

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  088002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/13/2015
NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 8TH STREET WILMINGTON, DE 19806	
(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	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced annual survey was conducted at this facility from February 4, 2015 through February 13, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 148. The Stage 2 survey sample size was 28.</p> <p>Abbreviations used in this report are as follows:          NHA - Nursing Home Administrator;          DON - Director of Nursing;          RN - Registered Nurse;          RNAC - Registered Nurse Assessment Coordinator;          RD - Registered dietitian;          LPN - Licensed Practical Nurse;          CNA - Certified Nurse's Aide;          UM - Unit Manager;          SW - Social Worker;          TD - Tardive Dyskinesia - (characterized by repetitive, involuntary, purposeless movements. Some examples of these types of involuntary movements include grimacing, tongue movements, lip smacking, lip puckering, pursing of the lips, excessive eye blinking);          AIMS - Abnormal Involuntary Movement Scale (test used to detect tardive dyskinesia [TD] and to follow the severity of a patient's TD over time);          MDS - Minimum Data Set (standardized assessment forms used in nursing homes);          MAR - Medication Administration Record;          MRR - Medication Regimen Review;          Anti-depressant - Drug to treat depression;          NN - Nurses' Notes;          OT - Occupational Therapy;          Psychotropic (medication)- any medication</p>	F 000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *LNHA* (X6) DATE: *3/12/15*

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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NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW NURSING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2801 W. 6TH STREET WILMINGTON, DE 19805</b>	
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F 000	Continued From page 1 capable of affecting the mind, emotions and behavior; PT - Physical Therapy.	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.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and review of other documentation, it was determined that the facility failed to notify the resident's legal representative for one (R90) out of 28 Stage 2 sampled residents when there was a significant change in R90's mental/behavioral status. Findings include:</p> <p>The facility's policy entitled, "Notification of Resident Change in Condition", dated 7/2013 stated, "... To ensure that all appropriate, interested parties are notified of significant changes in a resident's health ... 3. Related to medical care, the charge nurse will notify the resident, the resident's physician, and the POA (Power of Attorney)/responsible party when there is: ... Significant change in condition in physical, mental, ... status ...".</p> <p>Review of R90's "Admission History and Physical", dated 1/18/15, stated that the resident was admitted to the facility "... on 1/18/15 for post [after] acute care, PT, OT...". R90 was noted to be alert and oriented "x 2 with confusion in the hospital" and "Now disoriented, agitated, combative. Did not cooperate c (with) exam".</p> <p>Review of R90's fall incident report, dated 1/18/15 and timed 8:30 AM, stated that the resident was confused and disoriented. The facility's investigation, dated 1/21/15, included a witness statement, dated 1/18/15 that stated, "Resident mumbling word 2 (secondary) to confusion (sic)". The "corrective action taken with respect to the resident" was listed as "on therapy caseload, psych (psychotropic) meds (medications) to be reviewed".</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> <li>1. The family member was notified of the fall at the time the omission was identified. 2/11/15</li> <li>2. A random audit of resident falls in the previous six months was completed to ensure that family/MD notification was complete. 2/13/15</li> <li>3. The ADON/Designee will now be responsible for auditing all nurses notes related to falls to ensure family/MD notification is complete. All nurses have been re-educated on MD/family notification regarding changes in resident status/incidents. 3/15/15</li> <li>4. A Quality Assurance Program will be put into place to ensure that resident's families are notified of all changes in resident status. The DON will audit the "facility activity report" daily x 1 week to ensure MD/family notification of changes in status until 100% compliant for one consecutive week. Then, the audit will be completed 3x/week until we have maintained 100% compliance x3 weeks. Then, the audit will be completed monthly until 100% compliance is maintained x 4 consecutive months. The results will be reviewed in the QAA committee meeting. Ongoing</li> </ol>	

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F 157	Continued From page 3  R90's NN, dated 1/18/16 and timed 10:38 AM, stated, "Resident was sitting in the dining room on his geri-chair (mobile recliner), attempted multiple unsafe transfers, which was easily redirected, prior to an incident. He was observed climbing out of his geri chair and knelt on the floor before the nurse was able to get to him...". Review of both the incident report and the nurse's notes lacked evidence that R90's POA had been notified.  During an interview, on 2/11/16 at 11:27 AM, E5 (LPN/UM) confirmed the findings. E5 stated that resident families are to be "notified of all falls". The facility failed to notify R90's POA when R90 had a change in condition, became confused and had a witnessed fall on 1/18/15.	F 157			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272			

