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 _____	07/02/2014

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 06/30/14 and completed on 07/02/14, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F 157 1. Corrective action cannot be accomplished for resident as is deceased. 2. All residents have the potential to be affected. 3. Education on policy of change of condition and notification of legal representative/family will be discussed at mandatory nurses meeting 8/5/14. 4. 4 charts will be chosen at random, evaluated for change of condition, and notification of legal representative over the last 30 days. QA will be completed prior to 8/8/14 and then quarterly X 3. QA will be conducted by QA coordinator or designee and reviewed by the QA committee. 5. Completion date 8/8/14.	08/08/2014

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355096	A. BUILDING _____ B. WING _____	07/02/2014

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to notify a resident's legal representative/family of a change in physical status as identified in 1 of 1 closed record reviewed (Resident #10). Failure to promptly notify Resident #10's legal representative/family of a fall with clinical signs of a potential fracture does not allow the legal representative/family the opportunity to provide input and/or consent to immediate transfer to the emergency room. Findings include: Review of Resident #10's medical record occurred on 07/02/14. Resident #10's Progress Notes stated the following: *03/23/14 at 10:57 p.m. - "At 10:00 pm resident was changed. . . at 10:35 pm found resident sitting on the floor in the day room . . . Resident asked for help up. Resident was assisted up, but had noted pain immediately in his L. [left] hip area. Resident was unable to bear weight. Moved a big recliner over to resident and sat him in it. Attempted to ass ese [sic] resident, and everytime L. leg was moved resident called out in pain and said don't move it. [name of local hospital] called and informed of incident. Waiting for a call back from [name of on-call family nurse practitioner]."	F 157		

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 _____	07/02/2014

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 157	Continued From page 2 *03/23/14 at 11:47 p.m. - "At 10:35 pm found resident sitting on the floor in the day room . . . Assisted up with help of 3 people. Resident was unable to stand on his L. leg., cried out in pain. Placed resident in a recliner, and then attempted to lift his leg with his pants leg, and resident cried out in pain . . . At 10:50 pm [name of local hospital] notified of incident. At 11:10 pm [name of on-call family nurse practitioner] called back. Informed him of what had happened. States that if resident is stable and resting comfortably wait til AM to send to [name of local hospital] to be seen in the ER [emergency room] at that time. Keep resident NPO [nothing by mouth], may give Seroquel [antipsychotic medication] and Ativan [an antianxiety medication] prior to sending per Ambulance. Asked [name of on-call family nurse practitioner] if writer should call family at this time and he stated that waiting till morning when they know what the X-rays show would be best. Resident is now at 11:45 p.m. asleep in the recliner." Although Resident #10 exhibited acute pain to his left leg following a fall on March 23, the facility failed to immediately contact the resident's legal representative/family to inform them of this acute change in condition.	F 157		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

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 _____	07/02/2014

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 278	Continued From page 3 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 4 of 10 sampled residents (Resident #1, #3, #5 and #7) regarding Section M-Skin Conditions (Resident #5 and #7), Section E-Behaviors (Resident #3), Section H-Bowel and Bladder (Resident #1), and Section I-Active Diagnoses (Resident #1). Failure to accurately complete the MDS did not allow staff to develop a plan of care based on the resident's current status and needs.	F 278	F278 1. Corrective action for resident #3 was completed prior to survey on the last MDS submitted. Modification and correction will be submitted for residents #1,5, and 7 prior to 8/15/14. 2. All residents have the potential to be affected. 3. Education per YouTube video via CMSHHSgov MDS 3.0 CMS Provider Updates Section M will be viewed by MDS coordinator prior to 8/8/14. MDS coordinator will also review MDS 3.0 RAI Manual Sections E, H, and I, prior to 8/8/14. 4. QA of most recent MDS on all residents in facility census as of 7/2/14 will be completed prior to 8/15/14. Assessments will be checked for coding errors in sections E0100, H0500, I, and M1200D. Modifications and corrections will be submitted per QA results. QA will be repeated quarterly X 3 to assess for coding errors. QA will be completed by the MDS coordinator and reviewed by the QA coordinator. 5. Completion date 8/15/14.	08/15/2014

