

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/24/2015
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NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH BROOM STREET WILMINGTON, DE 19805
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F 000	INITIAL COMMENTS An unannounced bi-annual survey was conducted at this facility from November 18, 2015 through November 24, 2015. 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 91. The Stage 2 survey sample size was 48. Abbreviations/definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; FSD - Food Service Director; DA - Dietary Aide; ESD - Environmental Service Director; AC - Air Conditioner; Agitated - emotional state of restlessness; Anti-anxiety medication - medication used to treat any of several disorders that cause nervousness, fear, apprehension and worrying; Anxiety - unpleasant state of inner turmoil, often accompanied by nervous behavior; such as pacing back and forth; BS- blood sugar; amount of sugar or glucose in the blood; Depressed - feelings of sadness or a mood disorder that causes a persistent feeling of	F 241	A. Corrective action was taken at time of findings. Education was provided to E8 and E11 on first knocking and asking permission prior to entering a resident's room by the Food Service Director (FSD) on 11/18/15. The FSD was educated by the Administrator 11/19/15 using appropriate drinking cups and dessert bowls for resident dining. Styrofoam to be utilized for infection control or emergencies related to any hot water disruption. R77, R92 and R157 remain in the building and reported no further dignity issues. R46 is no longer a resident. R26, R40, R53, R56, R69, R74, R81, R86, R87, R91, R98, R100, R109 and R130 remain in the building and are receiving reusable drinking cups and dessert bowls. R41, R85, R113 and R124 remain in the building and are receiving reusable drinking cups. R5, R8, R14, R18, R40, R45, R53, R56, R63, R69, R74, R81, R96, R109 and R122 remain in the building and are receiving	1/8/16
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jane Kettermen* TITLE *Administrator* (X6) DATE *1/7/16*

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

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F 000	Continued From page 1 sadness and loss of interest that affects how you feel, think and behave; HVAC - Heating, ventilating, and air conditioning; lbs. - pounds; PEG tube - a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate; PRN - as needed; Pt - patient; NN's - nurse's notes; Sliding Scale with Insulin Coverage - a dosing schedule that is based on a particular blood sugar value; or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher. Each sliding scale needs to be tailored to the individual, as each patient has unique circumstances and different insulin requirements.	F 241	reusable dessert bowls.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to promote an environment that maintained or enhanced dignity and respect in full recognition of 30 (R5, R8, R14, R18, R26, R40, R41, R45, R46, R53, R56, R63, R69, R74, R77, R81, R85, R86, R87, R91, R92, R96, R98, R100, R109, R113, R122, R124, R130, and R157) out of 91 residents' individuality.	F 241	B. Other residents have the potential to be affected and on 12/2/15 rounds were done by the FSD to verify staff was entering resident rooms appropriately (attachment 2). Other residents have the potential to be affected and on 11/25/15 rounds were done by the FSD to determine appropriate dishes and glasses are utilized during resident meals (attachment 1). C. Re-education was needed in regards to first knocking and asking permission to enter resident rooms. Nurse Practice Educator (NPE) will in-service staff on the appropriate entry into resident rooms (attachment 4). In servicing will be completed by 1/8/16. Glasses and dessert bowls were cracking during the wash cycle. The root cause identified the need	

