stand lift to transfer Resident #37 to the toilet. The CNAs physically placed the resident's hands on the assist bars of the sit to stand lift. The resident's eyes remained closed with no response during toileting.</p> <p>The facility failed to ensure a licensed nurse or therapy completed an assessment to ensure this method of transfer was safe for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/02/25 at 10:20 a.m. showed Resident #37 asleep in the recliner, and leaned to the left side. The sit to stand lift was located beside the recliner chair. A CNA (#16) shook the resident's right shoulder and called her name several times as he attempted to wake the resident. The resident did not respond, and her eyes remained closed. When asked how the resident is to be transferred the CNA (#16) stated, We can pivot transfer her with one or we can use the pal lift [sit to stand mechanical lift]. The CNA (#15) stated they were going to assist the resident to the bathroom and they need to use the pal lift. The CNA (#16) stated, I will go ask the nurse. The CNA (#16) returned from talking to the nurse and stated, She [the nurse] said to not toilet her right now, and just to reposition her.</p> <p>The medical record lacked documentation to identify the resident's most appropriate method of transfer.</p> <p>During an interview on the afternoon of 04/03/25, an administrative nurse (#2) stated if gait belts are used, it would be reflected in the care plan and confirmed the medical record lacked a therapy or nursing sit-stand-walk data collection tool/assessment for Resident #37.</p> <p>27221</p> <p>2. Based on record review, review of the facility reported incident (FRI) and investigation, and review of facility policy, the facility failed to provide appropriate supervision and/or assistance to prevent an accident for 1 of 1 sampled resident (Resident #243) who fell during transport from the facility van. Failure to properly position the anti-rollbacks resulted in Resident #243's fall/injury and placed all residents transferred with the van at risk for falls/injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident.</p> <p>Findings include:</p> <p>The surveyor determined a deficient practice existed on 10/11/24. The facility implemented and completed corrective action on 10/16/24.</p> <p>Review of the facility policy titled Vehicle Transfer occurred on 04/03/25. This policy, revised 12/02/24, stated, . Incorporating safe resident handling practices . into . vehicle transfers reduces the risk of injury for both the resident and employee. It is the responsibility of the licensed nurse to determine the most appropriate method of transfer based on the resident's support needs. Occasionally employees will accompany the resident to medical appointments.</p> <p>Review of Resident #243's medical record occurred on all days of survey. Diagnoses included abnormal posture, dementia, hemiparesis secondary to cerebral vascular accident (CVA), and obesity.</p> <p>The care plan, dated 03/14/25, stated, . [Resident #243] has an ADL [activities of daily living] self-care performance deficit . Continuous oxygen per nasal cannula. 3 liters. Anti-tip bars on wheel chair . When Loading/Unloading into facility Van. Staff will position upwards while going up and down the ramp for safety. Once situated in the van or off the ramp staff will be [sic] position anti-tip bars on wheel chair downward. [Resident #243] is at risk for falls R/T needing assist for transfers with complete mechanical lift . 10/11/24 Resident had a fall while coming out of the van going to an appointment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the FRI, dated 10/11/24, stated, Resident was being transferred to eye appointment, driver had completed the transport safely she [driver] had removed all safety devices and was starting to back wheelchair out of the van down the ramp. While taking the resident down the ramp resident anti roll back [bar] caught the edge of the ramp, with the weight of the resident, oxygen and wheelchair the staff member was not able to hold on to the resident and the resident was lowered down to the floor of the ramp. Driver was not able to say for sure if the resident hit his head resident state [sic] he did. Driver did call 911 clinic staff did come out and help until EMS arrived.</p> <p>A progress note, dated 10/11/2024 at 4:28 p.m., stated, Resident denies pain or nausea, denies dizziness. Describes incident this am, and states he may have landed on the back of his head. No lump or bruising seen. He is requesting tylenol and cyclobenzaprine [a muscle relaxant].</p> <p>The facility final FRI investigation report stated, Facility went out and checked all residents' wheelchairs and made staff aware of what residents have anti-rollbacks on their chairs, we did add statement under ADLs on their care plan [sic] that follows</p> <p>* Anti Rollbacks PREFERENCES: When loading/Unloading into facility Van. Staff will position upwards going up and down the ramp for safety. Once situated in the van or off the ramp Anti Rollbacks will be positioned downward.