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 _____	07/02/2014

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 278	Continued From page 4 Findings include: - The Long-Term Care Facility RAI User's Manual, October 2013, page M-38, stated: "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements . . . Additional supplementation above the US Recommended Daily Intake (US RDI) has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment . . . If it is determined that nutritional supplementation . . . is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplement to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall and obtain dietary consultation as needed . . . ." Review of Resident #5's medical record occurred on all days of survey. Resident #5's significant change MDS, with an assessment reference date of 06/13/14, identified one unstageable suspected deep tissue injury in evolution and the implementation of nutrition or hydration interventions. Resident #5's most recent Nutritional	F 278		

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 _____	07/02/2014

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 278	Continued From page 5	F 278		

Assessment, dated 03/17/14, identified no lab value concerns and also identified that diet should provide adequate nutrients for her needs. This assessment indicated Resident #5's skin condition is "intact". In summary, the nutritional assessment stated, "Resident consumes [less than] 75% of pureed food consistency with CPEP [calorie protein enhancement program] for added calories and protein. Receives ensure 8 [ounces] TID [three times a day], and benefiber TID for added fiber to ensure regular bowels. Weight is stable." Facility staff failed to complete a nutritional assessment following the development of a deep tissue injury.

The above nutritional assessment did not identify any factors influencing Resident #5's wound healing, or any interventions implemented specifically to address Resident #5's nutritional needs. The assessment is lacking information to meet the definition of a nutrition or hydration program under Section M of the MDS.

Review of Resident #7's medical record occurred on July 1 - July 2, 2013. Resident #7's admission MDS, dated 01/14/14, quarterly MDS, dated 04/16/14, and significant change MDS, dated 04/19/14, identified one unhealed Stage III pressure ulcer and the implementation of nutrition or hydration interventions.

The Admission Nutritional Assessment, dated 01/09/14, stated, ". . . Resident receives a consistent CHO [carbohydrate] diet, intake is variable and sometimes unknown since he has snacks in his room. . . . "

The above nutritional assessment identified facility staff could not determine the adequacy of

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 _____	07/02/2014

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 278	Continued From page 6 Resident #7's intake and this does not meet the definition of a nutrition or hydration program under Section M of the MDS. During an interview on 07/02/14 at 11:10 a.m., a nursing staff member (#4) responsible for completion of MDSs stated she coded section M for nutrition or hydration interventions if a physician ordered Arginaid (a high calorie, protein supplement) or additional protein. This staff member confirmed she did not understand the coding requirements for coding nutrition and hydration interventions for Section M. The Long-Term Care Facility RAI User's Manual (Version 3.0), October 2013, pages E-2 - E-3 stated: ". . .E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnoses. Check all that apply. . . . *Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations, *If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. *If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion. . . ." Review of Resident #3's medical record occurred on June 30-July 2, 2014. The annual MDS, dated 10/15/13, identified the resident had delusions during the assessment period. The resident's medical record lacked evidence to support the coding of the delusions on the MDS.	F 278		

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 _____	07/02/2014

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 278	Continued From page 7 During an interview on 07/02/14 at 11:10 a.m., an nursing staff member (#4) responsible for completion of MDSs confirmed she did not understand the requirements for coding delusions. The Long-Term Care Facility RAI User's Manual, October 2013, page H-12 stated the following regarding bowel training program, "Steps for Assessment . . . Look for individualized, resident-specific documentation . . . three requirements have been met: implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern, evidence that the individualized program was communicated to staff and the resident . . ; notations of the resident's response to the toileting program and subsequent evaluations as needed. . . ." Page I-1, regarding active diagnosis, "Intent: the items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. Review of Resident #1's medical record occurred on June 30-July 2, 2014. An annual MDS, dated 03/24/14, identified the resident as cognitively intact, frequently incontinent of bladder and bowel, on a scheduled bowel toileting program, and coded for an active diagnosis of Parkinson's disease. Resident #1's current care plan stated facility staff assist the resident to the bathroom upon awakening, before and after meals, at 7 p.m., before bedtime and as needed. These times listed fail to meet the individualized,	F 278		