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F 272	<p>Continued From page 4</p> <p>Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that for two (R63 and R111) out of 28 Stage 2 sampled residents, the facility failed to ensure the accuracy of the comprehensive assessment in the area of behavior. Findings include:</p> <p>The facility's policy entitled, "Minimum Data Set 3.0 Completion", dated 7/15/13, stated, "Guideline: To ensure an interdisciplinary approach to the timely and accurate completion of the MDS 3.0."</p> <p>1. R111's annual MDS, dated 8/26/14, indicated the resident was severely impaired for daily decision making and exhibited no physical</p>	F 272			

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F 272	Continued From page 6 behaviors directed toward others.  Review of the CNA's Behavior Flowsheet for the period of assessment actually documented 1 episode of physical behavior toward others. The facility incorrectly coded the MDS and should have coded that behavior of this type occurred.  During an interview on 2/10/15 at 10:40 AM, E6 (SW) confirmed that the MDS, dated 8/26/14, was miscoded.  2. R63's admission MDS, dated 10/29/14, indicated the resident was moderately impaired for daily decision making and exhibited no physical behaviors directed toward others.  Review of the CNA's Behavior Flowsheet for the period of assessment actually documented 3 episodes of physical behaviors toward others. The facility incorrectly coded the MDS and should have coded that behavior of this type occurred.  During an interview on 2/10/15 at 4:45 PM, E6 confirmed that the MDS, dated 10/29/14, was miscoded.	F 272	F272, 1 and 2 1. R111 and R63's MDS have been corrected.  2. The RNAC completed a random audit of Section E of the MDS (behaviors) in the previous 3 months to ensure accurate coding.  3. The Social Services Director was re-educated on accurate coding of behaviors in Section E of the MDS. The SSD will now confer with the Unit Manager who will double check behavior occurrences prior to coding.  4. A QA program will be put into place to ensure accurate coding of behaviors in Section E of the MDS. The RNAC will audit all MDS's completed for one week until 100% compliance is achieved in Section E of all MDS's for one week. Then, the audit will be completed 3x/week until 100% compliance is achieved for 3 consecutive weeks. Then, ten random MDS's will be audited monthly until 100% compliance is maintained x4 consecutive months. The results will be reviewed in the QAA committee meeting.	2/13/15  2/13/15  3/15/15	
F 278 SS=D	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.  A registered nurse must sign and certify that the assessment is completed.			Ongoing	

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F 278	<p>Continued From page 6</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and clinical record reviews, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the residents' status for three (R80, R120 and R123) out of 28 Stage 2 sampled residents. Findings include:</p> <p>The facility's "Minimum Data Set 3.0 Completion" policy, dated 7/15/13, stated, "Guideline: To ensure ... the timely and accurate completion of the MDS ... The RNAC will be responsible for the coordination and timely completion of the MDS...".</p> <p>1. Review of R120's clinical record revealed a doctor's order, dated 10/14/14, for an antidepressant medication, Mirtazapine, to be</p>	F 278			

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F 278	<p>Continued From page 7 administered once a day.</p> <p>Review of R120's MAR from 1/2/15 through 1/8/15 revealed that R120 received a dally dose of Mirtazapline as ordered.</p> <p>R120's quarterly MDS, dated 1/8/15, included a diagnosis of depression, however, under section "N. Medications", it was coded "0" for antidepressant use.</p> <p>During an interview, on 2/13/15 at 11:41 AM, E4 (RNAC) confirmed the findings. The facility failed to ensure that the quarterly MDS assessment, dated 1/8/15, accurately reflected R120's status. Subsequently, a copy of the corrected MDS was provided.</p> <p>2. Review of R123's clinical record revealed a doctor's order, dated 8/18/14, for an antianxiety medication, Ativan, to be administered as needed.</p> <p>Review of R123's MAR from 11/13/14 through 11/19/14 revealed that R123 received two doses of Ativan.</p> <p>R123's quarterly MDS, dated 11/19/14, revealed that antianxiety use under section "N. Medications" was coded "0".</p> <p>Findings were confirmed with E4 on 2/13/15 at 11:24 AM. The facility failed to accurately reflect R123's status on the 11/19/14 quarterly MDS assessment when he received two doses of an antianxiety medication.</p>	F 278	<p>F278, 1, 2 and 3</p> <ol style="list-style-type: none"> <li>1. R120, R123 and R80's MDS's have been corrected to reflect the medications given.</li> <li>2. The RNAC completed a random audit of MDS's Section N that were completed over the last 3 months to ensure accurate coding of medications.</li> <li>3. A new "double check" system will be put into place to ensure accurate coding of MDS Section N. The Unit Manager will now "double check" Section N for coding accuracy prior to MDS transmittal. The RNAC and UM's have been educated on this process.</li> <li>4. A QA program will be put into place to ensure accurate coding of medications in Section N of the MDS. The RNAC will audit all MDS's completed for one week until 100% compliance is achieved in Section N of all MDS's for one week. Then, the audit will be completed 3x/week until 100% compliance is achieved for 3 consecutive weeks. Then, ten random MDS's will be audited monthly until 100% compliance is maintained x4 consecutive months. The results will be reviewed in the QAA committee meeting.</li> </ol>	2/13/15	2/13/15	3/15/15	Ongoing

