

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

PRINTED: 05/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2016
NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 8TH STREET WILMINGTON, DE 19805	
(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>INITIAL COMMENTS.</p> <p>An unannounced annual survey was conducted at this facility from April 21, 2016 through May 4, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 140. The Stage 2 survey sample size was 42.</p> <p>Abbreviations / definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; RNAC - Registered Nurse Assessment Coordinator; ADLs / Activities of Daily Living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ALS / Advanced Life Support - emergency medical services summoned by calling 911; accu-check(s) - blood glucose monitor used to check blood sugar levels; amp / ampule - single dose of liquid medication pre-packaged in a glass or plastic capsule ready for injection; antipsychotic- medication used to treat mental disorders; bgl / blood glucose level - measurement of the amount of glucose/sugar in the blood which then determines if insulin administration is needed and how much insulin based on the individual's needs (level within normal limits was 70-139 per hospital records); bm - bowel movement;</p>	F 000	<p>"REVISED"</p> <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

[Handwritten Signature]

TITLE
N/A

(X6) DATE
6/3/16

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 000	Continued From page 1 BP / blood pressure - the measure of the force of the blood against the walls of a blood vessel; BS / blood sugar - amount of sugar or glucose in the blood; Byetta - injectable diabetes medicine that helps control blood sugar levels; CMP / comprehensive metabolic panel - blood test that measures sugar level, electrolyte and fluid balance, kidney function and liver function; converse - engage in conversation; D50 dextrose - concentrated intravenous solution that restores blood glucose levels in hypoglycemia; decerebrate posturing - abnormal body posture that indicates severe damage to the brain; delusions - a belief held with strong conviction despite evidence to the contrary; dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; diabetes mellitus type 2 - chronic disease characterized by high blood sugar, insulin resistance or lack of insulin; diabetic - individual with diabetes; diaphoresis - profuse sweating; ECG / electrocardiogram - diagnostic test that records electrical activity of the heart; e.g. - for example; fortified - extra nutrients were added such as vitamins and minerals; Glucagon - hormone administered to treat severe low blood sugar by raising the blood sugar level; glucose - sugar; Haldol - antipsychotic medication used to treat agitation; hyperlipidemia - high cholesterol &/or triglycerides (fat proteins) associated with increased risk for heart disease & stroke; hypertension / hypertensive - high blood	F 000		

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F 000	<p>Continued From page 2</p> <p>pressure;</p> <p>hypoglycemia / hypoglycemic - low blood sugar;</p> <p>Humalog - fasting acting insulin to treat diabetes, used to cover meals and snacks, medication starts acting in 15 minutes, peaks 30-90 minutes, last 3-5 hours;</p> <p>IM / Intramuscular - Injection directly into the muscle;</p> <p>IV / Intravenous - administration of medications/fluids through a tube directly into a vein;</p> <p>Incontinence - loss of control of bladder &/or bowel function;</p> <p>Insulin - hormone that lowers the level of glucose in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own;</p> <p>LTC - Long Term Care;</p> <p>lethargic / lethargy - abnormal drowsiness;</p> <p>Levermir - long acting insulin used to control high blood sugar between meals and while sleeping for up to 24 hours, medication starts 1-3 hours, peaks 8-10 hours, lasts 18-26 hours;</p> <p>mg / milligram - a unit of mass;</p> <p>MAR / Medication Administration Record - list of daily medications to be administered;</p> <p>O2 sat / SpO2 - diagnostic measure of the amount of oxygenated hemoglobin (protein) in the blood;</p> <p>P / pulse - heart rate;</p> <p>po - by mouth;</p> <p>PRN - as needed;</p> <p>metabolic needs - breakdown of food and its transformation into energy;</p> <p>R / respirations - rate of breaths per minute;</p> <p>responsive - alert, answering;</p> <p>semi-fowler's - lying in bed with head of bed elevated 30 degrees;</p>	F 000		

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F 000	Continued From page 3 sliding scale with insulin coverage - dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher. Each sliding scale needs to be tailored to the individual, as each patient has unique circumstances and different insulin requirements; specimen - sample of something; subcutaneous - injection given into the fat layer between the skin and the muscle; T / temperature - measurement of hot or cold; Toujeo SoloStar insulin - long acting injectable insulin; u/ml - units per milliliter; unconscious - not awake or in a comatose state; unresponsive - does not respond to activity, touch, sound or other stimulation; urinalysis - diagnostic test used to determine presence of infection; UTI / urinary tract infection - bacteria in urine; VS / vital signs - clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure that indicate the state of a patient's essential body functions; < - less than; > - greater than.	F 000			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was	F 253			

