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 _____	07/16/2013

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 07/14/13 and completed on 07/16/13, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
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 manufacturer's instructions, review of facility procedure, and staff interview, the facility failed to properly prime (a procedure such as an airshot to expel air from the needle attached to an insulin pen) an insulin pen for 3 of 3 sampled residents (Resident #1, #7, and #13) observed receiving insulin. Failure to follow the manufacturer's recommendation for priming (airshot) an insulin pen has the potential for residents to receive an incorrect dose of insulin. Findings include: Review of the facility procedure titled "Injection/Subcutaneous" occurred on 07/16/13. This policy, updated 2012, stated, " . . . 14. Insulin Pens may be used per manufacturer guidelines." Review of the "Novo Nordisk" flexpen manufacturer's instruction sheet provided by the	F 281	F281 1. Corrective action was accomplished 7/16/13 for residents #1, #7, and #13. Staff nurses were educated by reviewing the Novo Nordisk flex pen manufacturer's instruction sheet. 2. All residents who are diabetic and use flex pens have the potential to be affected. 3. A mandatory in-service is scheduled for all licensed nurses on 8/8/13 at 2PM provided by Novo Nordisk. This in-service will provide education on priming of insulin pens. 4. QA will be conducted ~~one month after in-service~~, then quarterly X2. QA will be completed by the DON and reviewed by the ~~DON~~. QA committee. 5. Completion date 8/20/13. per TC Pepper Lippert, DON 8/1/13 4:20p DL	08/20/2013 prior to 8/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Cagle — TITLE: Administrator — (X6) DATE: 7/29/13

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 281	Continued From page 1 facility occurred on 07/16/13. This instruction sheet, stated, " . . . 4 Simple Steps for Use . . . Step 2. Performing the Airshot Before Injection -Turn the dose to 2 units. - Holding the Levemir or Novolog FlexPen with the needle pointing up, tap the reservoir gently with your finger a few times. - With the needle still pointing up, press the push button as far as it will go until a drop of insulin appears at the needle tip. This is called an airshot. . . - If a drop does not appear, repeat this procedure. . . " Observation on 07/15/13 at 8:40 a.m., showed a nurse (#2) administered Levemir insulin to Resident #1. The nurse primed (airshot) the insulin pen with two units of insulin while holding the pen horizontally with the cap on the needle. If air was present in the pen it would not have been expelled properly when the pen was held horizontally. Observation on 07/15/13 at 8:50 a.m., showed a nurse (#2) administered Novolog insulin to Resident #7. The nurse primed (airshot) the insulin pen with two units of insulin while holding the pen horizontally with the cap on the needle. Observation on 07/16/13 at 10:30 a.m., showed a nurse (#3) administered Humalog insulin to Resident #13. The nurse primed (airshot) the insulin pen with two units of insulin while holding the pen horizontally with the cap on the needle. During an interview on 07/16/13 at 1:10 p.m., an administrative nurse (#1) stated she expected staff to prime an insulin pen with the needle pointing upward without a cap on the needle.	F 281		