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F 278	Continued From page 8 3. Review of R80's clinical record revealed a doctor's order, dated 4/16/14, for an antidepressant medication, Zoloft, to be administered once every evening.  Review of R80's MAR from 8/21/14 through 9/10/14 revealed that R80 received a daily dose of Zoloft as ordered.  R80's quarterly MDS, dated 9/2/14, under section "N. Medications", was coded "0" for antidepressant use.  During an interview, on 2/12/16 at 3:48 PM, E4 confirmed the findings. The facility failed to ensure that the quarterly MDS assessment, dated 9/2/14, accurately reflected R80's status.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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F 280	Continued From page 9  This REQUIREMENT is not met as evidenced by: Based on record review, observation and Interview, it was determined that one (R82) resident's care plan out of 28 Stage 2 sampled, was not revised according to the needs of this resident as related to her Coumadin therapy (prevent harmful blood clots from forming or growing larger). Findings include:  The facility's "Food and Medication Interaction" guideline, stated, "In order to optimize the effectiveness of ...medication and to prevent negative side effects that may result from eating inappropriately while taking certain medications...follow the specific recommendations for ...medications...". The Food and Drug Interaction Guide Included: "Coumadin-Avoid drastic changes in consumption of foods high in Vitamin K (blood clotting vitamin) such as: Beef Liver, Broccoli, Brussel Sprouts, Cabbage, Collard Green Kale, Green Leafy Vegetables, Soybean Oil and Turnip Greens".  R82 had diagnoses that included peripheral vascular disease (disease of the blood vessel-arteries or veins located outside of the heart and brain) and acute embolism/thrombosis (formation of blood clot) of the lower extremities.  R82 was receiving the anticoagulant (causes blood to take longer to form clots) medication, Coumadin, tablets by mouth every day of the week.	F 280			

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F 280	<p>Continued From page 10</p> <p>The facility developed a care plan dated 12/15/14 on the problem of "Potential for excessive bleeding related to Coumadin Therapy". The care plan's approach included, "Monitor for other medications/foods contraindicated with ordered anticoagulant (Coumadin)".</p> <p>The care plan's goal (edited on 01/08/15) was "Resident will have no s/s (signs and symptoms) of excessive bleeding".</p> <p>R82 was prescribed a Regular (Small Portion) diet with No Added Salt.</p> <p>On 2/12/15 at 12:30 PM, it was observed that R82 was served beef with stir fry vegetables (broccoli and green beans). In an interview on 2/12/15 at approximately 1:30 PM, E8 (RD) stated that R82 could have the identified vegetables as long as she did not have a drastic change, that is, had multiple extra servings of green and leafy vegetable (Vitamin K).</p> <p>On 2/12/15 at approximately 3:00 PM, E7 (RN) was unable to identify to the surveyor the type of foods to be monitored as stated in the care plan.</p> <p>The care plan was edited on 01/08/2015, however, the care plan failed to be revised to specify the type of foods contraindicated and consumed by R82, that needed to be monitored, and the need to educate the staff, resident and family. Additionally, the care plan failed to identify R82's diagnosis as related to the Coumadin Therapy.</p> <p>The facility failed to ensure that R82's care plan was revised.</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> <li>R82's care plan was reviewed and revised. 2/11/15</li> <li>The care plans of all residents receiving Coumadin were audited and revised as needed. 2/11/15</li> <li>All nurses were educated on the care plan process for residents receiving Coumadin. The Dietician was consulted on correct dietary modifications for residents receiving Coumadin and the care plan library was adjusted accordingly. 3/15/15</li> <li>A QA program will be put into place to monitor compliance with care plan process for residents receiving Coumadin. The DON will audit to ensure completeness and accuracy of care plans R/T Coumadin therapy. Any resident admitted on Coumadin or ordered Coumadin will have their care plan reviewed by the DON after care plan initiation by the Unit Manager for a period of 2 quarters if 100% compliance is maintained. Ongoing</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805		
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F 280	Continued From page 11 The finding was discussed with E2 (DON) on 2/12/15 at approximately 3:30 PM and was further discussed with E1 (NHA) and E2 by the survey team on 02/13/15 at approximately 3:00 PM.	F 280			
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.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that	F 329			