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F 253	<p>Continued From page 4</p> <p>determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 8 rooms (111D, 116A, 204A, 302B, 303B, 304A, 306A, and 309C) out of 32 rooms surveyed. Findings include: On 4/21/16 and 4/22/16 during Stage 1 review and during the environmental tour with E10 (FMD) and E11 (Head of Housekeeping) on 4/22/16 between 2:00 PM and 3:15 PM, the following were observed:</p> <p>Room 111 - Bathroom floor was dirty; - Floor behind the bed against the window was dirty;</p> <p>Room 116 - Cracked tile behind the toilet; - Caulking around the toilet was missing;</p> <p>Room 204 - Chest at the foot of the bed had chipped wood on the top drawer;</p> <p>Room 302 - Two uncovered bedpans were stored on the bathroom floor;</p> <p>Room 303 - Bathroom sink was draining slowly;</p> <p>Room 304 - Caulking along the wall behind the bathroom sink was very dirty;</p> <p>Room 306 - Wall behind the bathroom sink had dried residue on it; - Floor along the bottom of the wall by the</p>	F253	<ol style="list-style-type: none"> 1. Discussion was held on findings with Maintenance Director, Environmental Director and Administrator at time of exit. Maintenance Director and Environmental Director immediately corrected deficiencies related to Room 111, 116, 204, 302, 303, 304 and 306 during survey. 2. An audit of all resident rooms was conducted to identify all needs in relation to findings during survey by Maintenance and Environmental. Corrections will be made accordingly as deficiencies are found in other resident rooms. 3. The Maintenance Director will add additional items identified during survey to resident room/bathroom monthly audit. In addition, this audit will be added to the TELS system for tracking. Environmental Director will inservice staff on daily resident room/bathroom cleaning instructions to include attention to flooring behind all areas. Staff Development Nurse will inservice all nursing staff on bedpan usage and disposal. 4. A sample size audit of 25% of the facility resident room/bathroom areas to identify items in disrepair will be conducted monthly by Maintenance Director and/or Designee. Environmental Director and/or Designee will conduct sample size audit of 25% of facility resident room/bathroom areas monthly to ensure thorough cleaning is being completed. Staff Development Nurse and/or Designee will conduct sample size audit of 25% of facility monthly to ensure bedpan usage and disposal is being maintained. Audits will be brought to monthly QA meeting and a PIP will be entered into facility QAPI program. 	<p>5/4/16</p> <p>6/17/16</p> <p>6/17/16</p>
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F 253	Continued From page 5 bathroom sink was dirty; Room 309 -Broken ceiling tiles above C bed; -Rubber corner cover was loose by the front door. Findings were reviewed and confirmed by E10 and E11 on 4/22/16 between 2:00 PM and 3:15 PM during the environmental tour.	F 253			
F 281 SS=D	Findings were reviewed with E1 (NHA) and E2 (DON) on 5/4/16 at approximately 11:45 AM. 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 observation, record review and interview, it was determined that the facility failed to ensure that services provided for one (R124) out of 42 Stage 2 sampled residents, met professional standards. Findings include: The facility's LTC Facility Pharmacy Services and Procedure Manual, dated 2013, entitled "General Dose Preparation and Medication Administration" stated, "... 5.9 Observe the resident's consumption of the medications...". On 4/21/16 at approximately 9:30 AM; during the medication pass observation, E8 (LPN) crushed 7 medication tablets (Lisinopril to treat high blood pressure, Keppra and Topiramate to prevent convulsion/seizure, Potassium chloride to treat	F 281			

