DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Parkview Nursing & Rehabilitation

DATE SURVEY COMPLETED: March 01, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification, Complaint and Extended survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality from 02/26/24 through 03/01/24. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	Cross Reference 2567 POC: F550, F600, F609, F610, F690, F757, and F880.	03/27/2024
	Survey Dates: 02/26/24-03/01/24. Survey Census: 126 Sample Size: 41		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.** **This requirement is not met as evidenced by:**		

Provider's Signature _____ Title NHA Date 3/22/24

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	Cross Refer to the CMS 2567-L survey completed March 1, 2024: F550, F600, F609, F610, F690, F757 and F880.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085002	A. BUILDING _____ B. WING _____	C 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING	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
E 000	Initial Comments A Recertification and Complaint Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 02/26/24-03/01/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality from 02/26/24 through 03/01/24. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/26/24-03/01/24. Survey Census: 126 Sample Size: 41	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		3/27/24

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

Electronically Signed | 03/22/2024

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one resident (Resident (R)106) out of a total sample of 41 residents was treated with dignity in toileting. Findings include: Review of R106's "Face Sheet," located in the hard chart, revealed he was admitted to the	F 550	A. 1. R106 is now on a toileting plan. 2. R106□s bowel and bladder care plan and tasks in the EMR have been updated. 3. All CNAs were educated on the facility□s policy for Promoting/Maintaining Resident Dignity. B. 1. All residents have the potential to be	

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F 550	Continued From page 2 facility on 12/27/23, from the hospital, with diagnoses of toxic encephalopathy (brain dysfunction) and sepsis (infection of the organs). Review of R106's admission "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 01/02/24, revealed R106 had a "Brief Interview for Mental Status (BIMS)" of 15 out of 15 which indicated the resident had intact cognition. Review of this "MDS" revealed R106 was dependent on staff assistance of two for care. Review of the "Bowel and Bladder" section of this "MDS" revealed R106 was on a toileting program for bowel and bladder incontinence. Review of the admission comprehensive care plan, located in the EMR under the "Care Plan" tab, with an initiated date of 12/27/23 and revised on 01/04/24, revealed a care plan for incontinence of bowel and bladder. A toileting program was not one of the interventions. During an observation and interview on 02/26/24 at 11:00 AM, R106 stated he could tell when he needed to go to the bathroom but he wore a brief and the staff changed him. During an interview on 02/29/24 at 4:32 PM, R106 revealed it "sucked" to have to go in a brief. R106 further revealed that when he had asked staff to take him to the bathroom, the staff told him to "just go" in his brief. During an interview on 02/26/24 at 9:40 AM, Certified Nursing Assistant (CNA) 8, who was providing care to R106, stated R106 was not on a	F 550	affected. 2. The DON/designee has reviewed the continence status of all residents and cross-reference it with their EMR tasks and bowel and bladder care plans for accuracy. Resident care plans and EMR tasks will be updated accordingly. C. 1. The Root Cause Analysis (RCA) determined that R106 had both a check and change and a toileting program assigned in the EMAR. The facility's policy for Promoting/Maintaining Resident Dignity was reviewed by the VP of Clinical 2. Services and updated to include respecting a resident's toileting preferences. The staff developer/designee will educate CNAs and licensed nurses on the facility's updated policy on Promoting/Maintaining Resident Dignity. 3. The Director of Nursing (DON)/designee will conduct weekly audits on 50 percent of the facility's census to monitor the correct assignment of EMR tasks for continence status and to monitor the accuracy of residents' bowel and bladder care plans." 4. On a weekly basis, the DON/designee will observe 4 staff providing continence care to monitor that they follow the facility□s updated policy on Promoting/Maintaining Resident Dignity policy."	

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F 550	Continued From page 3 toileting program but was a check and change (the brief) every two to three hours. CNA confirmed R106 went to the bathroom in his brief. During an interview on 02/28/24 at 9:43 AM, Licensed Practical Nurse (LPN) 4 revealed that the CNA task page indicated R106 was on a toileting program before meals, bedtime, and as needed. LPN4 further revealed the CNAs changed R106's brief after urinating or having a bowel movement because staff used a [mechanical] lift to get him up out of bed. LPN4 confirmed that R106 was alert and oriented and could make his needs known including when he had to use the bathroom. During an interview on 02/29/24 at 3:00 PM, the Director of Nursing (DON) revealed a toileting program was supposed to promote quality of life for those residents requiring assistance to and from the bathroom. During an interview on 03/01/24 at 8:28 AM, the Administrator revealed it was not appropriate for staff to say "just go" in your brief when a resident asked to be toileted. The Administrator further revealed it was a dignity issue and not acceptable. During an interview on 03/01/24 at 9:01 AM, the DON revealed it was not acceptable for staff to say, "just go in your brief" and it was a dignity issue. Record review of the facility's policy titled, "Promoting/Maintaining Resident Dignity," with a date of 04/01/20, revealed it was the practice of the facility to promote and protect residents' rights with respect and dignity in a manner that	F 550	D. 1. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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F 550	Continued From page 4 maintained or enhanced the resident's quality of life. The policy further revealed all staff involved in providing resident care was to promote resident dignity.	F 550		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure residents were free from physical abuse from: 1. one resident (Resident (R) 95) who demonstrated repeated acts of physical violence towards multiple other residents to include residents R24 and R109; and 2. R128's wandering behavior resulted in a resident-to-resident abuse between R128 and R6. The facility's Administrator was informed on 02/29/24 at 3:40 PM that Immediate Jeopardy (IJ) existed at F600-K Freedom from Abuse and Neglect when the facility failed to implement	F 600	A. 1. The State survey agency is now aware of incidents involving R95, dated 9/27/23, 10/19/23, 10/3/23, and 11/4/23. B. 1. All residents have the potential to be affected. 2. The DON or their designee conducted an audit on residents who displayed aggressive behavior (such as grabbing, hitting, pushing, scratching, kicking, or unsolicited touching) in the past 30 days.	3/27/24

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F 600	Continued From page 5 effective interventions to ensure residents were free from abuse from R95. The facility provided an acceptable removal plan for the Immediate Jeopardy on 03/01/24 at 12:21 AM. The survey team validated that the Immediate Jeopardy was removed on 03/01/24 at 1:45 PM. The removal was validated by observations, interviews, record review, and review of training records. The removal plan included training for all disciplines recognizing signs and symptoms of abuse and neglect, along with reporting and preventing abuse and neglect. All residents with known behaviors were reviewed and care plans were reviewed for effectiveness. Abuse policies were reviewed and updated to include resident to resident interactions. After removal of the Immediate Jeopardy, the deficiency remained at an "E" scope and severity for pattern with a potential for more than minimal harm. Findings include: 1. a. Review of R95's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed admission to the facility on 11/23/22 with diagnoses of traumatic subdural hemorrhage, irritability and anger, delusional disorders, and anxiety disorder. Review of R95's quarterly "Minimum Data Set (MDS)" under the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 08/31/23, revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated the resident was cognitively intact. Further review revealed R95 had physical behavior symptoms directed at others.	F 600	The audit aimed to identify whether such behavior occurred, assess the implementation and effectiveness of interventions, and update care plans accordingly. If interventions proved ineffective, were new strategies implemented. Corrections to care plans were made as necessary, and the audit results were reported during an ad hoc QA&A meeting with the Medical Director. C. 1. The facility developed a new protocol for licensed nurses to identify residents displaying aggressive behaviors (e.g., grabbing, hitting, pushing, scratching, kicking, or unsolicited touching) through a new order set in the EMR. This order set encouraged nurses to verify the implementation of interventions, assess their effectiveness, and implement new strategies if the initial interventions are ineffective. The order set has become a routine order for residents identified as either being potentially or are actually exhibiting aggressive behavior (e.g., grabbing, hitting, pushing, scratching, kicking, or unsolicited touching), while other residents will have a PRN order. The Staff Developer/designee has educated licensed nurses on the new order set. 2. The Staff Developer/designee provided re-education to staff across all disciplines regarding the facility's abuse policy. 3. The Staff Developer/designee provided re-education to CNAs and licensed nurses	