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F 329	<p>Continued From page 12</p> <p>one (R90) out of 28 Stage 2 sampled residents' drug regimen was free from unnecessary drugs and received adequate monitoring. The facility failed to complete an AIMS assessment as per the facility policy. Findings include:</p> <p>The facility's policy entitled, "AIM's Testing" and dated 8/2013, stated, "... All residents receiving an antipsychotic drug will receive routine monitoring for abnormal involuntary movement. 1. When a resident is initially placed on an anti-psychotic drug or is admitted to the facility on an anti-psychotic the nurse will administer an AIM's ... test. The AIM's test will again be administered 30 days after the anti-psychotic drug regime is initiated. ... will continue to be done every six (6) months thereafter...".</p> <p>Review of R90's clinical record revealed a doctor's order, dated 1/16/15, for an antipsychotic medication, Quetiapine, to be administered once a day at bedtime and twice a day as needed for anxiety/agitation. On 1/20/15, an additional daily dose was ordered for the morning.</p> <p>On 1/21/15, an "Antipsychotic Medication Consent" form was signed by R90's POA (Power of Attorney/responsible party) for antipsychotic use in the morning, at bedtime and twice a day as needed for Dementia (loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning) with behavioral dyscontrol (behaviors such as psychosis [an abnormal condition of the mind, often involving a loss of contact with reality], agitation/aggression, anxiety, depression [feeling sad] and sleep disturbance).</p> <p>R90's MAR, from 1/16/15 through 2/12/15,</p>	F 329	<p>F329</p> <ol style="list-style-type: none"> <li>R90 had an AIMS test completed when the omission was identified. 2/1/15</li> <li>All residents receiving an antipsychotic medication were audited to ensure AIMS tests were completed when indicated. 2/13/15</li> <li>All nurses received additional education re: AIMS tests. The facility will now review AIMS tests in the psychotropic reduction meeting to ensure timeliness of tests. 3/15/15</li> <li>The DON/Designee will complete a Quality Assurance audit for timeliness of AIMS testing to ensure tests are completed as indicated. The audits will be completed weekly x4weeks until 100% compliance is maintained for 4 weeks. Then, audits will be completed monthly x 4 months until 100% compliance is maintained for 4 consecutive months. Then, a quarterly audit will be completed until 100% compliance is maintained x2 consecutive quarters. The results of the audits will be reviewed in the QAA meeting. Ongoing</li> </ol>		

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F 329	Continued From page 13 revealed that R90 received the antipsychotic as ordered.  Review of R90's clinical record lacked evidence that an AIMS assessment had been completed as per the facility policy.  During an interview on 2/12/15 at 10 AM, E6 (LPN/UM) confirmed the findings and stated, "I missed it." The facility failed to ensure that one resident (R90) received adequate monitoring for Quetiapine, when the facility failed to complete an AIMS assessment as per the facility policy.	F 329		
F 428 SS=E	483.80(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that a consultant pharmacist performed a MRR review for September, 2014 for 4 (R80, R82, R109 and R123) out of 28 Stage 2 residents sampled. Findings include:  The facility's Pharmacy Policies and Procedure	F 428		

