

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/04/2026
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 5 of 13 residents (Resident #5, #6, #11, #77, and #80) observed during medication administration. Six medication errors occurred during staff administration of 49 medications which resulted in a 12 percent error rate. Failure to follow and/or clarify physician's orders and pharmacy recommendations may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled Medication: Administration Including Scheduling and Medication Aides occurred on 06/04/26. This policy, dated 03/30/26, stated, . PROCEDURE . Follow the 'Six Rights': Right medication, right dose . right route . Perform three checks: Read the label on the medication container and compare with the MAR [medication administration record] when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication .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 Order. Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice.Prescribing information found at https://www.drugs.com/mtm/orphenadrine.html, reviewed 07/30/25, stated, . Orphenadrine is a muscle relaxer. Do not crush, chew, or break an extended-release [ER] tablet. Swallow it whole. Prescribing information found at https://www.drugs.com/pro/klor-con-m.html, reviewed 11/20/25, stated, . Klor-Con M20 (potassium chloride extended-release tablets) is an immediately dispersing extended-release oral dosage form . To take each dose without crushing, chewing or sucking the tablets . Prepare an aqueous (water) suspension . Place the whole tablet(s) in approximately 1/2 glass of water (4 fluid ounces). Allow approximately 2 minutes for the tablet(s) to disintegrate.Prescribing information found at https://www.drugs.com/dosage/voltaren-gel.html, reviewed 08/22/25, stated, . The proper amount of VOLTAREN GEL should be measured using the dosing card supplied in the drug product carton. The dosing card should be used for each application of drug product. The gel should be applied within the rectangular area of the dosing card up to the 2 gram [gm] or 4 gram line .- Review of Resident #5's medical record occurred on 06/03/26. Physician's orders included Voltaren gel (a topical pain medication) two grams to the shoulders and knees four times a day. Observation on 06/03/26 at 9:45 a.m. showed a medication aid (MA) (#7) dispensed an undetermined amount of the gel into a medication cup, entered the resident's room, and applied small amounts of the gel to the resident's left and right wrists, elbows, and shoulder joint areas.- Review of Resident #6's medical record occurred on 06/03/26. Physician's orders included (continued on next page)		

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
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Orphenadrine Citrate ER (an extended-release muscle relaxant) by mouth two times a day and Klor-Con ER (potassium) by mouth once a day. Orphenadrine and Klor-Con are non-crushable medications. Observation on 06/04/26 at 8:27 a.m. showed a nurse (#3) prepared Resident #6's medications, crushed the Orphenadrine and the Klor-Con, placed the medications in water, and administered the medications through the resident's peg tube.- Review of Resident #11's medical record occurred on 06/01/26. Physician's orders identified NovoLOG (a rapid-acting insulin) 12 units subcutaneously (under the skin) three times a day. Observation on 06/01/26 at 11:34 a.m. showed a nurse (#3) administered 12 units of Humalog (a rapid acting) insulin and failed to administer the physician's ordered NovoLog insulin. During an interview on 06/02/26 at 9:59 a.m., a nurse (#5) confirmed Resident #11's physician ordered NovoLog insulin. - Review of Resident #77's medical record occurred on 06/03/26. A physician's order, dated 10/11/25, identified Lidocaine External Patch (a topical pain patch) to the low back once a day. The treatment administration record (TAR) identified to apply the patch in the morning and remove in the evening. Observation on 06/03/26 at 9:16 a.m. showed a lidocaine patch on Resident #77's right lower back. The MA (#6), present during the observation, stated, They [nursing] forgot to take it off last night. The facility staff failed to remove Resident #77's lidocaine patch as ordered.- Review of Resident #80's medical record occurred on 06/03/26. A physician's order, dated 01/13/26, stated, Cranberry Oral Tablet 450 MG [milligrams] . Give 500 mg by mouth two times a day . Observation on 06/03/26 at 9:07 a.m. showed a MA (#6) removed an over-the-counter box (stock medication) of cranberry with vitamin C from the medication cart. The MA showed the surveyor the back of the box, explained a serving size as two caplets, or 500 mg, of cranberry, and administered two caplets to the resident. The facility staff failed to clarify Resident #80's order for the cranberry tablets and ensure the current stock medication formulary accommodated the order. During an interview on 06/03/26 at 2:45 p.m., an administrative staff member (#1) stated she expected staff to follow the six rights of medication administration, follow specific instructions for correct dosing, and clarify any ambiguous orders.