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	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing	2801 W. 6th Street Wilmington, DE 19805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 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 facility on [DATE], 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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 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 [DATE] at 3:40 PM that Immediate Jeopardy (IJ) existed at F600-K Freedom from Abuse and Neglect when the facility failed to implement effective interventions to ensure residents were free from abuse from R95. The facility provided an acceptable removal plan for the Immediate Jeopardy on [DATE] at 12:21 AM. The survey team validated that the Immediate Jeopardy was removed on [DATE] 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 [DATE] 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 [DATE], 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. Review of R95's Care Plan, located under the Care Plan tab of the EMR and dated [DATE], 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 [DATE] 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nurse's Note, located under the Notes tab in the EMR and written by Assistant Director of Nursing (ADON), dated [DATE] 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 Notes tab in the EMR and written by RN9, dated [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] at 1:26 AM, indicated R95 was exhibiting very aggressive 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 [DATE] 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 [DATE], 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 [DATE] 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nurse's Note, located under the Notes tab in the EMR and written by LPN1, dated [DATE] 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 [DATE] at 10:58 AM, LPN1 stated that on [DATE], 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 [DATE], 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 [DATE] 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 [DATE] 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 a day) one day, Ativan 0.5 mg tab BID and discontinue mirtazapine (anti-depressant medication). On [DATE], a new order for Depakote 250 mg QD (once a day). During an interview on [DATE] 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 [DATE] at 5:53 AM, indicated R95 was physically aggressive throwing punches, kicking at staff and attempting to hit a fell ow 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 [DATE] at 9:24 AM, RN7 stated she did not remember who the resident was that R95 tried to hit on [DATE], 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 [DATE] at 10:28 PM, indicated R95 was being resistive to care, and staff attempted to provide reassurance to R95 who appeared to calm down. 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 [DATE] 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] 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 [DATE], 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 [DATE] 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 [DATE] 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 [DATE] at 9:24 AM, 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 [DATE] 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 [DATE] 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 [DATE] at 10:08 AM, the 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 [DATE] 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of R6's Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE]. Diagnoses included dementia, psychotic disturbance, mood disturbance, and anxiety. Review of R6's MDS with an ARD of [DATE], 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 [DATE], indicated Resident is/has potential to be verbally aggressive r/t [related to] Dementia. Interventions were revised [DATE], STOP sign initiated at the door. Review of R128's Admission Record, located in the EMR under the Profile tab, indicated the resident was admitted initially to the facility on [DATE]. 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 [DATE] 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 [DATE]. Review of R128's Care Plan, located in the EMR under the Care Plan tab, dated [DATE], 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 [DATE] 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 [DATE], revealed on [DATE] 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 aware of the incident on [DATE], the facility placed a stop sign on R6's room doorway to redirect R128 away from her room. During an interview on [DATE] 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 [DATE] at 10:45 AM, ADON stated that R128 was a wanderer and had behaviors with touching other people. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] 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 [DATE] 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 interventions were revised on [DATE] to place STOP sign initiated at the door. Review of the facility's policy titled, Abuse, Neglect, and Exploitation, dated [DATE] and [DATE], 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. 26446 15879

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 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 [DATE] 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 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 fell ow 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 station. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 25232

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Parkview Nursing	2801 W. 6th Street Wilmington, DE 19805

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 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 [DATE] 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 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 fell ow 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. 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.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 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 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 [DATE], 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 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 revealed a plan of care would be developed and may include a bladder retraining program.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 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 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 [DATE] 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 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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided Incident Report [Number], (5-day summary) dated 08/31/23, revealed Root Cause Analysis: [R32] is an [AGE] 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 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. 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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. 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. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing	2801 W. 6th Street Wilmington, DE 19805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 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 [ROOM NUMBER] 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 [ROOM NUMBER]. Observation further revealed when Licensed Practical Nurse (LPN) 4, who was also the unit manager, went to 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 [ROOM NUMBER]. During observation on 02/26/24 at 12:15 PM, the isolation cart outside room [ROOM NUMBER] did not have any gloves in it. During an interview on 02/26/24 at 12:17 PM, in the hallway by room [ROOM NUMBER], 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 [ROOM NUMBER] there were no gloves in it, and she went and got some for the cart. During an interview on 02/28/24 at 8:55 AM, LPN4 revealed the isolation cart outside of room [ROOM NUMBER] 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 [DATE] 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. 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 [DATE] 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 on to 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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). 25232