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F 281	Continued From page 6 low potassium levels in the blood, Tylenol for pain, Senna to prevent constipation and chewable Aspirin to prevent heart attack/stroke) per doctor's order for R124. E8 crushed these medications per facility procedure and mixed all of the crushed tablets with vanilla pudding in a medication cup. E8 scooped two separate portions of the mixture with a teaspoon and fed it to R124 followed by sips of a liquid fortified drink supplement. The surveyor observed that R124 did not completely empty the teaspoon and medicine cup after taking the second portion of the mixture. There was some pudding remaining on the teaspoon with some traces of the crushed drugs. The surveyor advised E8 that as much medicine as possible needed to be given, so E8 did so and gave what remained to R124. E8 failed to ensure that R124 consumed all of her medication until advised to do so by the surveyor. Findings were discussed with E8 (LPN) and E9 (RN-PRN unit manager) on 4/21/16 at approximately 10:00 AM and with E5 (Staff Development) on 4/27/16 at approximately 1:45 PM.	F 281	F281 1. R124 received medications as ordered. The incident was discussed with E8. 5/4/16 2. All residents who receive crushed medications have the potential to be affected by this deficient practice. Additional training by the Staff Developer/Designee will be done to ensure all crushed medications will be administered to those residents needing such practice. 5/4/16 3. All nurses will receive additional training by the staff development coordinator/designee on medication administration techniques and processes. Training will include medication administration practices for crushed medications to ensure medication cup is scooped to completely empty cup and spoon. This training will now be part of new hire orientation as well as annually. 6/17/16 4. A quality assurance program will be put into place to monitor the effectiveness of the additional medication training for nurses. Facility supervisors will now conduct 5 random medication pass audits weekly until 100% compliance with medication administration is noted with all observed nurses x 4 consecutive weeks. Then, facility supervisors will conduct random audits monthly until 100% compliance with medication administration is achieved x 3 consecutive months. The findings will be reviewed at the monthly QA meeting and a performance improvement plan will be entered into the facility QAPI program. Ongoing	
F 309 SS=G	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	F 309		

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F 309	<p>Continued From page 7</p> <p>by: Based on review of clinical records and other documentation and interviews, it was determined that for 2 (R39 and R97) out of 42 Stage 2 sampled residents, the facility failed to provide the care and services necessary to maintain the highest practicable physical well-being in accordance with each individual's plan of care. For R39, the facility failed to have a system to evaluate R39 with 0% meal consumption after receiving a fast acting insulin which led to a significant hypoglycemic episode requiring emergency medical services and the administration of two medications: an intramuscular injection of glucagon and an intravenous amp of D50 dextrose. For R97, the facility failed to follow current physician orders and failed to obtain new physician orders for two insulin medications. Findings include:</p> <p>1. The manufacturer's prescribing information for Humalog insulin, last revised 11/16/15, stated, "Humalog is a rapid acting insulin ... administer Humalog by subcutaneous injection within 15 minutes before a meal or immediately after a meal ... the dosage of Humalog must be individualized based on the ... individual's metabolic needs, blood glucose monitoring results ... under Warnings and Precautions: ... Hypoglycemia: may be life-threatening. Monitor blood glucose and increase monitoring frequency with changes to ... meal pattern ... dosage adjustments may be needed with changes ... in meal patterns (... timing of food intake) ... other factors which may increase the risk of hypoglycemia include changes in meal pattern (e.g. ... timing of meals) ... hypoglycemia ... may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose."</p>	F 309		