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 _____	07/02/2014

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 278	Continued From page 8 resident-specific requirements of an toileting plan. Review of Resident #1's medical treatments, medical records, and nursing monitoring failed to identify any physician-documented diagnosis pertaining to Parkinson's disease. During interview on the morning of 07/02/14, a nursing staff member (#5) responsible for completion of the MDS stated Resident #1 manages her own bowel continence and agreed this resident does not meet the requirements of an individualized bowel toileting program. The facility failed to provide evidence of the physician documentation to support the coding of Parkinson's disease for Resident #1 when requested.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, facility staff failed to provide medications per facility policy for 1 of 1 supplemental resident (Resident #13) observed during medication pass with a gastrostomy tube. Failure to administer gastrostomy tube medications per facility policy can cause blockage of the gastrostomy tube, which may require replacement of the tube. Replacement of the gastrostomy tube has the potential to cause Resident #13 unnecessary pain/discomfort.	F 281		

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 _____	07/02/2014

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 281	Continued From page 9 Findings include: Review of the facility policy titled "Administration of Medication Via a Feeding Tube" occurred on 07/01/2014. This policy, dated January, 2006, stated, "Purpose: To assure that a resident with a feeding tube receives their medication properly. To assure that the resident's feeding tube is not plugged from the administration of medication. . . . Procedure: . . . 18. Flush the feeding tube with 30 ml. (milliliters) warm water or other prescribed flush. 19. Administer prescribed medication. Pour the liquefied medication into the syringe and allow to flow by gravity into the tube; never force fluid into the tube. Rinse medication cup with water or prescribed diluent and administer to assure delivery of the complete dose. 20. Flush the tube with 30 ml. of water or prescribed flush after administration of all medication to clear tube and decrease chance of clogging. . . ." - Observation made during the medication pass, on 06/30/14 at 3:07 p.m., showed a nurse (#4) administered liquefied medications via a gastrostomy tube (feeding tube) to Resident #13. The nurse (#4) checked placement of the gastrostomy tube and administered four liquefied medications, without first flushing the gastrostomy tube with 30 ml of water. The nurse (#4) administered each medication separately, but failed to rinse each medication cup as per policy. The nurse (#4) failed to flush the gastrostomy tube with 30 ml of water after completion of the medication pass and prior to beginning the scheduled feeding. The nurse (#4) failed to complete steps in the procedure as outlined by facility policy to prevent plugging the resident's gastrostomy tube.	F 281	F281 1. Corrective action for resident #13 was completed 7/1/14 by review of policy "Administration of Medication via a Feeding Tube" by nurse #4. 2. All resident who receive tube feedings have the potential to be affected. 3. Education of all licensed nursing staff will be completed at mandatory meeting 8/5/14. Review of facility policy "Administration of Medication via a Feeding Tube" will be conducted. 4. QA of administration of meds through a feeding tube will be completed by observation of 3 medication administrations via a feeding tube prior to 8/8/14 and repeated in 6 months. QA will be completed by QA coordinator and reviewed by QA committee.	8/8/2014