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F 241	<p>Continued From page 2</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 11/18/15 at 3:48 PM, E8 (CNA) entered R77's room without first knocking and/or asking for permission to enter, while a resident interview was being conducted. When the surveyor pointed out to E8 that she failed to knock prior to entering, she stated, "sorry." The facility failed to ensure R77 was treated in a dignified manner. During a dining observation of the 4th floor on 11/18/15 at 12:05 PM, disposable Styrofoam drinking cups and/or disposable Styrofoam dessert bowls were observed in use for the following nine (9) residents: R26, R45, R69, R74, R77, R81, R87, R98, and R130. During a dining observation of the 2nd floor on 11/18/15 at 1:10 PM, disposable Styrofoam drinking cups and/or disposable Styrofoam dessert bowls were observed in use for the following seven (7) residents: R40, R53, R56, R86, R91, R100, and R109. Observation of the 2nd floor dining area on 11/19/15 at 8:20 AM, revealed disposable Styrofoam drinking cups were in use for the following four (4) residents: R41, R85, R113, and R124. During a second dining observation of the 4th floor on 11/23/15 at 12:40 PM, disposable Styrofoam dessert bowls were observed in use for the following 11 residents: R5, R8, R18, R45, R63, R69, R74, R81, R96, R98, and R122. During a second dining observation of the 2nd 	F 241	<p>to order more product. Drinking cups and dessert bowls were ordered for replacement. FSD will in-service dietary staff by 1/8/16 on using Styrofoam only for infection control or emergency situations (attachment 3).</p> <p>D. Random audits of 10% of current census will be conducted by FSD to verify employees are first knocking and granted permission before entering the resident's room. The FSD will conduct random audits to verify appropriate dishes and glassware are used for meal service (attachment 5). Audits will be conducted weekly until 100% success is obtained for 3 consecutive evaluations, then monthly until 100% compliance for 3 consecutive evaluations is reached. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>	

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F 241	<p>Continued From page 3</p> <p>floor on 11/23/15 at 12:49 PM, disposable Styrofoam dessert bowls were observed in use for the following five (5) residents: R14, R40, R53, R56, and R109.</p> <p>All of the above listed findings were reviewed with E1 (NHA) on 11/23/15 at approximately 2:00 PM.</p> <p>7. During lunch observations of the 3rd floor halls on 11/18/15 at 12:10 PM, E11 (dietary aide) entered R92's room without knocking or asking permission to enter to inquire what R92 would like for the lunch entree.</p> <p>8. During lunch observations of the 3rd floor halls on 11/18/15 at 12:22 PM, E11 (dietary aide) entered R46's room without knocking or asking permission to enter to inquire what R46 would like for lunch.</p> <p>9. During lunch observations of the 3rd floor halls on 11/18/15 at 12:25 PM, E11 (dietary aide) entered R157's room without knocking or asking permission to enter to inquire what R157 would like for lunch.</p> <p>Findings were reviewed with E1 and E2 (DON) during the exit conference on 11/24/15 at approximately 4:45 PM.</p> <p>F 253 SS=E 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 241	<p>A. All areas noted have been corrected. R35 and R2's wheelchairs were cleaned. The hook on bathroom door for room 232 was fixed. Caulking was cleaned and/or replaced for rooms 325, 428 and 425A. The gap was sealed in the bathroom door for room 434 and door was fixed for the bathroom in rooms 421B and 200. Wallpaper in rooms 225 and 232 were resealed. Door frames were painted in room 225 and 200. Area was dusted behind the TV in room 232. Floors were cleaned in rooms 225, 434, 429B and 425A. Over bed tray table was replaced in room 304A and cleaned in rooms 421B, 429B, 422A, 428 and 425A. Tiles were cleaned, resealed and/or replaced for rooms 434, 234 and 425A. AC units were</p>
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F 253	<p>Continued From page 4</p> <p>Based on observations and interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 17 (225, 304A, 200, 421B, 434, 405, 234, 301, 325, 429B, 422A, 200, 232, 428, 414, 408, 425A) out of 31 rooms reviewed. Additionally, for two (R2 and R35) out of 35 Stage 1 residents sampled, the facility failed to ensure the resident's wheelchairs were clean.</p> <p>1. On 11/19/15 at 10:40 AM and on 11/23/15 at approximately 1:45 PM, during the environmental tour, R35's wheelchair was observed to be dirty and dusty.</p> <p>2. On 11/18/15 at 10:23 AM and on 11/23/15 at approximately 1:20 PM, during the environmental tour, R2's wheelchair was observed to be dirty and dusty.</p> <p>The following observations were made on 11/18/15 and 11/19/15 during Stage 1 review, and on 11/23/15 between 1:00 PM and 2:15 PM, during the environmental tour:</p> <p>3. Room 225: - wall paper peeling from wall between A and B beds; - bathroom wall has peeling paint and scratch marks; - doorframes have chipped paint; - floor dirty especially in corners and along perimeter of room.</p> <p>4. Room 304A: - overbed tray table has a corner in disrepair, lifting up.</p>	F 253	<p>repaired in rooms 405, 232 and 408. The wall in room 301 was repaired and the toilet was fixed in room 414. Bathroom wall was repaired and painted in room 225. AC unit was repaired in rooms 405, 408 and 232. All areas were addressed by the environmental services or maintenance departments.</p> <p>B. Other residents have the potential to be affected and on 11/25/15 rounds have been completed by Maintenance supervisor/designee to determine any further maintenance issues. There were 5 more areas noted to need paint/repair. Painting/repair was completed on these areas. There were 6 over bed tray tables needing replacing or cleaning.</p> <p>C. No process changes were needed. Maintenance supervisor/designee has a preventive maintenance schedule in place for paint/caulk</p>		