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F 309	Continued From page 8 R39 was admitted to the facility on 12/18/07 with diagnoses including diabetes mellitus type 2, hypertension, dementia, legally blind and a history of urinary tract infections. R39 was care planned for potential for complications related to diabetes mellitus, last revised on 4/1/16. R39's goal was that he would not have significant complications related to ... hypoglycemia episodes x 90 days. Interventions included: diet as ordered, patient education on dietary management, patient education s/s (signs and symptoms) of possible complications and praise for good dietary compliance. In addition, R39 was care planned for actual infection: UTI, last revised on 4/1/16, with an intervention to monitor food/fluid intakes. R39 had the following active physician orders on 4/18/16: - Accu-check before meals and at bedtime for diagnosis of diabetes mellitus. - Humalog Insulin 100 unit/ml - administer 8 units before meals. - Humalog Insulin 100 unit/ml - administer per sliding scale before meals: If blood sugar is less than 80, call MD; If blood sugar is 80 to 250, give 0 units; If blood sugar is 251 to 300, give 2 units; If blood sugar is 301 to 350, give 4 units; If blood sugar is 351 to 400, give 6 units; If blood sugar is greater than 400, call MD. - Levemir Insulin 100 unit/ml - administer 18 units at bedtime. 4/18/16 at 7:30 AM - R39's accu-check was 182 and he was administered 8 units of the routine dose of Humalog insulin. R39 ate 100% of breakfast and drank 360's ml's of fluid.	F 309	F309 (1) 1. R39's EHR and hospital record was reviewed by the DON. The resident was transferred to the hospital. The incident was reviewed with the unit staff to identify areas for improvement. 5/4/16 2. All residents who receive insulin have the potential to be affected by this deficient practice. The DON reviewed the diabetic MAR and meal monitors of all residents with diabetes. No other issues were identified. Unit Managers will monitor blood sugars. 8/17/16 3. Residents with diabetes will now have prompts for nurses entered into the diabetic EMAR to ensure that nurses are assessing meal consumption post insulin administration and documenting follow up for those residents who did not eat. Training on the new process will be provided to all nurses by the Staff Developer/Designee. Training will also be provided annually by the Staff Developer/Designee. 6/17/16 4. The DON/ Designee will audit all residents with diabetes meal consumption record daily to ensure adequate nursing follow up for those residents who did not eat. The unit managers will conduct these audits daily until 100% compliance is maintained x 3 consecutive weeks. Then, the audits will be conducted weekly until 100% compliance is achieved x 4 consecutive weeks. Then, we will conduct monthly audits until 100% compliance is maintained x 3 consecutive months. The findings will be reviewed at the monthly QA meeting and a performance improvement plan will be entered into the facility QAPI program. Ongoing	
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F 309	<p>Continued From page 9</p> <p>4/18/16 at 11:30 AM - R39's accu-check was 311 and he was administered 8 units of the routine dose of Humalog Insulin plus 4 units of Humalog insulin per the sliding scale. R39 ate 75% of lunch and drank 120 ml's of fluid.</p> <p>4/18/16 at 12:14 PM - A physician's progress note stated that she was asked to see R39 for increased confusion and delusions. The progress note stated that R39 was alert and oriented, slow to respond and able to converse appropriately. The progress note stated that R39's increased confusion was due to progressive dementia and multiple diagnostic tests were ordered, including an urinalysis.</p> <p>4/18/16 - According to the MAR, R39's accu-check was 102 and he was administered 8 units of the routine dose of Humalog insulin, which were both documented at 4:50 PM by E4 (RN). The facility's Meal and Intake Sheet stated that R39 did not eat dinner or drink.</p> <p>4/18/16 at 8:22 PM - A nurse's note stated, "At 19:45 PM (7:45 PM) CNA called this Nurse (E3) to check on resident. According to CNA she was about to check the resident for incontinence when she noticed that resident tongue was sticking out and was drooling and mouth foamy. CNA tried to wake him but unresponsive. On assessment resident diaphoresis accu-check was done with 120 ... result and also noted decerebrate posturing while taking vital signs. Called resident name but does not respond chest rub done still did not respond. VS T-94.5, P-66, R-16, BP-237/101, O2 sat-90% ... order to send to hospital for further evaluation. 911 was called and resident left ... at 2012H (8:12 PM) ...".</p>	F 309		

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F 309	Continued From page 10 The ALS report on 4/18/16 stated the following: "Primary Impression: Hypoglycemia ... Upon arrival, R39 was found in a semi-fowlers position in bed, slumped over to the left, drooling and unconscious. Facility staff stated that R39 was last seen at 5:30 PM and he is hypertensive, diabetic and had a blood glucose of 120 ... During transport, ALS reassesses the Pt and finds him to have a bgl of 41 ... give 1 mg of Glucagon. After administration of Glucagon, IV is established ... Pt's bgl is rechecked just prior to arrival at (hospital) ER ... is now 39 ...". It was unclear how the blood sugar was 120 at 7:45 PM in the facility and now 41 at 8:25 PM during transport. The ALS timellne on 4/18/16 was as follows: - 8:05 PM, dispatch notified. - 8:07 PM, ALS unit enroute to facility. - 8:12 PM, ALS unit arrived at patient's bedside. - 8:14 PM, ALS vital signs were blood pressure 230/120, pulse 70, respiration 22, SpO2 95% on low O2 concentration (1-6 L). - 8:15 PM, ALS - ECG interpretation: sinus rhythm. - 8:23 PM, ALS unit left facility. - 8:25 PM, ALS checked blood sugar, which was 41. - 8:27 PM, ALS administered 1 mg of Glucagon by Intramuscular injection. Response: unchanged. - 8:29 PM, ALS obtained IV access and obtained blood draw. Blood pressure 202/105, pulse 66, SpO2 99%. - 8:30 PM, ALS rechecked blood sugar, which was 39. - 8:32 PM, ALS arrived at hospital ER. R39's ER hospital records stated the following:	F 309			