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F 600	Continued From page 6 Review of R95's "Care Plan," located under the "Care Plan" tab of the EMR and dated 06/09/23, revealed "The resident has the potential to be physically aggressive related to poor impulse control as evidenced by swinging fist at others." Interventions in place were to calmly explain or reinforce why behavior was inappropriate or unacceptable. Intervene as necessary to protect the rights and safety of others. Provide programs of activities that were of interest and accommodated the resident's status. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Registered Nurse (RN) 2, dated 08/24/23 at 1:46 AM, indicated R95 was combative and verbally aggressive toward staff who were unable to redirect him. R95 became verbally aggressive toward both of his roommates waking them both up. Staff were unsuccessful at redirecting R95 out of the room and R95 attempted to hit staff. Staff offered snacks but R95 refused and wheeled (himself) to a different unit. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Assistant Director of Nursing (ADON), dated 08/24/23 at 3:15 AM (one and a half hours later) indicated R95 was found in R24's room swinging his arms at R24. R95 told staff he hit R24 in the face. Coffee was provided to R95 as requested which calmed him down for a short period of time but R95 became more aggressive and difficult to redirect by the staff. The physician was notified and R95 was sent out to the emergency room (ER). Review of a "Nurse's Note," located under the	F 600	regarding what to do in the event of behaviors not subsiding or escalating, and when implemented interventions prove ineffective. This includes increasing visual checks for residents, up to 1:1 supervision if deemed necessary by the RN supervisor, notifying the MD/physician extender about ineffective de-escalation techniques/interventions, and reinforcing the importance of removing other residents from potential threats. 4. The DON/designee will audit daily new order set, and progress notes for implementation of interventions, assess their effectiveness, and implement new strategies if the initial interventions are ineffective. D. 1. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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F 600	Continued From page 7 "Notes" tab in the EMR and written by RN9, dated 08/24/23 at 1:09 PM, indicated R95 returned from the ER at 9:00 AM and was moved to another unit and the Psychiatrist (PSYD) reviewed R95's medications and there was a new order for Ativan (anti-anxiety medication) 0.5mg (milligram) tab one dose and for Ativan IM (intramuscular) 1mg every six hours PRN (as needed). During an interview on 02/28/24 at 5:39 AM, RN2 stated R95 was combative and noncompliant towards both staff and other residents. She stated staff tried redirection, keeping him by the nurse's station, offering fluids, snacks, and general safety checks every two hours. RN2 stated R95 was moved to another unit after hitting R24 in the face but she was unsure of any changes to his care plan for aggressive behaviors. During an interview on 02/29/24 at 9:24 AM, RN7 stated R95 was very aggressive, and staff tried calming him down and were aware of some things that worked such as offering coffee or Pepsi. RN7 stated was not aware of changes made to his plan of care when he was readmitted. During an interview on 02/29/24 at 10:17 AM, the Social Services Director (SSD) 1 stated R95 was very authoritative, and thought he was the boss. SSD1 stated it was best for them to walk away and reapproach later. She stated the interdisciplinary team (IDT) met a lot to discuss him and tried to have consistent staff provide care since he liked consistency. b. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Licensed Practical Nurse (LPN) 1, dated 09/27/23 at 1:26 AM, indicated R95 was exhibiting very aggressive	F 600		

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F 600	Continued From page 8	F 600		

behaviors and went into a female residents' room and was touching their feet and both residents yelled at R95 to get out of the room. R95 got up off his wheelchair and sat down on one of the female resident's wheelchairs. R95 could not be redirected and started kicking and punching at female staff members. A male nurse from another unit came and picked R95 up and placed him in his own wheelchair and he eventually self-propelled to another unit. No change in plan of care.

During an interview on 02/28/24 at 10:58 AM, LPN1 stated R95 was very aggressive and argumentative to staff, but he was much more aggressive towards other residents at the facility. She stated staff tried to keep him away from other residents and he was moved to other areas of the facility, but staff were unable to redirect him during the 11:00 PM to 7:00 AM shift. LPN1 stated staff tried to stay out of his range. LPN1 stated they would provide fluids, and sometimes he accepted but there was a skeleton crew at nighttime which made it more difficult to redirect or intervene. On 09/27/23, she stated she remembered R95 very inappropriate and calling out racial names and attempting to hit staff before he went into a female resident's room and was touching their feet

c. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by LPN1, dated 10/19/23 at 7:53 PM, indicated R95 became physically aggressive throwing punches and kicking at staff and struck R109 on the arm. No change in plan of care.

Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by LPN1,

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F 600	Continued From page 9	F 600		

dated 10/22/23 at 3:38 AM, indicated R95 continued with behaviors and wandering in and out of female resident rooms and calling two female aides [derogatory language]. R95's roommate complained that R95 kept purposely running into his bed with his wheelchair to wake him up. At 3:45 AM, R95 continued being aggressive and kicked a nurse in the leg twice and hit her in the face.

During an interview on 02/28/24 at 10:58 AM, LPN1 stated that on 10/19/23, R95 was in the hallway in his wheelchair and when R109 passed by and attempted to speak to R95, R95 punched R109 in the face. LPN1 stated she witnessed R95 hit R109 in the face.LPN1 stated a few days later, on 10/22/23, R95 could not be redirected and went into another room of female residents. and while attempting to redirect R95, he kicked her in the knees multiple times and punched her in the face. She stated R95's medications were changed, and he was moved off her unit to another unit, but she was unsure what, if any additional changes in his plan of care were put into place after these incidents.

d. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by the ADON and dated 10/23/23 at 1:46 PM, indicated the IDT team met and requested a room change and another psychological evaluation to be completed for R95. The resident was moved to another unit.

Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by LPN10, dated 10/26/23 at 4:25 PM, indicated at 4:25 PM, a psychological evaluation was completed on R95. Medications were reviewed and new orders for Depakote (mood stabilizer) 125mg BID (twice

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F 600	Continued From page 10 a day) one day, Ativan 0.5 mg tab BID and discontinue mirtazapine (anti-depressant medication). On 10/27/23, a new order for Depakote 250 mg QD (once a day). During an interview on 02/28/24 at 2:00 PM, the Administrator stated there were no psychological evaluations completed on R95, but the PSYD completed a medication review. e. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by RN7, dated 10/31/23 at 5:53 AM, indicated R95 was physically aggressive throwing punches, kicking at staff and attempting to hit a fellow resident, but staff intervened and redirected the resident away from the other resident. R95 continued to be aggressive and attempted to hit any staff that passed by. The staff's attempts to redirect were unsuccessful. R95 had another room change and was moved to a different unit. No other changes in the plan of care. During an interview on 02/29/24 at 9:24 AM, RN7 stated she did not remember who the resident was that R95 tried to hit on 10/31/23, but that R95 had multiple behaviors during that time. She stated R95 was sitting in his wheelchair and tried to punch the nurse and the staff were attempting to calm him down, but he could not be redirected. RN7 stated he was kicking at staff who tried offering him coffee or snacks, but he continued to refuse that along with his medications f. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by RN1, dated 11/03/23 at 10:28 PM, indicated R95 was being resistive to care, and staff attempted to provide reassurance to R95 who appeared to calm down.	F 600		

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	085002	A. BUILDING _____ B. WING _____	C 03/01/2024

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F 600	Continued From page 11	F 600		

However, after care was provided R95 punched a nurse on the cheek and struck another nurse in the left eye. R95 was sent out to the ER for further evaluation. He came back to the facility on 11/04/23 at 1:27 AM. At 11:10 AM, the physician gave an order for one time Ativan 0.5mg by mouth. No other changes in the plan of care.