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F 428	Continued From page 14 effective date August 1, 2008 entitled, "Consultant Pharmacist Reports" stated... "The consultant pharmacist performs a comprehensive medication regimen review at least monthly ... Includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy..."  1. On 2/11/15, review of R82's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly medication regimen review being completed in September, 2014.  2. On 2/11/15, review of R109's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly medication regimen review being completed in September, 2014.  The findings were discussed and acknowledged by E7 (RN) on 2/11/15 at approximately 9:40 AM and with E1 (NHA) and E2 (DON) on 2/13/15 at approximately 3 PM.  3. Review of R123's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly medication regimen review being completed in September, 2014.  Findings were confirmed with E7 on 2/13/14 at 9:48 AM.  4. Review of R80's "Consultant Pharmacist Record of MRR" lacked evidence of a monthly medication regimen review being completed in September, 2014.	F 428	F428, 1, 2, 3 and 4 1. R82, R109, R123, and R80 had no adverse effects from deficient practice.  2. The residents on the DuPont and Westover Units were affected by the deficient practice.  3. Pharmacy consultant will be provided a facility census upon entrance into facility to conduct monthly review. Pharmacy consultant will cross reference census with actual reviews to ensure all residents were reviewed. Pharmacy recommendation forms will then be given to DON/Designee as second check to ensure all residents were reviewed.  4. Pharmacy Director/Designee will audit compliance ensuring each resident in facility has had a monthly review completed on a monthly basis for three consecutive months until 100% compliance is achieved. Then, quarterly for three quarters or until 100% compliance has been achieved. The results will be reviewed in the QAA meeting.	2/13/15  2/13/15  3/31/15  Ongoing	

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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 8TH STREET WILMINGTON, DE 19806		
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F 428	Continued From page 15	F 428			
F 431 SS=E	<p>On 2/13/15 at 8:36 AM, E2 confirmed the findings.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431			

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F 431	Continued From page 16  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that residents' drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled on multiple occasions on 2 medicine carts (Dupont Unit and Westover Unit). Findings include:  According to the facility's Pharmacy Policies and Procedures dated August 1, 2008 on "Medication Ordering and Receiving from Pharmacy", "Accountability for Controlled Substances is maintained as follows:... c. The incoming and outgoing nurses must verify the inventory of controlled substances at each change of shift."  On 2/11/15 at approximately 9:30 AM, review of the facility's Dupont Unit's Control Drug Inventory Record revealed that E10 (LPN) had already signed out on the controlled drug inventory reconciliation form as the outgoing nurse on the 11:00 PM shift for 2/11/15, while still working on the 7-3 AM shift of that day. E9 (RN/UM) and E10 confirmed this finding. Additionally, further review of the Dupont Unit's Controlled Drug Inventory Record for drug reconciliation revealed that there were 18 nurses reconciliation signatures missing from 10/01/14 to 01/20/15.  On 2/11/15 at approximately 11:30 AM, review of the West Over Unit's Controlled Drug Inventory Record revealed that there were 6 nurses' reconciliation signatures missing from 12/17/14 through 1/19/15. This finding was discussed with E7 and was confirmed.	F 431	F431 1. The controlled drug inventory record was reviewed by the DON.  2. An audit of all controlled drug inventory records was completed by the DON. A root cause analysis reflected the need for a double check system.  3. All nurses were educated on the importance of signing the controlled drug inventory record at the beginning and end of each shift. The records are now double checked on a daily basis by the Unit Manager to ensure 100% compliance.  4. A QA program will be put into place to ensure 100% compliance with signing the controlled drug inventory records. The DON will audit the records daily x2 weeks. If 100% compliance is maintained x 2 consecutive weeks, the records will be audited 3x/week for 3 consecutive weeks. If 100% compliance is maintained x3 consecutive weeks, the records will then be audited monthly until 100% compliance is achieved for 2 consecutive quarters. The results will be reviewed in the QAA meeting.	2/11/15  2/11/15  3/15/15  Ongoing	

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F 431	Continued From page 17  This finding was discussed with E1 (NHA) and E2 (DON) during the exit on 2/13/15 at approximately 3:00 PM.	F 431			



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-8661

STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Parkview Nursing and Rehab Center

DATE SURVEY COMPLETED: February 13, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from February 4, 2015 through February 13, 2015. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 146. The survey sample size was 28.</p> <p><b>Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>Cross refer to the CMS 2567-L survey date completed 2/13/15, F157, F272, F278, F280, F329, F428, and F431.</p>	<p>Cross Refer CMS 2567-L</p>	

Provider's Signature

*Sandra J. K... [Signature]* Title LNA

Date

3/12/15