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 8TH STREET WILMINGTON, DE 19805		
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F 309	<p>Continued From page 11</p> <ul style="list-style-type: none"> - 8:38 PM, blood pressure was 183/102, pulse 77, respirations 18, SpO2 93% on 4 L of oxygen. - 8:38 PM, D50 dextrose medication administered. - 8:48 PM, blood pressure was 163/95, pulse 73, respirations 18, 98% SpO2 on 4 L of oxygen. - 8:41 PM, blood glucose was 54. - 8:46 PM, R39 was moaning. - 8:50 PM, R39 was administered IV Haldol. - 9:14 PM, blood pressure was 183/74, pulse 57, respirations 13, Temp 35.1 degrees C, SpO2 100% on 4L of oxygen. - 9:51 PM, blood pressure was 184/71, pulse 61, respirations 14, Temp 36.0 degrees C, SpO2 100% on 2L of oxygen. - 11:07 PM, blood pressure was 162/64, pulse 59, respirations 13, Temp 36.6 degrees C, SpO2 100% on room air. <p>The hospital ER's assessment and plan stated, "Patient initially found to be hypoglycemic and I suspect this is origin of patient's altered mental status ... We'll administer D50 and repeat Accu-Chek (sic) ... After receiving an amp of D50 patient's mental status immediately started improving. He woke up became combative. He moved all his extremities equally with good strength. His verbalizations are mostly moaning and screaming. He was given Haldol IV ... Is improving after hypoglycemia ... Final impression ... Hypoglycemia, UTI, altered mental status ... Blood sugar 231 and 243 on repeat after D50.</p> <p>Further review of the hospital records revealed that blood pressure medication was not administered until 4/19/16 at 3:38 AM after R39 was admitted to a hospital medical floor.</p> <p>In an interview on 4/28/16 at 3:26 PM, E6 (CNA)</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>stated that she was R39's routine assigned CNA. When asked about the events on 4/18/16, E6 stated that R39 wanted to go to bed before dinner and she persuaded him to stay up in his chair. Dinner was at 5 PM, R39's meal tray was delivered to the hallway on the second cart (approximately 10 minutes later) and she set it up in his room. E6 explained what was on the meal tray and offered him a drink as R39 was legally blind. R39 stated that he did not want to eat. E6 removed the meal tray and placed it back on the cart in the hallway then went to feed another resident. Between 5:45 PM and 6:00 PM, E6 returned to R39's room and offered him something to drink. R39 drank approximately 1 ounce of apple juice while E6 held the cup for him. E6 then put R39 to bed ensuring placement of his oxygen nasal cannula and exited the room. E6 stated that she returned to the room at approximately 7:45 PM to assist R39's roommate and found R39 laying in bed on the left side with saliva coming out of his mouth. E6 stated that R39 did not respond when she called him by name and that she could tell something was wrong. E6 immediately called E4 (RN) to the room. E6 stated that E4 tried talking to R39 and vital signs were taken. E4 asked E6 to call E3 (RN, UM), who was in another unit, to assist. E6 stated that E3 asked E4 what was R39's blood sugar level. During the interview, E6 stated that she did not tell E4 that R39 did not eat dinner nor did E4 ask her if he ate dinner before R39 was found unresponsive in his room.</p> <p>In an interview on 4/28/16 at 3:57 PM, E4 stated that she was the routine evening shift nurse for R39. On 4/18/16, E4 stated she performed her accuchecks but was not sure about the time. E4 stated that she saw a stack of trays in the hallway</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>and at that point gave her insulin's between 5:00 PM and 5:15 PM then continued with her medication pass. E4 stated that CNA's were cleaning up meal trays and she was still giving out medications. E4 stated at approximately 7:45 PM, E6 stuck her head out of R39's room and yelled there was something wrong with R39. E4 stated that R39 was drooling, decerabrate hands, unresponsive and his oxygen nasal cannula was pulled off. E4 stated that E3 came from another unit, vital signs were taken and R39's blood sugar was 120. E4 stated that E3 called 911 and it took about 10-15 minutes for EMS to arrive. E4 stated that R39 was still unresponsive. E4 stated that E3 asked E6 if R39 ate and E6 sald that he did not eat but drank some apple juice. E4 stated that the hospital ER called and spoke with E3 later and stated that R39's blood sugar was 40. E4 stated that she had no reason to believe that R39 would not eat or wasn't feeling well. E4 also stated that CNA's would tell her if residents refuse their meals.</p> <p>The facility failed to provide the care and services necessary to maintain the highest practicable physical well being in accordance with R39's plan of care when the facility failed to have a system to evaluate R39 with 0% meal consumption after receiving a fast acting insulin which led to a significant hypoglycemic episode requiring emergency medical services and the administration of two medications: an intramuscular injection of glucagon and an amp of D50 dextrose injected intravenously.</p> <p>Findings were reviewed with E2 (DON) on 4/28/16 at 4:30 PM.</p> <p>2. R97 had a physician's order, dated 4/22/16, for</p>	F 309		

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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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Continued From page 14.