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F 253	Continued From page 5 6. Room 200: - inside bathroom door with dark discolored line across bottom. 6. Room 421B: - accordion bathroom door in disrepair, not closing fully; - overbed tray table steel frame dirty/rusty. 7. Room 434: - corners of floors dirty; - gap/space measuring approximately 1/2 inch, between inside of bathroom door frame and wall on left side; - rust colored stain on floor behind toilet and discolored caulking at base of toilet. 8. Room 405: - AC unit panel in disrepair, pulled away on one side. 9. Room 234: - four (4) cracked floor tiles under bed and along wall between window and dresser. 10. Room 301: - hole in wall to left of AC unit, piece of sheet rock missing. 11. Room 325: - top of bathroom sink with missing and/or cracked caulking. 12. Room 429B: - floor dirty, especially corners and along perimeter of room; - steel frame of the overbed tray table was dirty/rusty.	F 253	(attachment 6). The existing process was not being followed. Environmental services director will continue with random environmental audits to include over bed table cleanliness (attachment 7). Re-education (by the Administrator) was provided to the maintenance and environmental departments (by the environmental services director) on related deficiencies (attachment 8). D. Random audits by the maintenance supervisor/designee and EVS director/designee will be completed monthly until 100% is successfully reached over 3 months. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.	

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F 253	Continued From page 6 13. Room 422A: - steel frame of overbed tray table was dirty/rusty. 14. Room 200: - Inside bathroom door has dark discolored line across bottom. 15. Room 232: - wall above television (TV) plastered but in need of painting; - hook on back of bedroom door broken; - AC unit panel pulled away on right side; - dust behind TV set. 16. Room 428: - dirty caulking around base of toilet; - steel frame of overbed tray table dirty/rusty. 17. Room 414: - toilet bowl water constantly running. 18. Room 408: - AC unit cover in disrepair, pulled away on one side. 19. Room 425A: - cracked floor tile on right side of toilet; - dirty caulking around base of toilet; - floor dirty especially in corners and around perimeter of room; - steel frame of overbed table dirty/rusty. All of the above listed findings were confirmed during the environmental tour on 11/23/15 from 1:00 PM through 2:15 PM by E1 (NHA) and E9 (ESD).	F 253	A. All areas noted have been corrected. Light bulbs were replaced in rooms 423, 422 and 329. B. Rounds have been completed by Administrator/designee to determine there were no further issues with light bulbs not working. C. Maintenance supervisor/designee has put a preventive maintenance schedule in place for assessing adequate and comfortable lighting are provided (attachment 7). Education was provided to the maintenance department on related deficiencies (attachment 8). Preventive maintenance schedule will be followed for timely maintenance needs.	1/8/16
F 256	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS	F 256		