During an interview on 02/27/24 at 4:25 PM, RN1 stated R95 would wander the halls and staff tried to redirect by offering coffee or food. But she was unsure if there were specific interventions on R95's care plan that listed things staff should do to effectively redirect or engage him. During the incident that occurred on 11/03/23, she stated R95 punched one of the nurses in the head and she called 911 and she thought R95 was transported to ER. RN1 stated when he returned, he was moved to another unit, but she was unsure if there were any changes made to his plan of care.

Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by RN5, dated 11/04/23 at 2:37 PM, indicated R95 continued to be agitated and running into other residents with his wheelchair and kicking door of nurse's station. Re-direction unsuccessful but staff continued to re-direct.

Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by the Director of Nursing (DON), dated 11/06/23 at 1:18 PM, indicated the IDT team met and R95 medications were reviewed and there was a new order to discontinue Lorazepam (anti-anxiety medication) and start Ativan gel.

During an interview on 02/29/24 at 9:24 AM,

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F 600	Continued From page 12 ADON stated R95 could be very aggressive, and at times redirected. The ADON stated they sent him out to the ER to get him psychiatric treatment, but the ER would send him right back to the facility. She stated they tried to address his aggressive and violent behavior by moving him to other rooms but that was only effective for a short period of time. She stated that the facility was not protective of other residents since R95 was able to physically assault other residents on multiple occasions.. She stated his behavior only stopped due to his physical decline. During an interview on 02/29/24 at 10:36 AM, the PSYD stated he was at the facility every Thursday seeing residents. He stated when he made rounds, he physically saw each resident and reviewed their medical record along with their medications. He stated R95 had some behaviors and was on every Thursday list to be seen. anytime there was physical altercation the residents' medications were reviewed and adjusted and he followed-up within a week.. He stated R95 was a chronic patient, but he did not document that anywhere in the EMR because he kept his own notes. During an interview on 02/29/24 at 10:36 AM, the DON stated R95's behavior depended on the day. She stated staff tried redirecting him. She stated they offered him coffee or activities of his choice like football, which he liked. The DON stated there were some staff he really took to, so they tried assigning those staff to provide his care. She stated they tried finding the right room/unit in the facility and PSYD made several medication adjustments. During an interview on 03/01/24 at 10:08 AM, the	F 600		

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Administrator stated staff attempted to address R95's aggressive behaviors by sending him out to the ER in hopes the hospital would send him for psychiatric treatment. But she stated they would send him back to the facility. She stated staff tried redirection, offering coffee, putting on football. But R95's aggression was out of control no matter what staff did.

Further review of the "Care Plan" revealed no updates to the care plan since it was implemented on 06/09/23 despite R95's multiple abusive behaviors towards other residents. One intervention, not documented on the care plan, was to transfer R95 to different units of the facility where the abusive behaviors continued.

2. Review of R6's "Admission Record" located in the EMR under the "Profile" tab, indicated the resident was admitted to the facility on 03/30/23. Diagnoses included dementia, psychotic disturbance, mood disturbance, and anxiety.

Review of R6's "MDS" with an ARD of 04/05/23, revealed a "BIMS" score of ten out of 15 which indicated moderate cognitive impairment. R6 was independent with ambulation and was documented as wandering for one to three days of the assessment period.

Review of R6's "Care Plan" located in the EMR under the "Care Plan" tab, dated 04/25/23, indicated "Resident is/has potential to be verbally aggressive r/t [related to] Dementia." Interventions were revised 07/28/23, "STOP sign initiated at the door."

Review of R128's "Admission Record," located in the EMR under the "Profile" tab, indicated the

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F 600	Continued From page 14	F 600		

resident was admitted initially to the facility on 05/24/23. Diagnoses included dementia with behavioral disturbances, restlessness and agitation, schizoaffective disorder, mood disorder, and generalized anxiety.

Review of R128's "MDS" with an ARD of 05/30/23 revealed a "BIMS" score of 99 which indicated severe cognitive impairment. R128 required one person supervision for ambulation and was documented as wandering daily. R128 expired on 09/14/23.

Review of R128's "Care Plan," located in the EMR under the "Care Plan" tab, dated 06/09/23, indicated resident had "Socially inappropriate behavior: inappropriate touching AEB [as evidence by]: touching other's hair and/or rubbing others' head." Interventions were revised on 08/01/23 to include, "Intervene and redirect when inappropriate behavior is observed."

Review of the "Investigation Report" of resident-to-resident physical abuse provided by the facility, dated 07/23/23, revealed on 07/23/23 at 12:10 PM, RN10 and CNA9 heard R6 yelling for help and immediately responded to the resident. R128 was observed by CNA9 trying to grab and swing at R6, and R6 was trying to push the resident out of her room. CNA9 separated the residents. RN4 documented that R6 told the nurse that R128 had come into her room, and she told him to get out, but R128 continued and then grabbed her on the shoulder. R6 then told RN10 that R128 hit her on the left side of her face, but not hard. R128 sustained a small skin tear to the left upper arm, right forearm, and chest. R6 had no visible injuries. R128 was difficult to redirect. Upon the facility becoming

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F 600	Continued From page 15 aware of the incident on 07/23/23, the facility placed a stop sign on R6's room doorway to redirect R128 away from her room. During an interview on 02/28/24 at 10:10 AM, CNA9 stated that she could not recall the incident but did recall R128 wandered up and down the hallway with his walker and was difficult to redirect. She stated that he did not like to stand still and would wander into other residents' rooms. She stated R6 preferred to stay in her room and could be easily agitated when someone tried to come in. During an interview on 02/28/24 at 10:45 AM, ADON stated that R128 was a wanderer and had behaviors with touching other people. During an interview on 02/28/24 at 12:50 PM, RN10 stated that R128 had entered R6's room and she only saw that R6 had pushed R128. She stated that R128 was a wanderer and liked to get into the personal space of other residents. She stated that he had not shown signs of aggressive behavior, but due to his constant shadowing of other residents and getting into their space, the other residents would become upset and that would lead to altercations. She stated they continued to try new interventions such as one on one, keeping him in the dining room with activities, and adjustments to his medication. During an additional interview on 02/28/24 at 1:33 PM, the ADON stated the facility had used stop signs to keep him from "visiting" other resident rooms and had also tried to keep him engaged. Further review of R6's "Care Plan" located in the EMR under the "Care Plan" tab, revealed	F 600		

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F 600	Continued From page 16 interventions were revised on 07/28/23 to place "STOP sign initiated at the door." Review of the facility's policy titled, "Abuse, Neglect, and Exploitation," dated 04/01/22 and 07/25/22, revealed "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." The policy revealed "appropriate corrective action" should be done once abuse was identified and the care plans should be revised.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		3/27/24