</p> <p>The facility failed to ensure Resident #243's anti-rollbacks were properly positioned while being transferred up/down the van ramp.</p> <p>Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for other residents who may be affected by the deficient practice as follows:</p> <p>* Completed an investigation into Resident #243's fall,</p> <p>* Updated the care plan for all residents with anti-rollback wheelchairs,</p> <p>* Re-education and competency evaluations provided to all facility drivers regarding anti-rollback wheelchairs on 10/11/24, and</p> <p>* Implemented audits on van transfers.</p> <p>52000</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>27221</p> <p>Based on observation, record review, review of facility policy, review of facility assessment, review of resident council meeting minutes, review of call light logs, review of staffing schedule, confidential resident and family interviews, and staff interviews, the facility failed to ensure sufficient nursing staff and related services are available at all times to meet the residents' needs for 2 of 23 sampled residents (Resident #243 and #293) and 11 confidential residents (Resident A, B, C, D, E, F, G, H, I, J, and K) who required staff assistance. Failure to provide sufficient staffing does not promote each resident's rights, physical, mental, and psychosocial well-being, and/or provide a safe environment for the residents.</p> <p>Findings include:</p> <p>Review of the facility assessment occurred on 04/03/25. The assessment stated, . [Facility] utilizes an interdisciplinary approach to meet the needs of our population and its individuals across all shift [sic] including nights and weekends . As the needs of the population change as indicated by the number of residents served, acuity levels, MDS [Minimum Data Set] results and care plans the staffing pattern is adjusted to meet those needs. We consider variability in care needs across day, evening, and night shifts, including weekends and holidays, and adjust as necessary. We confirm needs are met by engaging in frequent communication with residents, their families and representatives with regular care conferences, rounding, quality assurance audits, resident group meetings, availability of suggestion/concern forms and email surveys.</p> <p>Review of the facility policy titled Call Light occurred on 04/02/25. This policy, revised 07/29/24, stated, When resident's call light is observed/heard, go to the resident's room promptly.</p> <p>Review of the resident council meeting minutes, dated November 2024-February 2025, identified the following resident concerns:</p> <ul style="list-style-type: none"> * Call light was on for long periods of time. * Call light was on for 30 minutes to a hour. <p>The Resident Council met on 03/31/25 at 1:20 p.m. The residents voiced the following concerns during the meeting:</p> <ul style="list-style-type: none"> * Resident F stated he/she has waited 30 minutes for his/her call light to be answered. He/she also reported activities are often delayed and/or cut short due to a lack of staff. * Resident G stated he/she has waited 30 minutes for his/her call light to be answered, especially at 8:00 a.m. , 2:00 p.m., or 10:00 p.m. * Resident H stated he/she has waited over 30 minutes for his/her call light to be answered, and has experienced pain/discomfort waiting to go to the bathroom. He/she also reported the activities department was short staffed. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Confidential resident and family interviews identified the following:</p> <ul style="list-style-type: none"> * 03/31/25 Resident A stated, call lights were not answered around shift change, certified nurse aides (CNAs) seem rushed, and he/she has been left in the bathroom for long periods of time. * 03/31/25 Resident B stated, staff are so busy and rushed in the evening and after 10:00 p.m., they don't always check on me during the night. * 03/31/25 Resident C stated, he/she has waited 30-40 minutes at times for the call light to be answered. Stated, it is worse around 3:00 p.m. Sometimes they forget about me, they forget my breakfast and lunch and then they bring it to me late. Resident C stated one time they forgot to give me the call light (Resident not able to access call light on his/her own) and I was without it from 10:00 p.m. until 3:00 a.m. and then I started yelling and they came. Resident C stated there have been a few other times staff have forgotten to place the call light and he/she has just had to wait for a staff member to come. The resident stated he/she has tried calling the nurses' station, but not able to get through. * 03/31/25 Resident D stated, staff are so busy in the evening, I have to wait