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F 258	Continued From page 7 The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to provide adequate and comfortable lighting levels in three (329, 422, and 423) out of 31 rooms reviewed. Findings include: 1. On 11/18/15 at 4:02 PM and on 11/23/15 at approximately 1:30 PM, during the environmental tour, the bathroom light fixture in room 423 had two (2) of three (3) light bulbs not working. This resulted in inadequate lighting in the bathroom area. 2. On 11/19/15 at 8:34 AM and on 11/23/15 at approximately 1:20 PM, during the environmental tour, the bathroom light fixture in room 422 had one (1) of three (3) light bulbs not working. This resulted in inadequate lighting in the bathroom area. 3. On 11/23/15 at approximately 1:45 PM, the bathroom light fixture in room 329 had two(2) of three (3) light bulbs not working. This resulted in inadequate lighting in the bathroom area. All of the above findings were confirmed by E1 (NHA) and E9 (ESD) during the environmental tour on 11/23/15 from 1:00 PM to 2:00 PM.	F 256	D. Random audits, on 50% of current resident rooms, by the maintenance supervisor/designee will be completed weekly until 100% is successfully reached over 3 weeks, then monthly until 100% compliance is reached for 3 consecutive evaluations. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed. A. A family meeting was previously scheduled including the ombudsman at time of survey to evaluate appropriate interventions for R86. Resident was already being followed by psychiatric services with medication adjustments. Conversations and education regarding alternative treatment options were provided to family and will continue.	1/8/16
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS	F 258		

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F 258	<p>Continued From page 8</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and observations, it was determined that for 2 (R36 and R64) out of 48 Stage 2 sampled residents, the facility failed to maintain comfortable sound levels in one out of two residential hallways on the second floor. Findings include:</p> <p>1. During a resident interview on 11/18/15 at 10:59 AM, R64 stated "a (resident) across the hall ... screams and gets on your nerves so bad, day and night, curses like a sailor ...".</p> <p>2. An observation during a resident interview with R36 on 11/18/15 at 3:47 PM in her room with her door closed revealed a female resident in the same hallway repeatedly screaming "hey, hey, hey" that was heard clearly through the walls.</p> <p>During a resident interview on 11/18/15 at 3:50 PM, R36 stated that R86, another resident, was screaming "hey, hey, hey." R36 stated that R86 screams constantly, especially at night. R36 stated that the "screaming has gotten worse over the past several months, and that she cannot take it and has told staff multiple times". R36 stated she keeps her door closed at all times. R36 stated that she has screamed out loud herself when she reached her "boiling point" with R86's screaming.</p> <p>Subsequent observations were made as follows: - on 11/20/15 at 12:31 PM from the hallway, R86</p>	F 258	<p>B. Other residents have the potential to be affected. An audit by the Administrator identified comfortable noise levels were maintained in all resident areas, including additional residents in R86's hallway. No issues were identified.</p> <p>C. R86's attending physician and psychiatric services had attempted multiple drug changes in an attempt to find the most effective drug regime for this resident. Diversion techniques were found to be ineffective. The family and ombudsman meeting was held November 24, 2015 resulting in an agreed upon treatment plan.</p> <p>D. Administrator/designee will monitor noise levels to verify comfortable levels are obtained (attachment 9). Monitoring will occur weekly until 100% is successfully reached over 3 weeks, then monthly until 100%</p>		

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F 258	<p>Continued From page 9</p> <p>was heard screaming out loud in her room with her door partially closed and a family member present stating, "I got to go, I got to go, come on, come on, ah ah ah ... hey, hey I don't want to ah, ah, ah ... It hurts, it hurts".</p> <p>- on 11/23/15 at 9:09 AM from the hallway, R86 was heard screaming out loud in her room with her door open stating, "ah ah ah ... I want ice cream. Please".</p> <p>- on 11/23/15 at 9:12 AM from the hallway, R86 screamed out "I don't want to go".</p> <p>- on 11/23/15 from 9:14 AM until 9:37 AM, from the centralized open 2nd floor nurse's station which was located six (6) resident rooms from R86's room, R86 was heard continuously yelling "ah ah ah ah ah ah" out loud in her room for approximately 23 minutes.</p> <p>An interview in the nurse's station on 11/23/15 at 9:37 AM, E17 (LPN) stated that R86's screaming was a regular occurrence especially in the morning. E17 confirmed that she can hear R86 screaming at the present time in the nurse's station.</p> <p>An interview in the nurse's station on 11/23/15 at 9:46 AM, E5 (UM, RN) confirmed that R86 was screaming and she can be heard in the nurse's station. E5 also confirmed that R86's screaming was affecting the other residents in that hallway.</p> <p>Additional observations were made as follows:</p> <p>- on 11/24/15 at 8:09 AM from the hallway, R86 screaming "ah, ah, ah, ah, I want ... I want ... ah, ah, ah, ah".</p> <p>- on 11/24/15 at 8:13 AM from the nurse's station, R86 screamed "Bitch" at an unidentified dietary staff person who was observed exiting R86's room after delivering her breakfast meal tray.</p>	F 258	<p>compliance is reached for 3 consecutive evaluations. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>	