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F 609	Continued From page 17 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to timely report to the state survey agency multiple incidents of abusive behavior of one resident (Resident (R) 95) out of a total sample of 41 residents. Findings include: Review of R95's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed admission to the facility on 11/23/22 with diagnoses of traumatic subdural hemorrhage, irritability and anger, delusional disorders, and anxiety disorder. Review of R95's quarterly "Minimum Data Set (MDS)" under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of 08/31/23, revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated the resident was cognitively intact. Further review revealed R95 had physical behavior symptoms directed at others. Cross Reference: F600-Free from Abuse and Neglect. 1. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Licensed Practical Nurse (LPN) 1, dated 09/27/23 at 1:26 AM, indicated R95 was exhibiting aggressive behaviors and went into a female residents' room	F 609	A. 1. The State survey agency is now aware of incidents involving R95, dated 9/27/23, 10/19/23, 10/3/23, and 11/4/23. B. 1. All residents have the potential to be affected. 2. The facility has reviewed the nursing notes of all residents for the past 30 days to audit for incidents of physical and aggressive behaviors (such as grabbing, hitting, pushing, scratching, kicking, and unsolicited touching), including any attempts that should have been reported to the state survey but were not. Any missed reporting will be reported to the state agency. The results of the audit will be presented in the facility's monthly Quality Assurance and Assessment (QAA) meeting. C. 1. The RCA determined that staff failed to recognize signs of abuse and neglect, resulting in the facility's failure to report timely. 2. The staff developer/designee has	

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F 609	Continued From page 18 and was touching their feet and both residents yelled at R95 to get out of the room. R95 got up off his wheelchair and sat down on one of the female resident's wheelchairs. R95 could not be redirected and started kicking and punching at female staff members. 2. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by LPN1, dated 10/19/23 at 7:53 PM, indicated R95 became physically aggressive throwing punches and kicking at staff and struck R109 on the arm. During an interview on 02/28/24 at 10:58 AM, LPN1 stated she reported the incidents that occurred on 09/27/23 and 10/19/23 to her supervisor, but she could not remember who that was. 3. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Registered Nurse (RN) 7, dated 10/31/23 at 5:53 AM, indicated R95 was physically aggressive throwing punches, kicking at staff and attempting to hit a fellow resident, but staff intervened before R95 struck the other resident. During an interview on 02/29/24 at 9:24 AM, RN7 stated all incidents on 10/31/23 were reported to the oncoming staff through the shift-to-shift report but that she did not report the incident to a supervisor as abuse since R95 attempted but wasn't able to hit the other resident. 4. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by RN5, dated 11/04/23 at 2:37 PM, indicated R95 continued to be agitated and running into other residents with his wheelchair and kicking the door of nurse's	F 609	re-educated all staff disciplines, including PRN (as needed) staff, on the Abuse Policy that was revised on 2/29/24. 3. Now, the facility has signage posted at each nursing station and by the time clock outlining how to recognize abuse and neglect, as well as the guidelines for timely reporting. 4. The DON/designee will conduct daily audits of nursing progress notes to monitor for any missed reporting of aggressive behaviors, such as grabbing, hitting, pushing, scratching, kicking, and unsolicited touching. D. 1. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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F 609	Continued From page 19 station. During an interview on 02/29/24 at 10:36 AM, the Director of Nursing (DON) stated any abusive behaviors should have been reported to a supervisor who would notify the DON and Administrator. The DON confirmed, as the abuse coordinator, that the incidents of abuse on 09/27/23, 10/19/23, 10/31/23, and 11/04/23 were not reported to the state survey agency within two hours or at all. During an interview on 03/01/24 at 10:08 AM, the Administrator stated she expected all incidents of aggression or abuse to be reported to the state survey agency within two hours. Review of facility's policy titled, "Abuse, Neglect and Exploitation," revised 07/25/22, revealed ". . . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, stage agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. the allegation involves abuse or results in serious bodily injury, note all alleged abuse will be reported to licensing not later than two hours. b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		3/27/24

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F 610	Continued From page 20 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, document review, and policy review, the facility failed to conduct a thorough investigation for multiple incidents of abusive behavior of one resident (Resident (R) 95) out of a total sample of 41 residents. Findings include: Review of R95's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed admission to the facility on 11/23/22 with diagnoses of traumatic subdural hemorrhage, irritability and anger, delusional disorders, and anxiety disorder. Review of R95's quarterly "Minimum Data Set (MDS)" under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of 08/31/23, revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated the resident was cognitively intact. Further review revealed R95 had physical behavior symptoms	F 610	A. 1. RN2, LPN1, and RN7 have been re-educated on the components of conducting a thorough investigation. Additionally, the facility implemented new protocols to monitor compliance with investigative procedures. B. 2. All residents have the potential to be affected. 3. The NHA/designee has audited all investigations conducted by the facility in the past 30 days involving alleged abuse, neglect, exploitation, or mistreatment for thoroughness. This audit included observing and documenting injuries, conducting interviews with the alleged victim and representative (if applicable) as well as the alleged perpetrator, relevant personnel, and other residents, reviewing the resident's record for pertinent	

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F 610	Continued From page 21 directed at others. Cross Reference: F600-Free from Abuse and Neglect. 1. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Registered Nurse (RN) 2, dated 08/24/23 at 1:46 AM, indicated R95 became verbally aggressive toward both of his roommates waking them both up. This incident of verbal abuse was not investigated. 2. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Assistant Director of Nursing (ADON), dated 08/24/23 at 3:15 AM, indicated R95 was found in R24's room swinging his arms at R24 while R95 was in his wheelchair and told staff he hit R24 in the face. Review of the facility's "Incident Report for Web Intake," provided by the facility, revealed investigation of the incident on 08/24/23 at 3:15 AM consisted of one staff's statement. There were no statements by any residents or additional staff. 3. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by Licensed Practical Nurse (LPN) 1, dated 09/27/23 at 1:26 AM, indicated R95 was exhibiting aggressive behaviors and went into a female residents' room, was touching their feet, and both residents yelled at R95 to get out of the room. R95 got up off his wheelchair and sat down on one of the female resident's wheelchairs. R95 could not be redirected and started kicking and punching at female staff members. A male nurse from another unit came and picked R95 up and placed him in his own wheelchair and he eventually self-propelled to another unit.	F 610	information, and notifying law enforcement if necessary. The facility has attempted to obtain any missing data identified on any investigations identified as incomplete. The results of the audit will be presented in the facility's monthly Quality Assurance and Assessment (QAA) meeting. C. 1. The RCA determined that the facility's senior leadership (NHA, DON, ADON, Staff Developer, and RN supervisor), who are responsible for conducting investigations, did not adhere to the facility's policy titled 'Abuse, Neglect, and Exploitation' regarding thorough investigation procedures. 2. The VPO/designee will provide 'Train the Trainer' education to the Staff Developer on conducting a thorough investigation. The Staff Developer will then educate senior leadership on the same. 3. The facility now mandates that investigations be concluded only after receiving a two-signature sign-off from senior leadership, indicating thorough review. 4. Prior to closing investigations the NHA/designee will audit all allegations of abuse, neglect, exploitation, or mistreatment to monitor for thoroughness. This includes monitoring for, but not limited to, observations and documentation of injuries, interviews with	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING	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 610	Continued From page 22 Review of the facility's "Incident Report for Web Intake," provided by the facility, revealed the incident that occurred on 09/27/23 at 1:26 AM was not investigated by the facility. 4. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by LPN1, dated 10/19/23 at 7:53 PM, indicated R95 became physically aggressive throwing punches, kicking at staff, and struck R109 on the arm. Review of the facility's "Incident Report for Web Intake," provided by the facility, revealed the incident that occurred on 10/19/23 at 4:58 AM consisted on one staff's statement. There were no statements by any residents or additional staff. 5. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by RN7, dated 10/31/23 at 5:53 AM, indicated R95 was physically aggressive, throwing punches, kicking at staff and attempting to hit a fellow resident. Review of the facility's "Incident Report for Web Intake," provided by the facility, revealed the incident that occurred on 10/31/23 at 5:53 AM was not investigated by the facility. 6. Review of a "Nurse's Note," located under the "Notes" tab in the EMR and written by RN5, dated 11/04/23 at 2:37 PM, indicated R95 was agitated and running into other residents with his wheelchair and kicking the door of nurse's station. Review of the facility's "Incident Report for Web Intake," provided by the facility, revealed the incident that occurred on 11/04/23 at 2:37 PM was not investigated by the facility.	F 610	relevant parties such as the alleged victim, representative, alleged perpetrator, personnel, and other residents, as well as reviewing resident records for pertinent information related to the alleged violation and notifying law enforcement if necessary. D. 1. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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F 610	Continued From page 23 During an interview on 02/29/24 at 10:36 AM, the Director of Nursing (DON) stated the incidents on 08/24/23 and 10/19/23 were investigated but agreed there should have been more staff and residents interviewed. The DON stated the incidents that occurred on 09/27/23, 10/31/23, and 11/04/23 were not investigated because staff did not report the incidents to her as the Abuse Coordinator. During an interview on 03/01/24 at 10:08 AM, the Administrator stated staff should have ensured staff and residents involved in an incident were all interviewed who may have had exposure or knowledge. Review of the facility's policy titled, "Abuse, Neglect, and Exploitation," dated 07/25/22, revealed an immediate investigation was warranted when suspicion of abuse neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include identifying staff responsible for the investigation; . . . investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect exploitation and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation.	F 610		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence.	F 690		3/27/24