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 _____	07/02/2014

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 281	Continued From page 10 During an interview on 07/01/14 at 3:40 a.m., an administrative nursing staff member (#2) stated, in regards to the above observation, "That would not be what our policy is."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to promote the optimal well-being of 1 of 1 resident's closed record (Resident #10) reviewed with complaints of pain following a fall with a fracture. Failure to immediately transfer Resident #10 for further evaluation following his fall and failure to administer as needed (PRN) pain medication resulted in the resident experiencing unrelieved pain for over two and one-half hours before being transferred to the local emergency room (ER). Findings include: Review of Resident #10's medical record occurred on 07/02/14. Medical diagnoses for Resident #10 include dementia with behavior disturbances and Alzheimer's disease.	F 309	F309 1. Corrective action cannot be accomplished as this resident is deceased. 2. All residents have the potential to be affected. 3. Education of all licensed nursing staff will be conducted at mandatory meeting 8/5/14. Nurses will review article on pain management and change of condition policy. 4. Random QA of 6 charts will be conducted prior to 8/8/14 and repeated quarterly X 3. Charts will be reviewed for documentation of pain, pain management, and notification of physician and legal representative/family. QA will be conducted by designated nursing personnel and reviewed by the QA coordinator. 5. Completion Date 8/8/14.	8/8/2014

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 _____	07/02/2014

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 309	Continued From page 11	F 309		

Resident #10 sustained a fall on 03/23/14 at 10:35 p.m. The facility transferred Resident #10 to the local hospital emergency room on 03/24/14 at 7:50 a.m. (9 hours and 25 minutes later.) The local hospital then transferred Resident #10 to an acute care hospital for treatment of a left hip fracture. Resident #10 remained hospitalized until 04/02/14.

Resident #10's Progress Notes stated:
*03/23/14 at 10:57 p.m. - "At 10:00 pm resident was changed . . . Then at 10:35 pm found resident sitting on the floor in the day room . . . Resident asked for help up. Resident was assisted up, but had noted pain immediately in his L. [left] hip area. Resident was unable to bear weight. Moved a big recliner over to resident and sat him in it. Attempted to ass ese [sic] resident, and every time L. leg was moved resident called out in pain and said don't move it. [name of local hospital] called and informed of incident. Waiting for a call back from [name of on-call family nurse practitioner]."

*03/23/14 at 11:47 p.m. - "At 10:35 pm found resident sitting on the floor in the day room . . . Resident was sitting on his buttock area wanting help up. Would not allow assessment. Assisted up with help of 3 people. Resident was unable to stand on his L. leg, cried out in pain. Placed resident in recliner, and then attempted to lift his leg with his pants leg, and resident cried out in pain. VS [vital signs] T [temperature] 98.4 P [pulse] 84 R [respirations] 20 BP [blood pressure] 119/65. At 10:50 pm [name of local hospital] notified of incident. At 11:10 pm [name of on-call family nurse practitioner] called back. Informed him of what had happened. States that if resident

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 _____	07/02/2014

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 309	Continued From page 12	F 309		

is stable and resting comfortably wait till AM to send to [name of local hospital] to be seen in ER at that time. Keep resident NPO [nothing by mouth], but may give Seroquel [an antipsychotic medication] and Ativan [an antianxiety medication] in the AM prior to sending per Ambulance. Asked [name of on-call family nurse practitioner] if writer should call family at this time and he stated that waiting till morning when they know what the X-rays show would be best. Resident is now at 11:45 pm asleep in the recliner."

*03/24/14 at 1:18 a.m. - "Resident continues to rest quietly in the recliner."

* 03/24/2014 at 3:49 a.m. - "Reasident [sic] is awake and a bit restless at this time. Is moving about, but noted not to be moving his L. leg at all."

*03/24/14 at 5:25 a.m. - "Resident has been trying to get up out of the recliner, but is unable due to pain in his leg. Told him he fell and hurt his leg and he is going to see the DR [doctor], will then sit back and stops trying to get up."

*03/24/14 at 6:37 a.m. - "Fall: Attempt made to notify family of fall and transfer, no answer . . . Ambulance notified of transfer to [name of local hospital]. Res [resident] sitting in recliner in . . . does complain of pain to L. hip."

*03/24/14 at 9:30 a.m.- "Transfer: [name of local hospital] called with follow-up. L. hip fracture noted. Res being transferred to [name of an acute care hospital] at this time."

