

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Aneta Parkview Health Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 113 5th St S Aneta, ND 58212	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46259</p> <p>Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring for 1 of 1 sampled resident (Resident #1) with an elopement. Failure to adequately monitor and supervise a resident with a known elopement risk placed the resident's health and safety at risk. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident.</p> <p>Findings include:</p> <p>This surveyor determined a deficient practice existed on 10/22/24. The facility implemented corrective action and completed staff education on 10/22/24.</p> <p>Review of the facility policy titled Standards of Care and Practice occurred on 10/23/24. This policy, dated April 2018, stated, . Each of the following is part of the routine care provided by caregivers, unless otherwise directed. Complete rounds every 2-3 hours during the day and night.</p> <p>Review of Resident #1's medical record occurred on 10/23/24 and included the diagnoses of generalized anxiety disorder, unspecified dementia, and schizoaffective disorder. The care plan, edited 10/22/24, stated, . I may try [sic] elope and have a history of sleep walking. Wanderguard: Due to being disorientation [sic], there are concerns I may try to elope or even sleep walk. Please help redirect me and ensure my safety. A physician's order, dated 09/30/24, stated, Check wanderguard placement each shift .</p> <p>Resident #1's progress notes included the following:</p> <p>* 09/30/24 at 4:05 p.m. Resident noted to be anxious, confused, and wandering in common area. Resident stated she is looking for her brother. Resident's brother told SS [social services] that resident is risk for elopement and has hx [history] of UTI [urinary tract infection] with confusion and anxiety. Wanderguard brace applied on R) [right] wrist.</p> <p>* 10/22/24 at 1:00 a.m. Resident was anxious and confused this evening . sat one on one with resident in common area for awhile and resident calmed down, warm blanket given and walked resident back to her room and she laid down to go to sleep.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* 10/22/24 at 5:50 a.m. Resident set off the door alarm this evening. Resident also then this morning followed the exit signs to the employee exit and got out without sounding the alarm. Writer found resident when writer was coming in from grabbing something from writer's car. Resident confused and was looking for a way home.</p> <p>During interviews on 10/23/24 an administrative nurse (#1) stated the facility investigation determined Resident #1 exited the building at 3:22 a.m. on 10/22/24 and staff returned the resident to the building at approximately 5:40 a.m. The staff member (#1) reported she expected night shift staff to complete rounds on residents every two hours at 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m. She confirmed staff failed to complete rounds as expected, and failed to discover the resident's elopement in a timely manner.</p> <p>Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions to ensure the deficient practice does not recur by:</p> <p>* All staff were educated on 10/22/24 as to the importance of monitoring residents at risk of elopement and those who currently utilize wanderguards.</p> <p>* The facility determined the wanderguard alarm system malfunctioned, and no alert sounded when Resident #1 exited the building. The facility contacted the alarm company immediately and reset the system to ensure proper functioning on 10/22/24.</p> <p>* Audits of the wanderguard system and staff rounding began 10/22/24.</p>