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F 690	Continued From page 24 §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure one of one resident (Resident (R) 106) was on a toileting program to enhance his	F 690	A. 1. R106 is now on a toileting plan. B.	

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F 690	Continued From page 25 continence out of 41 sampled residents Findings include: Review of R106's "Face Sheet" located in the hard chart revealed he was admitted to the facility on 12/27/23, from the hospital, with diagnoses of toxic encephalopathy, sepsis, atrial fibrillation, disorder of prostate, acute respiratory failure, depression, and anxiety. Review of R106's admission "Minimum Data Set (MDS)" located in the "MDS" tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 01/02/24, revealed R106 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated intact cognition. Review of the "Bowel and Bladder" section of the MDS revealed R106 was on a toileting program for bowel and bladder incontinence due to being incontinent of bowel and bladder. Further review revealed a toileting program could include scheduled toileting, prompted voiding, and bowel and bladder retraining. R106 was dependent on staff for care with the assistance of two staff. Review of the admission comprehensive care plan, located in the EMR under the "Care Plan" tab, with an initiated date of 12/27/23, targeted date of 03/22/24, and revised on 01/04/24, revealed a care plan for incontinence of bowel and bladder. Interventions included cleaning the peri area after incontinence and monitoring for any causes of incontinence. Toileting program was not one of the interventions. Review of the "Task" for Certified Nursing Assistants (CNAs) in the EMR under the "Task"	F 690	2. Incontinent residents who are cognitively intact (BIMS score of 12 or above) who are dependent on staff assistance but can recognize their need to use the bathroom may be affected. These residents will be identified and assessed for a toileting plan, with updates made to their EMRs and bowel and bladder care plans accordingly. C. 1. The RCA determined staff failed to recognize that a resident who is dependent on staff and cognizant of their bathroom needs, could benefit from a toileting plan, resulting in non-compliance with the facility's policy. The Staff Developer/designee has re-educated CNAs and licensed nurses on the updated policy for Promoting/Maintaining Resident Dignity 2. Weekly, the DON/designee will audit 100% of residents who are dependent on staff, and are incontinent, but recognize the need to use the bathroom, for compliance with their toileting plan. D. 3. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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F 690	Continued From page 26 tab, revealed R106 was on a toileting program that consisted of toileting after meals, at bedtime, and as needed. During an observation and interview on 02/26/24 11:00 AM, R106 was lying in bed in his room. R106 revealed he was incontinent, but he could tell when he needed to go to the bathroom. R106 revealed he wore a brief, and the staff changed him. During an interview on 02/26/24 at 9:40 AM, CNA8, who provided care to R106 that day, revealed R106 was not on a toileting program, but was a check and change every two to three hours. CNA8 revealed R106 could not tell ahead of time when he had to go but would be able to tell after he had urinated or had a bowel movement. During an interview on 02/28/24 at 9:43 AM Licensed Practical Nurse (LPN) 4 revealed, after reviewing the task page for the CNA, which told them how to care for a resident, that R106 was on a toileting program before meals, bedtime, and as needed. LPN4 further revealed the task probably should have been a check and change because he was using a [mechanical] lift to get up. LPN4 stated therapy was working with him and now he was a two-person physical assist. LPN4 further revealed R106 could still be on a toileting program and use a urinal and bedpan even if a [mechanical] lift was used. Interview with LPN4 further revealed the CNA task for nights did not show where the task of toileting had been done. LPN4 revealed R106 was alert and oriented and could make his needs known. LPN4 revealed being able to utilize a toileting program would give R106 more control, independence,	F 690		

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F 690	Continued From page 27	F 690		

and increase quality of life for him.

During an interview on 02/29/24 at 3:00 PM, the Director of Nursing (DON) revealed a resident was assessed for incontinence on admission, quarterly, annually, and as needed. The DON stated that they would determine the level of the resident's continence status. She further revealed either a toileting program or a check and change program would be initiated and it would be assigned as a task for the CNA on the computer. The DON further revealed if a resident was on a toileting program, proper staff should have offered toileting, a urinal, use a bedside commode, or taken them to the bathroom, if the resident was able. The DON further revealed if the resident needed a lift, they may have needed a bedside commode. The DON revealed that just because the resident used a [mechanical] lift did not mean they could not be toileted. She stated a toileting program was supposed to promote continence, as much as possible, quality of life and try to preserve as much function for the resident as they could. The DON revealed staff were trained on toileting programs and how to care for continence. She stated the unit manager was the person responsible for documenting the care plan over to the Task, so the CNAs knew what care to provide for the resident.

During an interview on 02/29/24 at 4:32 PM, R106 revealed he had asked staff to take him to the bathroom, but they told him to just go in his brief.

During an interview on 02/29/24 at 5:56 PM, LPN4 revealed she did the task for the CNAs under bowel and bladder. LPN4 revealed if R106 could tell when he had to have a bowel

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movement then staff should have put him on bedpan or used a urinal. LPN4 revealed she thought the CNAs were just changing him.

During an interview on 03/01/24 at 8:25 AM, the Administrator revealed staff followed the policy on toileting. The Administrator further revealed all CNAs were trained on the toileting program and provided appropriate care to the resident. The Administrator revealed if a resident told a staff member that they had to go to the bathroom then staff should have, at least, attempted to assist them.

During an interview on 03/01/24 at 11:02 AM the Director of Rehabilitation (DOR) revealed R106 had been receiving occupational therapy for about a month that included positioning and a splint to the left elbow. She revealed R106's right hand was okay. The DOR further revealed R106 would be able to use a urinal with the help of someone positioning him first and handing him the urinal. She stated he then would be able to do his business and hand the urinal back to the staff when he was finished. The DOR revealed R106 could also be put on a bedpan with assistance with rolling over to put it under him and removing it. The DOR further revealed R106 was able to tell you when he had to have a bowel movement or urinate.