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 1 sampled resident (Resident #6) with a peg tube (tube inserted in the stomach) and a peripherally inserted central catheter (PICC) (long term intravenous (IV) line). Failure to verify placement and patency of a peg tube prior to use, administer medications in prescribed forms and in individual doses, follow and/or clarify physician's orders, and document medications/treatments as completed on the correct date may result in adverse consequences to the resident. Findings include: Review of the facility policy titled Medication: Tube Administration occurred on 06/04/26. This policy, dated 03/02/26, stated, . The tube should be checked for placement and patency prior to administering medication . inject 5-10 ml [milliliters] of air through the tube to clear the tube. Then aspirate gastric contents to be sure the tube is in the stomach. Prepare medication as appropriate . It tablets can be crushed, crush finely, and mix with water . Administer each medication separately, Flush with 5 ml of water after each individual medication is given. Review of the facility policy titled Medication: Administration Including Scheduling and Medication Aides occurred on 06/04/26. This policy, dated 03/30/26, stated, . Follow the 'Six Rights' . right time, and right documentation . 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 Order. Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Page 836, stated, . Document medication administration after giving it . The record [medication or treatment administration record (MAR/TAR)] should also include the exact time of administration . Review of Resident #6's medical record occurred on all days of survey. The record identified a peg tube and a PICC line to the resident's right upper chest. Physician's orders included the following: * Meds [medications] via peg tube . * . medication administration: Flush with 30 cc [cubic centimeters - one cc equals on milliliter] of water, 5 cc between medication and 30 cc after all medication . * . PICC line transparent dressing . change every week and PRN [as needed] change the clave [needle free IV port] to the PICC line when changing the dressing . every Wed [Wednesday] . * Change IV solution bag and all tubing every 96 hours which is 5 days . (96 hours equals four, not five days). - Observation on 06/04/26 at 8:27 a.m. showed a nurse (#3) prepared Resident #6's medications. The nurse (#3) dispensed 10 medications approved to be crushed and one medication prescribed as do not crush, placed them into a plastic sleeve, crushed them all at the same time, and emptied the contents into a medication cup. The nurse then dispensed two extended-release potassium tablets, prescribed as do not crush, placed them into a plastic sleeve, crushed them, and emptied the contents into a second medication cup. The nurse opened a package of banana flakes, emptied the contents into a water cup, and measured a dose of liquid iron into another medication cup. At 8:33 a.m., the nurse (#3) entered Resident #6's room, mixed the banana flakes with water and the crushed potassium with water. The nurse attached the outer peg tube and failed to check for tube placement or patency. When the nurse administered the banana flakes mixed with water, the peg tube clogged. The nurse removed the outer peg tube, removed the flakes from the tube with a syringe, placed the contents into a cup, and rinsed the tube in the bathroom sink. The nurse reattached the tube, added more water to the flakes removed from the tube, and readministered them. Without flushing the peg tube with water, the nurse administered the crushed potassium with water. Observation showed visible undissolved particles and the tube clogged again. The nurse removed the outer part of the peg tube, used the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	syringe to remove the potassium solution, placed the contents into the cup, and rinsed the tube in the bathroom sink. The nurse reattached the tube, added more water to the potassium mixture removed from the tube, and readministered the medication. The nurse (#3) failed to verify placement and patency of the peg tube prior to use, failed to administer the medications in the prescribed forms and in individual doses, and failed to use an appropriate amount of liquid to minimize clogging on the peg tube which resulted in unnecessary manipulation of the peg tube. - Observation on 06/04/26 at 9:40 a.m. showed the nurse (#3) accessed Resident #6's PICC line, programmed an IV pump, and the pump began to run fluid from an IV-solution bag (sodium chloride) present on the IV pole. The date on the solution bag showed 05/30/26 (five days prior). The date on the transparent dressing covering