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F 309	<p>Continued From page 11</p> <p>weights may be obtained at the discretion of the interdisciplinary care team... Purpose - To obtain baseline weight and identify significant weight change; To determine possible causes of significant weight change..."</p> <p>1. R82's at nutritional risk care plan due to swallowing difficulties as evidenced by the need for a feeding tube to maintain needs was developed on 3/26/12 and last revised on 11/5/15. Interventions included the approach of dietary evaluation and monitoring.</p> <p>According to R82's Quarterly MDS assessment, dated 8/24/15, this resident had a feeding tube and was on a mechanically altered and therapeutic diet, with a weight of 199 lbs.</p> <p>Review of the Weights and Vitals Summary revealed that R82's weight on 9/1/15 was 199.6 lbs.</p> <p>Review of a Dietary Note, dated 10/21/15, revealed R82's monthly weight was 187 lbs., a decline of 12.6 lbs (6.3%) in 1 month. Although E19's (Dietician) note stated it was a significant decline, weight loss of greater than 5% in one month is a severe decline. R82 continued to tolerate the tube feeding regime well and E19's note suggested to monitor weekly weights for 4 weeks for stability and need for adjustment of the tube feeding.</p> <p>There was a lack of evidence in the clinical record that R82 was weighed during the week of 10/25/15 through to 10/31/15. His next recorded weight was 185 lbs. on 11/1/15.</p> <p>Review of a Dietary Note, dated 11/5/15, revealed i</p>	F 309	<p>parameter (attachment 13). DON/designee will perform random monthly audits for weekly weight completion/accuracy and that residents with BS checks have had MD notification (attachment 14).</p> <p>D. Audits by the DON/designee will be conducted monthly until 100% success is obtained for 3 consecutive evaluations. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>

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F 309	<p>Continued From page 12</p> <p>R82 had a slight weight decline in the last 3 months and E19 suggested to monitor weekly weights for 4 weeks.</p> <p>There was a lack of evidence in the clinical record that R82 was weighed during the week of 11/8/15 through to 11/14/15.</p> <p>A NN's, dated 11/9/15 at 10:32 AM, stated that R82's PEG tube was found on his bed and he was sent out to the emergency room to have it replaced.</p> <p>A Physician's order dated 11/9/15, also stated that R82 was sent out to the emergency room to have his PEG tube replaced.</p> <p>Review of a NN's, dated 11/9/15 at 5 PM, stated that R82 returned to the facility after his PEG tube placement.</p> <p>R82's next recorded weight was 184 lbs. on 11/16/15.</p> <p>In an interview on 11/20/15 at 2:48 PM, E5 (UM) stated that the expectation is that the resident should have been weighed the next shift, depending on the time he returned, or at least the following day. E5 further stated that the CNAs were to report to the RN and the following shift's CNAs that a resident's weight was not done as scheduled. E5 confirmed that following R82's return from the emergency room on 11/9, he was not weighted.</p> <p>In an interview on 11/23/15 at 1:31 PM, E19 stated that she as the dietician communicated the need for a resident's weekly weight or the doctor could order them. After reading her note, dated</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>10/21/15, based on her recommendation of weekly weights, E19 stated she would have expected to see a weight on R82 the following week. E19 confirmed that R82 was not weighed during the weeks of 10/25/15 and 11/8/15 while on weekly weights.</p> <p>The facility failed to provide the necessary care and services for R82 that was in accordance with his plan of care when they failed to obtain weekly weights on two occasions.</p> <p>Findings were reviewed on 11/24/15 at 8:59 AM with E2 (DON).</p> <p>2. R46 had admission orders, dated 11/4/15, for insulin per sliding scale to be done before meals and at bedtime. The physician order included to call the physician if the BS was less than 60 or greater than 400.</p> <p>Review of the November MAR revealed that R46 had a BS of 462 on 11/8/15 and a BS of 421 on 11/16/15. There was nothing in the MAR stating that the physician was called on 11/8/15 or 11/16/15 and nurse's notes lacked evidence that the physician was called for BS's over 400 on these dates.</p> <p>Findings were confirmed with E3 (ADON) on 11/23/15 at 1:20 PM. E3 stated the nurse should have written a note and called the physician on both dates. She further stated, "how'd she (the nurse) know what dose (of insulin) to give?"</p> <p>The facility failed to provide care and services to attain or maintain the highest practicable physical well-being, in accordance with the plan of care as per a physician's order to call MD for BS's above</p>	F 309	