Toujeo SoloStar Insulin 300u/ml administer 112u daily (7:30 AM) and to hold if BS < 100 and call MD if > 400.

R97 had a care plan for potential for complications related to diabetes, dated 4/19/16. Interventions included to administer medications as ordered.

A. Review of the April 2016 MAR revealed that on 4/26/16 at 7:30 AM, R97's BS was 97. A site was listed for the Insulin injection indicating it was given and there were no comments listed. There were also no nurse's notes written as to why the Toujeo SoloStar Insulin was given when the BS was < 100 and it should have been held according to the current physician's order.

B. Review of the April 2016 MAR revealed that on 4/27/16 at 7:30 AM, R97's BS was 88. A site was listed for the Insulin injection and there were no comments listed. There were also no nurse's notes written as to why the Toujeo SoloStar Insulin was given when the BS was < 100 and it should have been held according to the current physician's order.

C. Review of the April 2016 MAR revealed a new physician's order, dated 4/27/16, for Toujeo SoloStar Insulin 110u daily (7:30 AM) and to hold if BS < 100 and call MD if > 400.

Review of the April 2016 MAR revealed that on 4/28/16 at 7:30 AM, R97's BS was 74. A site was listed for the Insulin injection and a comment was written "held to after breakfast." There were no nurse's notes written as to why the Toujeo SoloStar Insulin was given when the BS was < 100 and it should have been held according to the

F 309

F309 (2)

1. R97's diabetic EMAR was reviewed by the DON and the documentation in question was discussed with E14. R97's Insulin orders and parameters were reviewed by the MD for accuracy. E14 received verbal coaching regarding Insulin orders and blood sugar parameters. 5/4/16
2. All residents with parameters for Insulin have the potential to be affected by this deficient practice. The DON completed a random audit of diabetic EMAR's to ensure all residents had received Insulin as per MD order. 6/17/16
3. All facility nurses will receive additional diabetic training, including obtaining insulin orders, following parameters, administration techniques and documentation. This training will now be provided in new hire orientation as well as annually by the Staff Developer/Designee. 6/17/16
4. A quality assurance program will be put into place to audit compliance with insulin orders and documentation. The DON/Designee will audit 5 diabetic EMAR's daily until 100% compliance is achieved x 3 consecutive weeks. Then, the DON will conduct 5 audits weekly until 100% compliance is maintained x 4 consecutive weeks. Then, the DON will conduct 5 monthly audits until 100% compliance is achieved x 3 consecutive months. The findings will be reported in the monthly QA meeting and a performance improvement plan will be entered into the facility QAPI program. Ongoing

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F 309	<p>Continued From page 15 current physician's order.</p> <p>D. A nurse's note, dated 4/29/16 and timed 8:04 AM, stated that R97's BS was 50 at 7:00 AM and he was given Insta-glucose (to raise his BS). R97's BS was 65 when rechecked at 7:30 AM and at that point, he was given 8 ounces of orange juice. Upon recheck at 7:45 AM, R97's BS was 98 and "MD made aware and nurse was directed to hold all morning insulins." R97 also had sliding scale coverage with another type of Insulin based on his BS results, dated 4/21/16, however, it was only for 11:30 AM and 4:30 PM BS's and coverage started with BS's of 151 and above.</p> <p>Review of the April 2016 MAR revealed that on 4/29/16 at 7:30 AM, R97's BS was 98 (although nurse's note stated it was 65 at 7:30 AM) and the Toujeo SoloStar Insulin was held. Two conflicting comments were written by nursing at 8:11 AM, stating, "Not Administered... MD request to hold" and "... Insulin held until after resident eat (sic)." It is unclear by the comments written whether Toujeo SoloStar Insulin was administered or not, and if so, what time it was administered.</p> <p>R97 also had a physician's order, dated 4/19/16, for Byetta, an antidiabetic medication (not an Insulin) due twice a day at 7:30 AM and 4:30 PM with no BS parameters to hold it. MAR review revealed that the 7:30 AM dose of Byetta was held on 4/29/16 which was not in accordance with the current physician's order. Two conflicting comments were written by nursing at 8:11 AM, stating, "Not Administered... MD request to hold" and "... Insulin held until resident eats." It was unclear by the comments written whether Byetta was administered or not, and if so, what time it</p>	F 309		