the PICC line site showed 05/23/26 (13 days prior). Observation on the afternoon of 06/04/26 showed facility staff changed and dated the PICC line dressing. Resident #6's TAR showed dressing changes completed and documented on 05/27/26 and 06/03/26. These dates failed to match the dates observed on the dressing. Facility staff failed to clarify the physician's orders related to how often to change the IV solution bag, failed to change the PICC line dressing and clave as ordered, and failed to document the dressing changes as completed on the correct date. During interviews on 06/03/26 at 2:45 p.m. and 06/04/26 at 3:30 p.m., an administrative staff member (#1) stated she expected staff to ensure placement and patency of a peg tube prior to medication administration, administer medications individually, in their prescribed form, and in a manner to avoid complications of clogging the tube, administer treatments/medications as ordered, accurately document in the MAR/TAR when medications and treatments are completed, and clarify ambiguous orders.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident's medication regimen remained free of unnecessary medications for 1 of 3 sampled residents (Resident #3) reviewed for antipsychotic medications. Failure to complete a baseline assessment before starting an antipsychotic may result in undetected side effects and adverse consequences related to the antipsychotic medication. Findings include: Review of the facility policy titled Psychotropic Medications occurred on 06/04/26. This policy, dated 12/09/25, stated, . If the physician prescribes an antipsychotic for the resident, a registered nurse must complete . the Abnormal Involuntary Movement Scale [AIMS] . - Review of Resident #3's medical record occurred on all days of survey. Physician's orders included Seroquel (an antipsychotic) initiated on 03/18/26. The record lacked a baseline assessment or AIMS assessment. During an interview on 06/06/26 at 5:00 p.m., an administrative staff member (#1) confirmed the facility failed to complete a baseline assessment or AIMS assessment for Resident #3 upon initiation of the Seroquel.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow standards of infection control and prevention for 1 of 1 sampled resident (Resident #6) observed with a peripherally inserted central catheter (PICC) (long term intravenous (IV) line) during cares. Failure to practice infection control standards related to hand hygiene, glove use, and accessing PICC lines may result in adverse consequences to the resident and has the potential to spread infection throughout the facility. Findings include: Information found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, dated 02/27/24, stated, . Know when to clean your hands. Before performing an aseptic task such as . handling invasive medical devices. After touching a patient or patient's surroundings. After contact with . contaminated surfaces . Know when to wear (and change) gloves. Gloves are not a substitute for hand hygiene. Always clean your hands after removing gloves. When to change gloves and clean hands . If moving from work on a soiled body site to a clean body site on the same patient . have . body fluids on them after completing a task. Before exiting a patient room. Review of the Centers of Disease Control (CDC) guidance at https://www.cdc.gov/infection-control/hcp/intravascular-catheter-related-infections/summary-recommendations reviewed 02/28/24, stated, . 19. Needleless Intravascular Catheter Systems . Minimize contamination risk by scrubbing the access port with an appropriate antiseptic . Review of Resident #6's medical record occurred on all days of survey. The record identified a peg tube (a tube inserted into the stomach) and a PICC (peripherally inserted central catheter) line. The care plan identified enhanced barrier precautions (EBP) related to a multidrug-resistant organism (MDRO), a PICC line, and a peg tube and instructed staff to wear a gown and gloves when performing high contact care activities. Observations on 06/04/26 of Resident #6 showed the following: * 8:33 a.m. through 9:10 a.m., two unidentified maintenance staff entered and exited the resident's room on four different occasions to work on a malfunctioning call light. The maintenance staff touched three different call lights throughout the room multiple times and failed to sanitize their hands when exiting the room on all four occasions. * 9:40 a.m., a nurse (#3) assisted the CNA (#4) with a brief change. The nurse failed to remove the soiled gloves, perform hand hygiene, and apply clean gloves prior to attaching a syringe to the resident's PICC line port and failed to sanitize the PICC line port prior to accessing the port with the syringe. During an interview on 06/04/26 at 3:20 p.m., an administrative staff member (#1) stated she expected staff to practice appropriate infection control when working with Resident #6 and all other residents.		