about 1/2 hour for my call light to be answered. * 03/31/25 Resident E stated, one time they came in and turned off the call light and said someone would be right in, but then they didn't come back for an hour. * 03/31/25 Resident J stated, I had to wait one hour for help to the bathroom. I can't hold it that long. Review of the call light log confirmed a wait time of 59 minutes on 03/30/25. * 03/31/25 Resident K stated, The aide [CNA] told me to press the light when I was done on the toilet. I kept calling and calling and she never came back. * 03/31/25 Family Member #1 stated when she called on the phone, she could not get ahold of the nurse's station, the call light was not always placed in reach of the resident, oral cares were not completed, and the resident was not dressed/toileted timely for appointments. * 03/31/25 Family Member #2 stated the facility is short of staff on weekends and evenings and there is not enough staff to assist residents who need help with eating * 04/01/25 When asked about staff's response time after the call light is activated, Resident I stated, I have to wait 30 to 45 minutes, and staff are rushed and short, not enough help. <p>Review of the call light logs from 03/26/25 to 04/01/25 showed the following:</p> <ul style="list-style-type: none"> * Resident C waited 22 minutes or greater on 14 occasions, with the longest time being 51 minutes. * Resident D waited 20 minutes or greater on ten occasions, with the longest time being 33 minutes. <p>- Review of Resident #243's medical record occurred on all days of survey. The progress notes identified the following:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* 01/26/25 at 3:21 p.m., resident was yelling, swearing at staff in the AM, upset about PM shift the previous night. Upset about having to wait for his call light to be answered at bedtime.</p> <p>* 02/01/25 at 5:46 a.m., Resident slept till 0330 [3:30] am he stated he put on his light and was waiting to long for the cna. Nurse was notified by cna that resident called the police to help him, police had asked if resident was safe and the cna stated he is sitting in his wheelchair at the nurses table. Police officers left facility at that time .</p> <p>- Review of Resident #293's medical record occurred on all days of survey. The care plan stated, . TOILET USE: Resident requires check and change. Resident can be unaware of when he is wet/soiled. BRIEF USE: Resident uses incontinence products for heavy incontinence. Check every 2-3 hours and prn [as needed].</p> <p>Observations of Resident #293 on 03/31/25 showed the following:</p> <p>* At 2:12 p.m., seated in a wheelchair in the activity room, attempted to self-propel, and stated, I have to go, let me go. A CNA (#11) told the resident to stay there and sit down.</p> <p>* At 3:50 p.m., seated in a wheelchair stated, I have to go. The resident attempted to self-propel the wheelchair down the hallway and two CNAs (#11 and #12) told the resident to stay there and did not assist the resident to the bathroom.</p> <p>* At 4:21 p.m., showed urine ran down the wheelchair and on to the floor in the activity room.</p> <p>Review of Resident #293 toileting documentation for 03/31/25 showed the staff last toileted the resident at 1:33 p.m.</p> <p>During an interview on 03/31/25 at 5:18 p.m., an administrative nurse (#10) stated he expected staff to toilet residents as care planned and as needed.</p> <p>On 03/31/25 at 3:36 p.m. and 5:00 p.m., staff interviews identified the following:</p> <p>* A nurse (#21) reported being responsible for 37 to 57 residents during each shift. She also indicated there are days she is not able to complete all her assigned duties during the shift.</p> <p>* An administrative staff member (#22) reported staffing is based on the census, and stated weekends are staffed the same as weekdays, except for baths. Residents are bathed Monday-Friday.</p> <p>During an interview on 04/03/25 at 8:38 a.m. an administrative staff member (#1) stated she expected call light wait times under 15 minutes or under 20 minutes during mealtimes.</p> <p>19410</p> <p>39685</p> <p>52000</p> <p>51999</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>27221</p> <p>Based on observation and review of facility policy, the facility failed to ensure posting of accurate staffing information on 2 of 4 days of survey (March 31 and April 2, 2025). Failure to post accurate staffing data does not allow residents and visitors to be aware of the number of licensed and unlicensed staff on duty each shift.</p> <p>Findings include:</p> <p>Review of the facility policy titled Nursing Staff Daily Posting Requirements occurred on 04/03/25. This policy, revised on 12/02/24, stated, . skilled care locations will post daily the staffing and resident census at the beginning of each shift and update as appropriate .