Record review of the facility's policy titled, "Bowel and Bladder Management" version one, effective 04/01/20, revealed the purpose of the policy was to address residents' individual needs with respect to bowel and bladder. The policy revealed each resident would be assessed for bowel and bladder functioning on admission, each quarterly MDS, and any change in condition. The policy

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F 690	Continued From page 29 revealed a plan of care would be developed and may include a bladder retraining program.	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, review of facility provided incident (FRI), and review of facility policy, the facility failed to ensure that one of five residents (Resident (R) 32) reviewed for unnecessary medications out of 41 sampled residents, were free from unnecessary medications. R32 was administered another resident's (R9) medications resulting in a potential for R32 to have an adverse effect. In	F 757	A. 1. R32 now has an updated photo in the EMAR and is wearing a name identifier. B. 1. All residents have the potential to be affected. 2. The facility updated all residents'	3/27/24

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F 757	Continued From page 30 addition, two of five residents (R30 and 44) observed during medication administration, were not identified using two of four identifiers. Findings include: 1. Review of R32's "Face Sheet," provided by the facility, revealed that R32 was admitted to the facility on 02/11/19 with diagnoses of Alzheimer's disease, anxiety, major depressive disorder (MDD), and mood disorder. Review of "Incident Report [Number]," (initial reporting) provided by the facility and dated 08/25/23, revealed "On 08/24/23, an agency nurse on dementia unit administered medications to the wrong resident. Resident [R32] immediately assessed and physician notified. The physician orders to monitor blood pressure every four hours for 24 hours and to hold trazodone (anti-depressant medication) dose for today. [R32's] vital signs have remained stable. Investigation in progress." Review of "Event Investigation Interview Record," provided by the facility and dated 08/25/23, for Licensed Practical Nurse (LPN) 8, revealed "When giving medication, [R9] was in the dining room with other residents. Prior to giving medication, I asked another nurse who [R9] was because the resident's do not appear as the photos on EMAR [electronic medication administration record] and [R9] was not in the room to identify which bed [R9] was in. The nurse described [R9] with the blanket. So, I approached [R32] with the blanket and gave medication." Review of LPN3's "Event Investigation Interview Record," provided by the facility and dated	F 757	photos in the EMAR system. 3. A whole-house audit was conducted for ID identifiers. All residents who have been identified as non-adherent to wearing an ID band will be offered a second choice of ID band that is comfortable yet resistant to being torn off by the resident. C. 1. The root cause analysis (RCA) found staff did not adhere to the Seven Rights of Medication Administration for Nurses due to outdated photos in EMR and residents' refusal or removal of ID identifiers. The Staff Developer has re-educated licensed nurses on the Seven Rights of Medication Administration. 2. The facility implemented a new procedure to review residents' photos in the EMAR upon readmission, annually, quarterly, and with significant changes to review for likeness to the resident, and updating as necessary. 3. The facility has purchased a second ID band that is tear-resistant as alternative to residents who pull off their name bands. 4. The DON/designee will conduct weekly medication audits on 50% of scheduled nurses performing medication administration to ensure they use a second identifier when passing medications. Identifiers include a photo in EMR, ID bands, asking a resident their name, or asking another staff member to verify the resident. Observations will occur	

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F 757	Continued From page 31 08/25/23, revealed "Med nurse approached me and told me that she gave the medication to the wrong resident [R32]. I questioned her as to what happened. She stated the other nurse said the resident with the blanket. I checked [R9's] picture on EMAR, the photo looked the same as the resident. Informed the nurse that there is a photo (clear) on the EMAR." Review of the Assistant Director of Nursing (ADON) "Event Investigation Interview Record," provided by the facility and dated 08/25/23, revealed "Followed up [R9's] identifier on the EMAR. [R9's] photo appeared the same as the resident in person." Review of LPN9's "Event Investigation Interview Record," provided by the facility and dated 08/31/23, revealed "[LPN8] asked me who is [R9], and I said [R9] has the blanket over her head. [R32] has blanket on her lap." Review of facility provided "Incident Report [Number]," (5-day summary) dated 08/31/23, revealed "Root Cause Analysis: [R32] is an 85-year-old long term care female resident in the dementia unit. Has a diagnosis Alzheimer Disease, type 2 diabetes mellitus (DM), anxiety disorder, mood disorder, insomnia, dementia with behavior disturbance, bipolar disorder, osteoarthritis to hip, pain right ankle/joints, chronic kidney disease (CKD), gastroesophageal reflux disease (GERD), hypotension, myoclonus, atherosclerotic heart disease and vitamin deficiency. Medications include aspirin (ASA), sertraline, nitroglycerin, Lantus, trazodone, Humalog insulin, isosorbide mononitrate. Has a Brief Interview for Mental Status (BIMS) score of three (severely cognitive impairment). R32 has	F 757	on various days and shifts. D. 1. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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multiple behavior care plans in place such as unsafe transfers, attempting to put self on the floor to pray, asking repetitive questions, hoarding, physical aggression, and verbal aggression. Uses a wheelchair for locomotion and independently wanders around in her wheelchair. Requires one person assist with transfers. She passively participates in activity, 1:1 and requires invitation to activity of choice. Her favorite activities: visit from Deacon, church service, music, folding items and socializing with others. Result of Investigation: On 08/24/23 at 09:28 AM, a resident [R32] was inadvertently given another resident [R9] medication of Amlodipine (blood pressure medication) 10 milligrams (mg) and Risperdal (anti-psychotic medication) .5 mg. Nurse A [LPN 8] who was involved with the medication variance stated that R9 was in the dining room with other residents on the dementia unit. Prior to administering the medications, Nurse A [LPN8] asked Nurse B [LPN9] to verify the residents [R9] identify. Nurse B [LPN9] described the resident [R9] as the one with the blanket. Nurse A [LPN8] then approached a resident [R32] with a blanket and gave the medication. After administering the medications Nurse A [LPN8] realized that there were two residents in the dining room who had blankets. In fact, [R32] was administered [R9's] medications. Once the variance was identified [R32] was immediately assessed. Vital signs were within normal limits and [R32] was in no apparent distress. The physician was immediately notified, an order was obtained to monitor blood pressure (BP) every four hours for 24 hours. [R32's] BP and pulse remained stable, with no signs or symptoms of distress/discomfort, along with good fluid intake within the monitoring period.

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F 757	Continued From page 33 Additionally, an order was provided to hold [R32's] trazodone for 24 hours. The family was informed of the variance and physicians orders. A drill down of the event indicated that Nurse A [LPN8] to identify did use two identifiers prior to administering the medications (picture in electronic health record (EHR) and confirming the resident's identity with [LPN9]). However, the descriptor provided by Nurse B [LPN9] "the one with the blanket" was not specific enough for Nurse A [LPN8] to identify the correct resident. Nurse A [LPN8] should have asked Nurse B [LPN9] to verify the resident's identity by physically approaching the resident vs [versus] a generalized description "the one with the blanket." Nurse A [LPN8] was immediately educated on the seven rights of medication administration. Emphasis was placed on the right individual and two sources required to ensure that the medication is administered to the right resident. What is considered a two-patient identifier? 1. Resident's photo on EMAR. 2. If the resident is alert and oriented ask the resident to identify him/herself and cross reference to picture on EMAR. 3. If the resident is not alert and oriented ask another staff member to verify. This is accomplished by walking up to the resident then confirming identity with another staff member and not using general descriptors such as "resident with gray hair," "the resident wearing a blanket" to identify a resident. 4. Use resident's arm name band if they use one. A medication administration competency was completed for Nurse A [LPN8] before her next scheduled shift. A facility wide education for licensed nurses was initiated on the day of the medication variance. Education was provided emphasizing the correct of two identifiers during	F 757		

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medication administration. Additionally, the education was placed on the dashboard in the electronic health record (EHR) for all nurses to view when in the EHR. A further drill down indicated that on the [name of unit] unit (the dementia unit) identifier (ID) bands were not being utilized due to resident's being nonadherent. The facility implemented a system change on the [name of unit] unit. Residents on the [name of unit] unit will now wear name ID bands. An order to check placement of ID band every shift has been implemented. Residents that are identified as nonadherent will be care planned and the second identifier will be another staff member physically identifying the resident vs a generalized statement "the resident with the blanket." Were changes made to the care plan? Yes. If yes, please explain: vital signs monitored as ordered. Medication reviewed with on hold medication order. Were system changes put into place? Yes. If yes, please explain: The facility will have the Staff Developer/designee complete one random medication administration competency for agency nurses weekly x four, then monthly x three, then quarterly x three until 100% compliance is achieved. Results of audit will be reported and discussed in quality assurance (QA)."