Resident #10's March 2014 Electronic Medication

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 _____	07/02/2014

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 309	Continued From page 13 Administration Record showed the resident had a PRN order for Tramadol 50 milligrams 1 tablet every 12 hours. This record showed facility nursing staff did not administer the PRN Tramadol to Resident #10 at anytime on March 23, following his fall (even after verbal complaints and objective signs/symptoms of pain) or at anytime on March 24 prior to his transfer. During a telephone interview on 07/02/14 at 10:35 a.m., the facility's medical director (#12) (after being read the above Progress Notes) confirmed Resident #10 did exhibit signs of pain and stated he would have expected the nursing staff and the on-call family nurse practitioner to manage Resident #10's pain during the night or consider immediate transfer to the local emergency for further evaluation and treatment. Record review and staff interview confirmed Resident #10 experienced and exhibited signs of pain following his fall on March 23. The facility failed to update the on-call family nurse practitioner and inform him of the resident's pain and failed to administer as needed analgesic medications to manage his pain pending transfer to the ER.	F 309		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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 _____	07/02/2014

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 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, manufacturer's instructions, professional literature review, and staff interview, the facility failed to thaw food in a safe and sanitary manner in 1 of 1 certified nursing assistant (CNA) storage room. Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume this food. Findings include: The 2009 Food Code, published by the Food and Drug Administration (FDA), Public Health Reasons, page 405, states, ". . . Freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins. . . ." Manufacturer labeling on the Kemps Plus 2 container stated, "Store Frozen. Thaw at or below 40 [degrees] F [Fahrenheit]. Use thawed product within 14 days. Keep Refrigerated." An observation made during the medication room inspection, on 07/01/14 at 3:03 p.m., showed a box containing eight cartons of Kemps Plus 2 thawing on the counter in the CNA storage room. The cartons were beaded with water and when the surveyor shook one, movement of the contents showed it was thawed. The nurse (#3) present identified the cartons of Kemps Plus 2 were to be refrigerated and placed the cartons in	F 371	F371 1. Corrective action was completed on 7/2/14 with education of staff and destruction of Plus 2 thawed incorrectly.. 2. All residents on supplements have the potential to be affected. 3. A new policy on Proper Storage of Supplements and Plus 2 was written on 7/25/14. Plus 2 will be thawed in cooler and kept under refrigeration at all times. Licensed nursing staff will be educated and review new policy at mandatory meeting 8/5/14. Dietary staff will review policy prior to 8/8/14. 4. QA of storage and thawing of supplements and Plus 2 will be conducted prior to 8/8/14 and repeated in 6 mo. QA will be conducted by dietary manager and reviewed by the QA coordinator. 5. Completion date 8/8/14	8/8/2014

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 _____	07/02/2014

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 371	Continued From page 15	F 371		

the refrigerator.

During an interview on 07/02/14 at 8:45 a.m., an administrative dietary staff member (#1) stated dietary staff provided nursing staff with frozen Plus Two supplements as needed. This staff member stated she expected facility staff to thaw these supplements in a refrigerator.

During an interview on 07/02/14 at 9:25 a.m., an administrative nursing staff member (#2) confirmed nursing staff received frozen Kemps Plus Two supplements from dietary staff and these supplements should be refrigerated.

During an interview on 07/02/14 at 11:40 a.m., a nursing staff member (#4) reported she directed another staff member to thaw the Kemps Plus 2 as observed. When asked, the nurse (#4) identified she was not aware of the manufacturer's instructions to thaw the product at 40 degrees or less. The nurse (#4) identified the nursing practice is to thaw the Kemps Plus 2 on the counter for a portion of the thawing process.

On the morning of 07/02/14, upon request, the facility threw out the improperly thawed Kemps Plus 2.

Failure to thaw a high protein, milk-based food product using a proper thawing method with temperature control placed the thawing product at risk for temperatures above 41 degrees F, increasing bacterial growth and the risk for food borne illness.