</p> <p>Observation of the daily staffing report occurred on all days of survey as follows:</p> <p>* 03/31/25 at 3:50 p.m., the date of the report showed 03/29/25.</p> <p>* 04/02/25 at 10:25 a.m., the date of the report showed 04/03/25.</p> <p>The facility failed to ensure staffing information was posted on the correct day.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>39685</p> <p>Based on observation, facility policy, record review and staff interview the facility failed to ensure accurate reconciliation and storage of medications for 1 of 2 sampled residents (Resident #68) observed during medication pass. Failure to reconcile and dispose of medications may result in medications errors and the potential for drug diversion.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Medications: Acquisition Receiving Dispensing Storage occurred on 04/03/25. This policy, dated 03/04/25, stated, .Controlled: . To provide verification and reconciliation of all controlled medications . For all schedule II-controlled medications . the nurse/going off shift unlocks the controlled medication storage unit and then will go to the narcotic count book and read each controlled substance to the on-coming nurse . the on-coming nurse will verify the physical medication count matches the remaining amount listed in the controlled substance book for each medication . the on-coming nurse will physically examine the containers/packages of each controlled medication for evidence of tampering (opened packages) . should evidence of tampering be present, an incident report should be completed and the director of nursing notified immediately . if the physical count is NOT in agreement with the controlled substance book, the error must be completed prior to the end of shift and reported to the director of nursing before staff administering medications for the shift leave the building .</p> <p>Review of Resident #68's medical record occurred on all days of survey. The current physician orders included Morphine Sulfate Concentrate 20 mg/ml (milligrams per milliliter). Give 0.25 ml oral four times a day for pain and 0.25 ml every hour as needed.</p> <p>Observation on 04/02/25 at 8:40 a.m., showed a staff nurse (#23) opened the medication cart, obtained Resident #68's empty morphine sulfate bottle. Review of the narcotic count sheet showed 4.25 ml of morphine sulfate remained in the bottle.</p> <p>During an interview on the afternoon of 04/02/25, an administrative nurse (#2) stated she expected staff to reconcile and report discrepancies with narcotic medications immediately to nursing management per facility policy.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19410</p> <p>Based on observation, review of facility policy, test tray, and resident interviews, the facility failed to serve foods at palatable temperatures in 3 of 3 units ([NAME] Place, Sacred Heart Place, and [NAME] Place). Failure to serve food at a temperature that is acceptable and palatable to residents' places residents at risk of decreased intake, weight loss, and nutritional decline.</p> <p>Findings include:</p> <p>Review of the facility policy titled Dining Service Standards occurred on 04/03/25. This policy, dated 06/13/24, stated, . Definitions: Food Distribution - the process of getting food to the resident. This may include holding hot foods in a steam table or cold foods under refrigeration for temperature control, dispensing food portions for individual residents, and dining services including service to resident room. Meals assembled in the kitchen and delivered to residents' rooms or dining area must be covered individually or in a mobile food cart. PURPOSE: To provide an overview of desired expectations for a pleasant and positive dining experience . POLICY: . Residents will be provided meals that are nourishing, attractive, and palatable and are served at . appetizing temperature.</p> <p>Review of the facility policy titled Food Temperature Monitoring - Food and Nutrition Services occurred on 04/03/25. This policy, dated 12/16/24, stated, . Definitions: . Proper serving temperature - A temperature that is appetizing to the resident . this is the temperature when the food reaches the resident. Procedure: . Test tray monitoring occurs as a part of quality assurance monitoring to ensure temperatures are acceptable when the location uses room trays or satellite dining rooms. Temperatures for test trays are based on proper serving temperature, not tray line holding temperatures based on food safety. Test tray is checked after all residents have been served.