During an interview on 02/26/24 at 4:05 PM, the Staffing Development Coordinator (SD) stated that after the incident, the nurse [LPN8] that gave the wrong medication to the wrong resident was immediately in-serviced and a medication observation was observed on her. The staffing coordinator Indicated that prior to the medication error, all nurses, including agency nurses, were in-serviced on appropriate identifiers to be used.

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F 757	Continued From page 35 Review of "Medication Administration Inservice," provided by the facility and dated 08/07/23, revealed LPN8 attended the in-service. The in-service included a medication error scenario and talked about the seven rights of medication administration. Review of undated "Seven Rights of Medication Administration for Nurses," provided by the facility, revealed " .... Let's look at the rights of Medical Administration: 1. Right Individual: You need to check at least two sources to make sure you are giving the medication to the right person. Even if you know the patient well, it is possible to make a mistake and to give the medication to the wrong person. This can happen particularly when you are doling out medications to more than one patient at the same time. You can avoid errors by collecting medication for only one individual at a time. Do not hold onto the medication but instead give the medication to the patient immediately. Do not talk to anyone from the time you take the medication out of the locker and the time you give it to the patient. When you are giving out medications, focus on that task alone and do not do anything from the time you first have contact with the medication and the time the patient is given the medication. If there is any doubt that you are giving a medication to the wrong person, do not give the medication until you are sure you are giving it to the correct individual." 2. During medication administration observation on 02/27/24 at 8:34 AM while gathering R44's medication, LPN6 looked at R44's picture, but while administering medications, LPN6 did not use another source of identifier to appropriately identify R44.	F 757		

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F 757	Continued From page 36 During medication administration observation on 02/27/24 at 9:46 AM while gathering R30's medication, LPN5 looked at R30's picture, but while administering medications, LPN5 did not use another source of identifier to appropriately identify R30. During an interview on 02/27/24 at 1:50 PM, LPN8 indicated that she had to write a statement for an incident that occurred while she was passing medication on the dementia unit. She stated that she had not worked in that unit before the day of the incident. She stated that most of the residents did not wear armbands, nor did their pictures in the EMAR look like them. She stated that the pictures on the EMAR were so old, she told the Director of Nursing (DON) that residents should have armbands on, and pictures should be updated. She stated that day she had to ask another staff member as to which resident was which. She stated that she did ask another nurse [LPN9] who the resident was; however, did not get a particular description of the resident [R9]. LPN8 stated the other nurse said that this resident was the one with a blanket and gray hair, as she was pointing in the direction of two residents [R9 and R32] but not being specific which resident was who. She claimed that she did not ask for further clarification. She claimed that the other nurse did not go over to either resident or say who was who. She stated that she was re-educated and worked at the facility after this incident. During an interview on 02/27/24 at 4:15 PM, the Staffing Development Coordinator stated that she gave all nurses an in-service on medication administration on 08/07/23. She stated that she went over the four resident identifiers, which were	F 757		

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photos in the EMR, asked the resident their name, looked at their arm bands, and/or asked another staff to verify the resident, that nurses needed to follow during medication administration. She confirmed that these were the resident identifiers that were currently being used by nurses administering medication. She confirmed that LPN8 attended this in-service on 08/07/23.

During an interview on 02/28/24 at 5:15 PM, LPN9 stated that the issue was identifying the residents at the time to give medication. She indicated that she described R9 and R32 to LPN8. She stated these two residents were African American, gray hair, females, sitting in the dementia unit's dining room. LPN9 stated she did not recall if R32 and R9 were sitting close together. She stated that LPN8 did not work on the dementia unit, so she was not familiar with the residents. She indicated that sometimes in the EMR, the pictures are old and did not reflect the resident's appearance at that time. She stated in addition, not every resident wore wrist bands.

During an interview on 02/28/24 at 6:00 PM, the Director of Nursing (DON) stated that she expected staff who were administering mediation to use at least two identifiers to ensure that the medication was being given to the correct resident. She stated that nurses could use another staff member to identify the resident, asked residents their name if there was no cognitive impairment, using pictures in the EHR, and the nurse could use the resident's name band.

During an interview on 02/29/24 at 12:38 PM, the ADON stated that the unit manager reported to

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her that LPN8 had made a medication error. She confirmed that R32 received R9's medications. She stated that she followed up with LPN8, asking her what happened, and LPN8 stated that the other staff said that R9 was the one with a blanket. During further interview, she stated that LPN8 recognized the medication error right away because there were two residents with blankets. The ADON stated that R32 liked her blanket on her lap and R9 liked the blanket over her head. She stated that LPN8 completed training afterwards. She stated in addition, pictures were discussed about being updated.

During an interview on 02/29/24 at 3:20 PM, LPN6 confirmed that back in August 2023, she was trained over the phone about the necessary identifiers when administering medication. LPN6 stated these were wrist band, photo, asking resident their name, and/or getting another staff member.

During an interview on 02/29/24 at 3:45 PM, LPN5 confirmed that she should have used at least two identifiers when administering R30's medication. She stated that R30 had an arm band on his wheelchair; however, she did not look at it. She stated that she received training upon hire regarding this.

Review of facility's policy titled,. "Resident Identification," revised 12/26/22, revealed "The law requires nursing home to promote and protect the rights of each resident and places a strong emphasis on individual dignity and self-determination. To meet federal guidelines the facility will identify the residents to provide care. Procedure: 1. All residents' information will be entered in the EMAR once admitted to the facility

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F 757	Continued From page 39 and will be updated as needed. 2. Information from the referral sources will be used in conjunction with the family/resident interview. 3. Identification of residents prior to all tasks rendered to the residents. 4. The facility will update the resident's picture as needed. Resident Identifier: A. When asking the resident for their name, cross reference resident name with EMAR. B. May use residents' photo from the EMAR. C. May use residents name band/bracelet. D. May resource other staff." Review of facility's policy titled, "Medication Administration," dated 04/01/20, revealed "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines... 3. Identify resident by photo in the medication administration record (MAR)."	F 757		
F 880 SS=E	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:	F 880		3/27/24

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F 880	Continued From page 40 §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 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.	F 880		

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F 880	Continued From page 41 §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 observations, interview, record reviews, and facility policy review, the facility failed to ensure four out of four isolation carts were fully stocked with the supplies needed to promote infection control, Resident (R) 30 did not consume a pill dropped on the ground, and staff utilized proper hand hygiene after wiping R116's nose of 41 sampled residents. Findings include: 1. During an observation on 02/26/24 at 10:30 AM, Room 403 had signage on the door showing that the room was an isolation room and isolation carts were outside the door. The signage included contact precautions and droplet precautions and indicated a face shield, or goggles were to be donned (put on) when entering the room. During an observation on 02/26/24 at 10:30 AM, there were no face shields or goggles noted to be on the isolation cart of Room 403. Observation further revealed when Licensed Practical Nurse (LPN) 4, who was also the unit manager, went to	F 880	A. 1. Isolation carts are now stocked with all PPE. 2. LPN 5 was re-educated on infection control during a medication pass, including the procedure for discarding any medication that drops on the floor and offering the resident a new one. 3. C.N.A. 7 was re-educated on the World Health Organization patient safety initiative 'Your 5 moments for hand hygiene. B. 1. All residents have the potential to be affected. C. 1. The RCA determined that the facility did not have a procedure for restocking isolation carts. The facility developed and implemented a procedure for restocking the isolation carts. The Infection Control	

