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 _____	05/12/2021

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 The Standard Medicare/Medicaid recertification survey started 05/10/21 and concluded 05/12/21.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of the Food and Drug Administration (FDA) Food Code 2013, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen (Main kitchen). Failure to ensure proper temperatures/procedures for food storage and cooling has the potential to result in foodborne illness to residents, staff, and visitors.	F 812	1. Food will be cooled to 70 degrees within 2 hours. Containers will be placed in the freezer for rapid cooling or placed in an ice bath before placing in the fridge. Temperatures will be monitored. Containers will be filled 4 inches or less and lids will be vented to let heat escape. Large containers have been purchased. This will allow the leftover food to spread out more to ensure faster cooling. Foods	6/10/21

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

Electronically Signed | 05/28/2021

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F 812	Continued From page 1 Findings include: Review of the facility policy titled "USE OF LEFTOVERS" occurred on 04/11/21. This policy, revised 06/20/19, stated, ". . . Excess leftovers should be avoided. Leftovers will be properly handled and used . . . Fill containers only 4 inches deep for quicker cooling . . . Leftovers must be cooled to <41 degrees F [Fahrenheit] within 4 hours (or cooled to 70 degrees within 2 hours and then down to 41 degrees within 4 hours . . ." The FDA Food Code 2013, page 90-91, stated, ". . . Cooling . . . Cooked Time/Temperature Control for Safety Food shall be cooled . . . Within 2 hours from 57 degrees C [Celsius] (135 degrees F) to 21 degrees C (70 degrees F) and . . . Shall be cooled within 4 hours to 5 degrees C (41 degrees F) or less . . . " The initial tour of the kitchen occurred on 05/10/21 at 12:15 p.m. Observation showed an unidentified dietary staff member placing leftover turkey with cranberry glaze and broccoli in three separate containers with lids. This surveyor measured the temperature of the food items, with a reading of 111.5 F for the turkey container #1, 115.2 F for the turkey container #2, and 111.5 F for the broccoli. On 05/10/21 at 2:15 p.m., this surveyor measured the temperature of the turkey with cranberry glaze and broccoli, which were tightly covered with a lid and showed large amounts of condensation. The temperature measured 74.2 F for the turkey container #1, 72.6 F for the turkey container #2, and 84.8 F for the broccoli. When	F 812	will be stores, prepared, distributed, and served for food service safety and under sanitary conditions to prevent foodborne illness to residents, staff and visitors. 2. All residents, staff, and visitors have the potential to be affected and will be included in the plan of correction. 3. A dietary in-service was held on May 26th, 2021 to educate all staff on policy and procedures for handling leftovers. At the in-service, we reviewed proper way to store, prepare, serve, and distribute food. Policy was updated to place all leftovers into an ice bath or freezer and to temp left overs before placing in fridge. Left overs that have not reached 70 degrees in 2 hours will be discarded. Thermometers were calibrated and within correct temperature at 32 degrees in an ice bath. Larger containers are ordered to allow foods to spread out for quicker cooling. QAPI will be done weekly for 4 weeks and monthly for the next 6 months. Quarterly reviews will be done for the next 12 months, 4 times a year. 4. The dietary Department will conduct the QAPI under the supervision of the dietary manager. All QAPI studies conducted will be given to the QAPI manager for review.	

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F 812	Continued From page 2 asked, the administrative dietary staff member (#1) stated staff does not check the temperature of foods that are cooling and confirmed the food had not been cooled within the required time frame and discarded the items.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		6/10/21

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F 880	Continued From page 3 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of	F 880	1. Corrective Action	

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F 880	Continued From page 4 the facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 1 resident (Resident # 230) on transmission-based precautions. Failure to follow appropriate infection control practices has the potential for infections to be transmitted to other residents, staff, and visitors. Findings include: Review of the facility policy titled ". . . Isolation - Initiating Transmission-Based Precautions occurred on 05/12/21. This policy, dated January 2012, stated, "Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. . . . If a resident is suspected of, or identified as, having a communicable infectious disease, the Charge Nurse or Nursing Supervisor shall notify the Infection Preventionist and the resident's Attending Physician for appropriate Transmission-Based Precautions. . . . Transmission-Based Precautions shall remain in effect until the Attending Physician or Infection Preventionist discontinues them, which should occur after pertinent criteria for discontinuation are met. . . . Explain to the resident (or representative) the reason(s) for the precautions. . . ." Review of Resident #230's medical record occurred on all days of survey. The current care plan stated, ". . . I am on quarantine [room isolation] until May 14th 2021 . . . I often wander, please redirect me as needed. . . ." Observations on 05/10/21 showed Resident #230 performed the following while unmasked:	F 880	The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff encourage residents to remain in/return to their rooms while on transmission-based precautions, in accordance with guidelines from the CDC. (2) Ensuring staff consistently encourage and assist residents to use a facemask or acceptable face cover when in common areas and when in near proximity to others, in accordance with guidelines from the CDC. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate staff member (#2) and all other Special Care Unit staff on the importance of and techniques for encouraging residents to remain in/return to their rooms while on transmission-based precautions. (2) Educate staff member (#2) and all other Special Care Unit staff on the importance of and techniques for encouraging and assisting residents to	

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F 880	Continued From page 5 * At 12:17 p.m., ambulated into the dining room, sat down at a table with four other residents, and ate her noon meal. * At 1:58 p.m., participated in a group activity in the dining room. * At 3:34 p.m., conversed with staff member (#2) by the special care unit nurses' station before walking down the hall with staff (#2) to the dining room for a snack. During an interview on 05/11/21 at 8:45 a.m., an administrative staff member (#3) confirmed Resident #230 is on isolation for new admission until 05/14/21 and stated she would expect staff to encourage/redirect the resident to remain in her room. The administrative staff (#3) also stated staff are to provide/encourage surgical mask use when isolation residents are outside their room. Facility staff failed to encourage/redirect Resident #230 to remain in her room while on transmission-based precautions and also failed to provide/encourage her to wear a surgical mask when outside her room.	F 880	use facemasks or a suitable face covering when in common areas or near proximity to others. 2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current COVID-19 nursing facility guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 06/10/2021 the facility shall complete the following actions: (1) DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to encourage residents to remain in/return to their rooms while on transmission-based precautions. b. Failure to encourage and assist residents to use masks or face coverings when in common areas and near proximity to others. (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate all staff on the importance of and techniques/strategies for encouraging residents to remain in/return to their rooms while on transmission-based precautions.	

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F 880	Continued From page 6	F 880	b. Educate all staff on the importance of and techniques/strategies for offering and encouraging residents to use masks or face coverings when in common areas and near proximity to others. (3) The facility leadership is encouraged to contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observe common areas of the building to determine if staff are redirecting/encouraging residents to remain in their rooms while on transmission-based precautions. (2) Observe common areas of the building to ensure residents are utilizing and staff are offering and encouraging masks/face covers. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for	

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F 880	Continued From page 7	F 880	the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 06/10/2021	