</p> <p>Sacred Heart Place and Emmanuel Place Resident Interviews and Observations:</p> <ul style="list-style-type: none"> - Observation on 03/31/25 at 11:40 a.m. showed Resident #393 in his room eating lunch. The resident stated, The food is always cold. - During an interview on 03/31/25 at 11:58 a.m., Resident #44 stated the hot food is not always hot, she always eats in her room, and the toast is always cold because they make it ahead of time. -During an interview on 03/31/25 at 12:17 p.m., Resident #33 stated he always eats in his room for the evening meal and the food is not hot. - During an interview on 03/31/25 at 12:25 p.m., Resident #40 stated most of the time the food is cold, as I get my tray late. - Observation on 04/01/25 at 8:40 a.m., showed Resident #38 laying in bed with his breakfast tray at the bedside. The resident stated, I'm waiting to eat. She [the CNA assisting him] went to go make me some toast that is warm. - During an interview on 04/01/25 at 10:14 a.m., Resident #8 stated, Dining room food is cold when served. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Observation on 04/01/25 at 11:20 a.m. showed Resident #393 assisted to the dining room by a CNA. The resident stated, I'm going to the dining room because when I get my food in my room it is ice cold.</p> <p>- During an interview on 04/01/25, at 11:58, Resident #44 stated, the food is not hot</p> <p>- During an interview on 04/01/25 at 12:05 p.m., Resident #11 stated she ate in the dining room today and the temperature of the food was hot, but when she eats in her room by the time it gets to me it is cool.</p> <p>[NAME] Place Test Tray:</p> <p>Upon request, the kitchen staff sent a meal test tray in a cart to [NAME] Place. The cart arrived at 11:52 a.m. A staff member took the last tray out of the cart at 12:15 p.m. and delivered it to a resident. The surveyor took the test tray out at the same time, brought it to the conference room, and checked the temperatures of each food item. Temperatures were as follows: Chicken 104.8 degrees Fahrenheit (F), Zucchini 98 degrees F, Pasta 94 degrees F. The surveyors tasted the meal, and all confirmed the food was lukewarm, not hot.</p> <p>51999</p> <p>52000</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>19410</p> <p>Based on observation, review of professional reference, and staff interview, the facility failed to maintain cold storage areas and kitchen equipment in a sanitary manner for 1 of 1 kitchen. Failure to clean fans, ceilings, walls in areas where food is stored and failure to ensure a cleanable surface for kitchen equipment has the potential for contamination of food and may result in a foodborne illness.</p> <p>Findings Include:</p> <p>The 2022 Food and Drug Administration (FDA) Food Code, Chapter 3 Food, Section 3-305 Preventing Contamination From the Premises, Section 3-305.11 states, A. Food shall be protected from contamination by storing the food: . 2) Where it is not exposed to . dust, or other contamination.</p> <p>The 2022 Food and Drug Administration (FDA) Food Code, Annex 3, Chapter 4 Equipment, . Section 4-101. 11 Characteristics . equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens . Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food.</p> <p>The initial observation of the kitchen occurred on 03/31/25 at 11:40 a.m.m The final observation of the kitchen occurred on 04/03/25 at 12:00 p.m. with an administrative dietary staff member (#9). Observation on both days showed the following:</p> <p>* Walk in Cooler - accumulation of thick, dark black dust/dirt on the fan and accumulation of dust on the ceiling/wall around two separate condenser fans.</p> <p>* Walk in Freezer - accumulation of dark black dust/dirt on the fan and accumulation of dust on the wall/ceiling around the condenser fan.</p> <p>* Oven - handles of one reach-in oven covered with peeling/tattered duct tape, making it a non-cleanable surface.</p> <p>During an interview on 04/03/25 at 1:00 p.m., the administrative dietary staff member (#9) confirmed the presence of peeling/tattered duct tape on the oven doors and confirmed he expected staff to clean the black dust/dirt from the fans, walls, and ceilings in the walk-in cooler and freezer.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>27221</p> <p>Based on review of the State Agency (SA) facility files, survey findings, review of facility policy, and staff interview, the facility failed to develop a Quality Assurance and Performance Improvement (QAPI) process to evaluate and identify problems and opportunities to improve services/outcomes, decrease or prevent likelihood of problems or occurrence of adverse events, and ensure compliance with federal requirements.</p> <p>Findings include:</p> <p>Review of the facility policy titled Quality Assurance and Performance Improvement - QAPI occurred on 04/03/25. This policy, revised on 10/09/23, stated, . The QAPI program uses data to monitor the effectiveness and safety of services and quality of care; identify and prioritize problems and process improvement opportunities and takes action to address areas in need of improvement. Performance Improvement project activity will be monitored for progress and sustainability by the location.