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F 309	Continued From page 14 400. R46 had BS's exceeding 400 on 11/8/15 and 11/16/15, however, the facility failed to notify the physician, thus not allowing the physician to have the opportunity to order another dose of Insulin or make adjustments to the Insulin order(s).	F 309	A. All areas noted have been corrected. R 79's AC units' electrical plug was replaced. R 36's bed brakes were replaced and are working properly. Side rails were replaced for R53, R35, and R19. B. Other residents have the potential to be affected and on 11/25/15 rounds were completed by Administrator/designee to determine any further maintenance issues. The maintenance department/designee has attached c clamps, bushings and or replaced side rails as needed. No other issues were identified with AC unit plugs. C. Maintenance supervisor/designee has a preventive maintenance schedule in place for checking loose side rails and AC (HVAC) units (attachments 15-18). No	1/8/16	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure that the resident environment remains as free of accident hazards as is possible for five (R19, R35, R36, R53, and R79) out of 48 residents sampled. For R19, R35 and R53, the facility failed to ensure that bed siderails were secure and not loose. For R79, the facility failed to ensure the AC electrical plug was properly plugged into the outlet. For R36, the facility failed to ensure that bed brakes were functioning properly. Findings include: 1. Observations on 11/19/15 at 9:21 AM and on 11/23/15 at approximately 1:15 PM, during the environmental tour, revealed that for R79 the AC units' electric plug was too short and was not fully plugged into the electrical wall outlet.	F 323			

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F 323	<p>Continued From page 15</p> <p>Finding was confirmed by E1 (NHA) and E9 (ESD) on 11/23/15 at approximately 1:15 PM.</p> <p>2. Observations on 11/18/15 at 4:42 PM and on 11/23/15 at approximately 2:00 PM, during the environmental tour, revealed that R36's bed brakes were not functioning properly. Leaning against the bed caused it to skid to the side presenting a potential accident hazard.</p> <p>Findings were confirmed by E1 and E9 on 11/23/15 at approximately 2:00 PM.</p> <p>3. Observations on 11/18/15 at 11:00 AM and 11/23/15 at 8:56 AM revealed that R53's quarter side rail was loose.</p> <p>Finding was immediately confirmed by E5 on 11/23/15 at 8:56 AM during the second observation. The facility failed to ensure that R53's side rail was secure and not loose.</p> <p>4. Observations on 11/18/15 at 11:20 AM and 11/23/15 at 8:53 AM revealed that R35's quarter side rail was loose.</p> <p>Finding was immediately confirmed by E5 on 11/23/15 at 8:53 AM during the second observation. The facility failed to ensure that R35's quarter side rail was secure and not loose.</p> <p>5. Observations on 11/19/15 at 10:27 AM and 11/23/15 at 8:55 AM revealed that R19's quarter side rail was loose.</p> <p>Finding was confirmed by E5 (UM, RN) on 11/23/15 at 8:55 AM during the second observation. The facility failed to ensure that R19's quarter side rail was secure and not loose.</p>	F 323	<p>process change was needed. It was identified maintenance was not following the preventive maintenance schedule. Re-education was provided by the Administrator to the maintenance department on related deficiencies on 11/24/15 and to the new maintenance supervisor 12/14/15 (attachment 8). Preventive maintenance schedule will be followed for timely maintenance needs.</p> <p>D. Random audits by the maintenance supervisor/designee will be completed monthly until 100% success is reached x 3 consecutive evaluations. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>	

