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 08/07/2019

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 An unannounced Emergency Preparedness survey was conducted at this facility beginning July 31, 2019 to August 7, 2019 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census the first day of the survey was 137. For the Emergency Preparedness survey, all contracts, operations plan, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual/complaint and emergency preparedness surveys were conducted at this facility from July 31, 2019 to August 7, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 137. The survey sample size was 52. Abbreviations/Definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; NHA- Nursing Home Administrator.	F 000		
F 550 SS=E	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	F 550		9/20/19

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

Electronically Signed | 08/22/2019

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 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 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 observations and interviews, it was determined that for 11 (R24, R33, R41, R89, R130, R1, R73, R36, R58, R107, R129) out of 52	F 550	1. The kitchen was made aware that the residents had not received a sufficient number of cups on their meal trays. An	

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F 550	Continued From page 2 sampled residents, the facility failed to 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 individuality. Findings include: 8/6/19 from 12:40 PM to 12:51 PM - Observations during lunch revealed the following residents were served beverages in disposable plastic cups and/or styrofoam cups: - five (5) residents (R24, R33, R41, R89 and R130) in the DuPont assisted dining room; - two (2) residents (R1 and R73) in their rooms in the Greenville unit; and - four (4) residents (R36, R58, R107 and R129) in the Westover dining room. 8/6/19 at 12:42 PM - During a combined interview with E5 (Acting Food Service Director) and E6 (CNA) in the DuPont assisted dining room, E5 was asked why the residents were served beverages in disposable cups and E5 stated to ask nursing. E6 (CNA) was asked why the residents were served beverages in disposable cups and E6 stated there were no beverage glasses present on the meal trays when they were delivered from the kitchen to the dining room. 8/6/19 at 12:51 PM - During an interview, E4 (Unit Manager) acknowledged that 4 residents in the Westover dining room were served beverages in disposable plastic cups and/or styrofoam cups. 8/7/19 at 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 550	additional supply was ordered. 2. All residents receiving meal trays have the potential to be affected by this deficient practice. On the next meal, a facility wide audit was conducted to ensure that each resident was sent a sufficient number of non-disposable cups on their tray. 3. In addition to increasing the number of cups sent on each tray, the kitchen will now also send an additional tray of cups with each meal cart. Education about this new practice will be provided to all nursing and dietary staff by the Staff Developer. 4. The RD/Designee will audit 20 resident trays and 2 meal carts daily to ensure that an ample supply of cups are sent on trays and carts. The audits will continue until 100% compliance is achieved for 8 consecutive weeks. Then, the RD/Designee will audit 20 trays and 2 carts per week until 100% compliance is maintained for 2 consecutive quarters. The results of the audits will be reported, reviewed and discussed in the monthly QAPI meeting by the IDT.	

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F 609	Continued From page 3	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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. §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 review of the State of Delaware Division of Healthcare Quality (DHCQ) Incident Reporting Program, it was determined that for three (R47, R49, R56) out of four sampled residents, the facility failed to notify the state agency within 2 hours of alleged	F 609	1. The DON and Medical Director reviewed the medical records of the residents affected by this deficient practice, reviewed in QAPI. 2. All incidents occurring in the previous 90 days will be reviewed to ensure proper	9/20/19

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F 609	Continued From page 4 violations of potential abuse involving resident to resident altercations. Findings include: The facility's policy entitled Freedom from Abuse, Neglect, and Exploitation, Version #4 effective date 6/25/17, stated, " ...Reporting and Response:... 2. The facility will report all alleged violations ...to the state agency ...". 1. Review of R56's clinical record revealed: 2/15/19 at 12:25 PM - A facility event report stated, " ...Resident to Resident/Aggressive/Combative Behavior ...Resident (R56) grabbed onto another resident (R47), resulting on (sic) a physical altercation with (sic) other resident (R47) ...". Review of the State Survey Agency's report of incidents revealed that the alleged violation of abuse involving a resident to resident altercation between R56 and R47 on 2/15/19 was not reported by the facility. 8/7/19 at 1:47 PM - During an interview, findings were reviewed with E2 (DON). E2 stated that the facility was following a past directive from the State Survey Agency on reporting requirements. 2. Review of R47's clinical record revealed: 2/22/19 at 2:57 PM - A nurse's note stated, "Resident (R47) went in another resident's room (R56) and took stuffed animal off resident (sic) table. Fellow resident (R56) attempted to grab item back, ... resident (R47) pushed fellow resident (R56) to the floor in a sitting position ...". 3/11/19 at 9:36 PM - A nurse's note stated,	F 609	reporting. Will report all reportable incidents accordingly. 3. All nurses were in-serviced on F609, Reporting of Alleged Violations, by the Staff Developer. All newly hired nurses will be in-serviced on F609. On-going education will be provided during the monthly nurses meetings by the DON. 4. The DON/Designee will review all events daily to ensure thorough investigating and appropriate reporting to the Division of Healthcare Quality. An incident tracking system will be put into place to ensure all events have been appropriately reported. The tracking system will continue until events have been investigated and reported with 100% compliance for 2 consecutive quarters. The findings will be reviewed by the IDT at the monthly QA meeting.	

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F 609	Continued From page 5 "Resident (R47) became physically aggressive with another resident (R56) tonight; the resident (R47) was found in another resident's room (R56) by a CNA, the CNA reported that the resident (R47) took a cup from the other resident (R56) and pushed that resident (R56) down to the floor; the resident (R47) was kicked by the other resident (R56) ...". Review of the State Survey Agency's report of incidents revealed that the two alleged violations of abuse involving resident to resident altercations between R47 and R56 on 2/22/19 and 3/11/19 were not reported by the facility. 8/7/19 at 1:47 PM - During an interview, findings were reviewed with E2 (DON). E2 stated that the facility was following a past directive from the State Survey Agency on reporting requirements. 8/7/19 at 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON). 3. Review of R49's clinical record revealed: 12/10/18 6:30 PM- An interview done as part of a facility investigation stated that R71 hit R49 on the face two times. R49's face was slightly red. R49 said he/she was in R71's room trying to get his/her chair out when R71 struck him/her. 12/10/18 6:58 PM- An incident statement from an event, stated that R71 punched R49 on the right side of his/her face. R49 was in R71's room getting his/her chair. R49 removed himself/herself from R71's room immediately after the attack. R71 denied attacking R49.. 12/13/18 A facility care plan evaluation note	F 609		

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F 609	Continued From page 6 documented that R71 was involved in a resident to resident altercation. . On 8/6/19 at 12:17 PM, review of the State of Delaware DHCQ Incident Reporting Program revealed no evidence that the incident between R71 and R49 was reported to the state agency. 8/7/19 at 2:30 PM - Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 609		

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

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Parkview Nursing and Rehab. Center **DATE SURVEY COMPLETED: August 7, 2019**

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. An unannounced annual/complaint and emergency preparedness survey was conducted at this facility from July 31, 2019 to August 7, 2019. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 137. The survey sample size was 52.		
3201	**Regulations for Skilled and Intermediate Care 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:** Cross Refer to the CMS 2567-L survey completed August 7, 2019: F550, and F609.	Cross Reference CMS 2567L F550 and F609	9/20/2019

Provider's Signature [signature] Title NHA Date 9/9/19