</p> <p>Review of the state agency files indicated the facility failed to maintain compliance at F657, F725, F761, F804, F812, and F880 as indicated by deficiencies cited during the last standard survey on 02/29/24. Refer to the F657, F725, F761, F804, F812, and F880 for specific findings.</p> <p>During an interview on 04/03/25 at 12:00 p.m., two administrative staff members (#18 and #19) indicated they developed a plan of correction, conducted audits throughout the year, and monitored performance. They also completed spot audits to ensure improvements were maintained.</p> <p>Failure of the facility to effectively utilize QA resulted in continued noncompliance in the following areas:</p> <ul style="list-style-type: none"> * F657 Care Plan Revisions * F725 Sufficient Nursing Staff * F761 Label and Store Medications * F804 Palatable Foods * F812 Store, Prepare, and Serve Food in Sanitary Manor * F880 Infection Control 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19410</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 5 sampled residents (Resident #78) in Enhanced Barrier Precautions (EBP) and 1 of 4 sampled residents (Resident #25) who required staff assistance with perineal care. Failure to practice infection control standards related to EBP, urinary catheter care, and perineal care has the potential to spread infection throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility policy, Standard and Transmission-Based Precautions occurred on 04/03/25. This policy, dated, 04/02/24, stated, Purpose: . To prevent the spread of infection . Enhanced Barrier Precautions (EBP): Enhanced barrier precautions expand the use of PPE [personal protective equipment] beyond situations in which exposure to . body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities . Enhanced Barrier Precautions are needed for residents with . Indwelling Medical devices (. indwelling urinary catheters). High-Contact Resident Care Activities include: . device care or use (. urinary catheter).</p> <p>Review of the facility policy titled Perineal Care occurred on 04/03/25. This policy, revised 07/29/24, stated, . using gentle downward strokes from the front to the back of the perineum .</p> <p>- Review of Resident #78's medical record occurred on all days of survey. The care plan stated, . The resident requires Enhanced Barrier Precautions (EBP) R/T [related to]: foley catheter. Instruct staff to wear disposable gloves and gown when performing high contact resident care activities .</p> <p>Observation on 04/02/25 at 11:11 a.m. showed Resident #78's room with signage for EBP on the door and a supply cart located at the entrance of the room. The certified nurse aide (CNA) (#4) entered the room to empty the resident's urinary drainage bag. The CNA applied gloves, failed to apply a gown, cleaned the end of catheter tubing with an alcohol swab, emptied urine into a collection container, then emptied the urine into the toilet. The CNA (#4) failed to apply a gown when providing high-contact care (emptying a urinary drainage bag) for Resident #78.</p> <p>- Review of Resident #25's medical record occurred on all days of survey. Diagnoses include acute cystitis without hematuria (bladder inflammation without blood in urine) and a history of urinary tract infections. The quarterly Minimum Data Set (MDS), dated [DATE], identified occasionally incontinent of urine and a UTI within the last 30 days.</p> <p>Review of Resident #25's laboratory values over the past six months showed positive urine cultures in November 2024, February 2025, and March 2025 (indicating UTIs). The resident was hospitalized from February 14-18, 2025 related to a UTI requiring IV (intravenous) antibiotics.</p> <p>The current care plan stated, . at risk for bladder infections R/T [related to] HX [history] of UTI . Monitor/document for s/s [signs and symptoms] UTI . TOILET USE: . Wears a liner in her own undergarments. Peri [perineal] care assist of 1 .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER St Vincent's - A Prospera Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 N 26th St Bismarck, ND 58501	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of Resident #25 on 04/01/25 showed the following:</p> <p>* At 8:05 a.m., A certified nursing assistant (CNA) (#3) assisted Resident #25 to the toilet. Resident #25 wore two briefs and a liner and stated it was hard to sleep and uncomfortable. The CNA (#3) took a washcloth from the basin filled with soapy water and wiped Resident #25's perineal area from back to front and then wiped back to front.</p> <p>During an interview on 04/01/25 at 8:05 a.m. the CNA (#3) confirmed staff are not supposed to double brief residents.</p> <p>During an interview the afternoon of 04/03/25, an administrative staff member (#1) confirmed she expected staff to wear a gown when performing high contact care for a resident in EBP and two administrative staff members (#1 and #2) confirmed perineal cares were not completed correctly.</p> <p>52000</p>