STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355096	A. BUILDING _____ B. WING _____	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANETA PARKVIEW HEALTH CTR	113 5TH ST S ANETA, ND 58212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on September 20, 2011 and completed on September 22, 2011 the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Carter	Administrator	10/17/11

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.

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, professional reference, and staff interview, the facility failed to ensure adequate monitoring of a medication for 2 of 2 sampled residents (Resident #2 and #6) who receive digoxin (a cardiac medication). Failure to monitor blood levels has the potential to increase the resident's risk of digoxin toxicity. Findings include: The Center for Medicare and Medicaid Services (CMS) has outlined the standard of practice regarding the use of digoxin. The drug should be used with caution in individuals with impaired renal function and closely monitored for adverse consequences, especially digoxin toxicity. -Review of Resident #6's medical record occurred on all days of survey. Diagnoses included atrial fibrillation, congestive heart failure, and chronic kidney disease stage 4. The current physician orders listed Digoxin 125 mcg (micrograms) once a day, with a start date of 06/21/10. The medical record lacked a physician order identifying the frequency with which to monitor digoxin levels. Review of lab results for Resident #6 listed a digoxin level done on 06/15/10 indicating a result of 0.8 and a reference range of 0.8 - 2.0 ng/ml (nanogram/milliliter.) The pharmacy reviews, dated 01/18/11 and 07/12/11 listed "6-15-10 Dig [digoxin] level 0.8." During an interview on 09/22/11 at 11:30 a.m., a nursing staff member (#2), stated, "[the resident's	F 329	1. Corrective action was made for resident #2 by lab ordered of digoxin level (9/28/11) drawn and reviewed (10/12/11) per attending physician. Resident #6 expired on 10/5/11 prior to lab being drawn; however a level was scheduled to be completed on 10/12/11. 2. All residents on digoxin have the potential to be affected. 3. A) Charts of all residents receiving digoxin will be reviewed for corresponding annual labs. If no lab is on file, provider will be contacted to obtain an order for digoxin level and drawn and reviewed per order. B) Contract with new pharmacy consultant has been established. Services will begin 10/18/11. The pharmacy consultant will review charts monthly for medication monitoring. C) Pharmacy consultant and medical director will be educated per CMS standard of practice for use of digoxin and monitoring. D) QA of consultant pharmacist notes and corresponding residents on digoxin will be performed monthly X6. Minimal frequency of digoxin lab monitoring will be considered as annually unless noted per provider. 4. The QA coordinator will be responsible for the completion and review of all QA. 5. Completion Date10/27/11.	10/27/2011

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F 329	Continued From page 2	F 329		

name] last dig [digoxin] level was June 2010."

- Review of Resident #2's medical record occurred on September 20-22, 2011. The facility admitted the resident in January 2009. The resident's current diagnoses included atrial fibrillation (abnormal heart rhythm), congestive heart failure, nephritis (inflammation of one or both kidneys), and hypertension. The current physician orders listed Digoxin 125 mcg (micrograms) once a day, with a start date of 03/27/11. The medical record lacked a physician order identifying the frequency with which to monitor digoxin levels.

Review of Resident #2's lab reports showed a digoxin blood level of 0.9 with a reference range identified as 0.8-2.0 ng/ml obtained on 01/20/09. Further review of Resident #2's medical record showed the facility failed to complete a digoxin blood level test since 01/20/09.

During an interview on 09/22/11 at 12:40 p.m., an administrative nursing staff member (#1) stated, regarding completion of a digoxin blood level test for a resident receiving digoxin, "Expect it every year."