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F 880	Continued From page 42 get a face shield from the other three isolation carts, she could not find any on the other carts. Observation further revealed LPN4 had to go to central supply to get the face shields and put them on all the carts. During an interview on 02/26/24 at 10:35 AM, LPN4 revealed it was okay to go into an isolation room if you had glasses on as long as your eyes were covered. During an interview on 02/26/24 at 10:35 AM Certified Nursing Assistant (CNA) 8 revealed she did not know the facility had face shields to use but she had glasses on when she went into Room 403. During observation on 02/26/24 at 12:15 PM, the isolation cart outside Room 406 did not have any gloves in it. During an interview on 02/26/24 at 12:17 PM, in the hallway by Room 406, the Housekeeping Director (HSKPD) revealed there were no gloves in the isolation cart. The HSKPD revealed she was responsible for restocking the linens and bags and if she had gloves on her cart, she would restock them as well. The HSKPD further revealed the CNAs and nurses would restock the gloves and masks. During an interview on 02/28/24 at 8:51 AM, LPN4 revealed the isolation carts should have had gowns, N95 masks, face shields, red bio bags, yellow bio bags, vinegar bags, trash bags, gloves, and hand sanitizer stored on them. Interview with LPN4 further revealed after looking in the isolation cart outside Room 403 there were no gloves in it, and she went and got some for the	F 880	and Prevention (ICP) manual was updated, and the staff developer/designee educated staff on the new procedure. 2. The RCA determined that the medication administration competency did not include discarding a pill if it drops on the floor. The competency has been updated to include discarding medication if it drops on the floor. The staff developer/designee will educate licensed nurses on this updated competency. 3. The RCA determined that staff did not follow the World Health Organization patient safety 'Your 5 moments for hand hygiene.' The staff developer/designee will re-educate on the World Health Organization patient safety 'Your 5 moments for hand hygiene.' 4. The facility has posted 'Your 5 moments for hand hygiene' at nursing stations for staff reference, reminding them of proper hand hygiene practices 5. The DON/designee will conduct daily audits of isolation carts to monitor for proper PPE par levels. The DON/designee will conduct medication competency assessments on four licensed nurses per week with the updated competency that includes discarding any medication that drops on the floor and offering the resident a new one. Additionally the DON/designee will conduct 10 weekly staff observations to ensure correct hand hygiene implementation across different days and	

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F 880	Continued From page 43 cart. During an interview on 02/28/24 at 8:55 AM, LPN4 revealed the isolation cart outside of room 406 did not have any N95 masks in it. LPN4 revealed the isolation carts should be fully stocked and supplies should be fully available to help stop the spread of whatever was going around. LPN4 revealed she did not know why the face shields were not on the isolation cart and she was not sure where the system failed. LPN4 revealed she monitored the supplies by making rounds and it was everyone's responsibility to make sure the isolation carts were stocked. During an interview on 02/28/24 at 10:11 AM, the Infection Preventionist/Staff Development (IP/SD) revealed she made rounds to ensure staff used PPE appropriately and to make sure the isolation carts were stocked. IP/SD further revealed sometimes she would just visualize the isolation carts and not actually open them to make sure they were stocked. IP/SD further revealed she and the unit manager were ultimately responsible for the carts to be stocked. IP/SD revealed each isolation cart should have been stocked with face shields especially if a resident was on droplet precautions. IP/SD revealed the staff should have had the supplies available right then when they needed them. The IP/SD revealed glasses did not stop the spread of germs and that was why face shields were utilized. During an interview on 02/28/24 at 1:45 PM, the Director of Nursing (DON) revealed there was not just one particular person responsible for stocking the isolation cart daily and that included opening the isolation carts and looking inside for supply stock.	F 880	shifts." D. 1. Results of the audits will be reported in the monthly Quality Assurance and Assessment (QA&A) meetings until 100% compliance is achieved for three consecutive months.	

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F 880	Continued From page 44 During an interview on 03/01/24 at 8:18 AM, the Administrator revealed isolation carts were to be stocked and sanitized by housekeeping. The Administrator further revealed that the unit manager and the nurses were to make sure the isolation carts stayed stocked. The Administrator revealed she also made rounds on the unit and randomly would inspect the isolation carts. The Administrator revealed it was not a good idea to gown up with the PPE and then have to go get supply. She revealed it was an infection control issue. The Administrator further revealed that housekeeping would stock the carts with gloves, gowns, booties, face shields, yellow bags, and red bags when they went to the floor. 2. During medication pass observation on 02/27/24 at 9:46 AM, Licensed Practical Nurse (LPN) 5 gathered R30's medication and went to the sunroom where R30 was sitting by himself. LPN5 handed R30 a cup of medications, and while taking pills out one by one, one pill dropped onto the floor. After the pill dropped on the floor, R30 picked up the pill and placed it in his mouth without LPN5 intervening. Review of R30's "Face Sheet," provided by the facility, revealed R30 was admitted to the facility on 07/19/23 with diagnoses that included hypertension, seizure, anemia, and overactive bladder. During an interview on 02/29/24 at 3:45 PM, LPN5 confirmed that she should have intervened when R30 dropped his medication on the floor, and discarded that one, and obtained another one.	F 880		

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F 880	Continued From page 45 3. During an observation on 02/26/24 at 10:30 AM Certified Nursing Assistant (CNA) 7, wiped R116's right nostril that had yellowish unknown substance coming out of it with a Kleenex. After CNA7 wiped R116's nose, CNA7 did not wash her hands and/or sanitize her hands. Review of R116's "Face Sheet," provided by the facility, revealed R116 was admitted to the facility on 12/04/23 with diagnoses of dementia, schizophrenia, anxiety, and major depressive disorder (MDD). During an interview on 02/28/24 at 6:00 PM, the DON stated that if a pill fell onto the floor during medication pass, she would have expected the nurse to pick it up, identify the medication, discard that current medication, and get the resident another pill. The DON stated in addition, if a staff member was providing care to a resident, such as wiping a resident's nose, then she would have expected afterwards that staff washed their hands and/or used hand sanitizer. Review of the facility's policy titled, "Infection Prevention and Control Program," dated "4/1/20, 11/1/21. 5/2023, and 2/13/24," revealed the facility had "established and maintained an infection prevention and control program to help prevent the development of and transmission of communicable diseases and infections". The policy revealed "all staff would use personal protective equipment (PPE) according to facility policy". The policy revealed the "IP [Infection Preventionist] was responsible for the oversight of the program and served as a consultant to the staff for implementation of isolation precautions." Review of facility's policy titled "Hand Hygiene,"	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085002	A. BUILDING _____ B. WING _____	C 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW NURSING	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 880	Continued From page 46 dated 04/01/20, revealed "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 3. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom ...Hand Hygiene Table... After handling items potentially contaminated with blood, body fluids, secretions, or excretions ...Before preparing or handling medications ...After sneezing, coughing, and/or blowing or wiping nose either soap and water or alcohol-based hand rub (ABHR is preferred)."	F 880		