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F 309	<p>Continued From page 16 was administered.</p> <p>A nurse's note, dated 4/29/16 and timed 10:13 AM, stated, "... (name of physician) assessed... Med review completed... new order to change accu checks... with sliding scale. Decrease Toujeo to 40 units in the AM... hold byetta if blood sugar less than 200..."</p> <p>A physician progress note, dated 4/29/16 and timed 6:46 PM, stated, "... Hypoglycemia: appetite poor this AM, will hold Toujeo and byetta..."</p> <p>Concerns were discussed with E2 (DON) during a telephone interview on 5/3/16 at 4:16 PM. E2 stated she would discuss concerns with E14 (LPN) the next morning.</p> <p>E2 was interviewed again via telephone on 5/4/16 at 8:40 AM. E2 stated it was E14's day off, however, she talked to him via telephone and E14 reported that for all of the above examples when R97's BS was < 100, a physician was present and aware of R97's status. E2 also stated that E14 further told her that the physician gave verbal orders to give the Insulins after breakfast, however, he forgot to write the physician orders.</p> <p>The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for R97 in accordance with his comprehensive assessment and plan of care. The facility failed to follow current physician orders for R97's Toujeo SoloStar Insulin at 7:30 AM daily from 4/26/16- 4/28/16 (although BS's < 100, Toujeo was given despite a parameter to hold for BS < 100) and although listed as held on the MAR on 4/29/16, it was unclear whether</p>	F 309		

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F 309	Continued From page 17 Toujeo SoloStar Insulin and Byetta were administered or not due to conflicting comments written. Additionally, the facility failed to obtain new physician orders to give Toujeo SoloStar Insulin (and Byetta on 4/29/16 at 7:30 AM) after R97 ate breakfast for the above dates and times.	F 309		
F 323 SS=D	Concerns were discussed with E2 during an exit conference on 5/4/16 at 11:45 AM. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure the environment was free from accident hazards in three rooms (116A, 302B, and 402A) out of 32 rooms surveyed. Findings include: On 4/21/16 and 4/22/16 during Stage 1 review and during the environmental tour with E10 (FMD) and E11 (Head of Housekeeping) on 4/22/16 between 2:00 PM and 3:15 PM, the following were observed: Room 116A - Toilet bolts were exposed;	F323	<ol style="list-style-type: none"> Discussion was held on findings with Maintenance Director and Administrator at time of exit. Maintenance Director replaced call bell for Room302B at time of discovery. Entire building toilets will have toilet bolts covered and/or replaced and then caps put on bolts. An audit of all rooms was conducted to identify number of toilets in facility and call bells in need of repair by Maintenance Director and/or Designee. All toilet bolts will be covered and/or replaced by Maintenance Director and/or Designee. All toilet bolts will have caps put on for protections. All toilet bolts and caps have been corrected. The Maintenance Director and/or Designee will add/change toilet bolts with caps as identified during survey. All call bell cords will be inspected and replaced if in disrepair. Toilet bolts with caps and call bell cords will be added to the TELS system for monthly tracking. A sample size audit of 25% of the facility will be conducted monthly by Maintenance Director and/or Designee of toilet bolts with caps and call bell cords to ensure they are not in disrepair. Audits will be brought to monthly QA meeting and a PIP will be entered into facility QAPI program. 	5/4/16 6/17/16 6/17/16 Ongoing

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F 323	Continued From page 18 Room 302B - Bedroom call bell had exposed wires showing from wall. E3 (RN) confirmed the finding and called maintenance to report; Room 402A - Two long rusty toilet bolts were uncovered at the base of the toilet. Findings were reviewed and confirmed by E10 and E11 on 4/22/16 between 2:00 PM and 3:15 PM during the environmental tour. Findings were reviewed with E1 (NHA) and E2 (DON) on 5/4/16 at approximately 11:45 AM. 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R85) out of 42 Stage 2 sampled residents, the facility failed to promptly notify the physician of abnormal lab results. Findings include: R85 was admitted to the facility on 8/12/15 with diagnosis including dementia. R85 was care planned for diagnoses of diabetes and hyperlipidemia, on 8/13/15, with an intervention for "Labs as ordered. Notify MD of abnormal results".	F 323		
F 505 SS=D		F 505		

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F 505	<p>Continued From page 19</p> <p>On 1/29/16, R85 was ordered to have a CMP blood test, which was performed the same day. The blood specimen could not be used so the test was rescheduled for the following morning on 1/30/16.</p> <p>Review of the CMP lab result revealed that the document was faxed to the facility on 1/30/16 at 12:57 PM and showed abnormal lab findings.</p> <p>A nurse's note, dated 1/31/16 and timed 6:23 PM, stated that she received R85's abnormal CMP lab result at 3 PM and notified the physician. It was unclear why it took the facility approximately 26 hours to notify the physician of R85's abnormal CMP lab result.</p> <p>In an interview on 4/27/16 at 3:38 PM, E14 (LPN) stated that lab results are faxed to the front office and placed in the mail slot for pickup by the house supervisor to be delivered to the respective unit. E14 stated that if the lab results are abnormal, the physician would be notified.</p> <p>The facility failed to promptly notify the physician of R85's abnormal CMP lab result for approximately 26 hours. Findings were reviewed with E2 (DON) on 4/27/16 at 3:49 PM.</p>	F 505	<p>F505</p> <p>1. R85's lab results were reviewed by the DON. The incident was discussed with the weekend supervisor. The physician was made aware of the lab results. 5/4/16</p> <p>2. All residents who have labs drawn have the potential to be affected by this deficient practice. All lab results received in the previous week were reviewed by the DON to ensure appropriate and timely follow up. No other issues were identified. All nurses will be educated on the new protocol and system change by the Staff Developer/Designee. 5/4/16</p> <p>3. A prompt will now be put into Matrix (EHR system) for nurses to follow up on all lab results in the shift immediately following the labs being obtained. All nurses will be educated on the new protocol. 6/17/16</p> <p>4. A quality assurance program will be put into place to audit compliance with timely follow through on lab results. The DON/ Designee will audit 5 lab results daily until 100% compliance is achieved x 3 consecutive weeks. Then, the DON/ Designee will conduct 5 audits weekly until 100% compliance is maintained x 4 consecutive weeks. Then, the DON/ Designee will conduct 5 monthly audits until 100% compliance is achieved x 3 consecutive months. The findings will be reported in the monthly QA meeting and a performance improvement plan will be entered into the facility QAPI program. Ongoing</p>	
F 514 SS=D	<p>483.76(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19805	
(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 514	<p>Continued From page 20</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R165) out of 42 Stage 2 sampled residents' clinical record, was maintained in accordance with accepted professional standards and practices that were accurately documented. Findings include:</p> <p>Review of R165's bladder documentation, failed to contain sufficient information to identify the resident's urinary status. CNA's documentation of this resident's ADL results of bladder toileting showed insufficient and inaccurate documentation of the plan of care and services provided on his bowel and bladder toileting. For example, R165's amount of urine was documented as large and was continent. However, the appliance used for toileting was both the toilet and a pad/brief and or the amount of urine was medium, resident was continent and the appliance used was pad/brief. E13 (Unit Manager) was interviewed on 4/27/16 at approximately 11:00 AM and confirmed the findings. She stated CNAs would be retrained for accuracy of documentation.</p> <p>The facility failed to ensure that R165's bladder toileting information was accurate.</p>	F 514	<p>F514</p> <ol style="list-style-type: none"> 1. R165's EHR was reviewed by the DON. The documentation in question was reviewed and noted by the DON. The surveyor was questioning the appliance used for resident, not urinary status. The residents urinary status was accurately documented. 5/4/16 2. All residents have the potential to be affected by this deficient practice. The DON completed a random audit of 10 records to ensure that residents continence status was accurately documented. No issues identified. 5/4/16 3. The facility will implement a system change to the EHR to more clearly communicate residents continence status. All CNA's will be educated on the new system by the Staff Developer/Designee. Training on toileting documentation/continence status will also be provided annually to all CNA's. 6/17/16 4. The DON/ Designee will audit 10 resident records weekly to ensure accuracy of CNA documentation on residents continence status until 100% compliance is maintained x 4 consecutive weeks. Then, the DON/ Designee will audit 10 resident records monthly until 100% compliance is achieved x 3 consecutive months. The findings will be reported in the monthly QA meeting and a performance improvement plan will be entered into the facility QAPI program. Ongoing

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2018
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6TH STREET WILMINGTON, DE 19806
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F 514	Continued From page 21 Findings were discussed with E2 (DON) during the exit conference on 5/4/2015 at approximately 11:45 AM.	F 514		



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 677-6661

STATE SURVEY REPORT

NAME OF FACILITY: Parkview Nursing and Rehab Center

DATE SURVEY COMPLETED: May 4, 2016

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 April 21, 2016 through May 4, 2016. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 140. The Stage 2 survey sample size was 42.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</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>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 4, 2016 F253, F281, F309, F323, F505, and F514</p>	<p>Cross Reference CMS 2567-L</p>	

Provider's Signature *Sharon J. K... ..* Title NTA Date 6/3/16