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F 362 SS=E	<p>483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL</p> <p>The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to employ sufficient support personnel competent to carry out the functions of the dietary service. Findings include:</p> <p>On 11/24/15 from approximately 11:50 AM to 12:25 PM, observations were made of the lunch service on the 3rd floor hall to residents eating in their rooms.</p> <p>The steam cart arrived on the 3rd floor about 11:50 AM. There were two (2) dietary aides [E11 and E18]; (E11) went into rooms to get entrée orders, delivered trays to the residents and went back and forth to wash her hands in the nutrition room between pushing the steam cart between locations on the 3rd floor and E18 plated food.</p> <p>At 11:55 AM on 11/18/15, E12 (CNA) was observed providing a carton of milk and a small bowl of diced fruit salad to R90 and 2 cartons of milk to R157.</p> <p>During an interview with R90 on 11/14/15 at 11:56 AM, he stated that the steam cart with entrees follows the drink carts because all of the carts (including medication carts) are unable to fit in the hall at the same time.</p>	F 362	<p>A. R90 and R157 remain in the facility and are receiving meals in a timely manner.</p> <p>B. No resident meals were affected by the deficient practice. Residents received their entrée, fluids and dessert for noted meals. Food Service Director (FSD)/designee completed rounds on the other two resident area. There were no other delays in receiving entrees 30 minutes after beverages.</p> <p>C. It was noted a process change was needed in meal service. Beverage care will be brought to the resident unit approximately 15 minutes prior to entrée service. Education will be provided by the FSD/designee to the nursing and dietary staff on the new process. Rounds on meal service will be completed by FSD/designee to verify entrees are served within a timely manner of receiving beverages and desserts (attachment 19).</p>	1/8/16

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F 362	Continued From page 17 During an interview with E12 at 12:00 PM, E12 stated that the usual lunch pattern on the 3rd floor was for a CNA to go around to the rooms with a hot beverage cart followed by another CNA serving cold drinks and dessert (if it needed to be kept cold). E12 stated that entrees were served after the hot and cold carts. R90 and R157 did not receive their entrees until 12:25 PM, 30 minutes after they received their beverages and dessert. The residents were given silverware when they received their entrees. E11 was interviewed by a surveyor on 11/18/15 at 12:50 PM and stated that one staff person was taken from them since the last survey and "that's why it (meal service) takes so long." Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 11/24/15 at approximately 4:45 PM.	F 362	D. FSD/designee will conduct rounds on meal service to verify that beverage and entrees are received timely and in close proximity of each other. Rounds will be completed daily until 100% success is reached x 3 consecutive evaluations and then weekly until 100% success is reached x 3. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary condltions This REQUIREMENT is not met as evidenced by:	F 371	A. Immediate action was taken on the items identified. E18 and E16 were educated on hand washing between glove changes. E11 was educated on appropriate cleaning of utensils. E11 was educated on changing gloves when contaminated and hand washing between glove changes. E13 was educated to wear beard guards while in the kitchen area. Food utensils were being wrapped in	1/8/16	

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F 371	<p>Continued From page 18</p> <p>Based on observations, interviews and facility documentation, it was determined that the facility failed to serve food under sanitary conditions when they failed to follow the facility policy for handwashing between glove changes. Findings include:</p> <p>The facility's undated policy entitled, "Handwashing - Dietary Staff" stated, "...Handwashing is the single most important procedure for preventing the spread of infection...Alcohol based hand rubs...cannot be used in place of proper handwashing techniques in a food service setting. When serving food from food cart: Must change gloves after pushing cart. Must wash hands with soap and water in between glove changes..."</p> <p>1. On 11/19/15 at 8:20 AM, during a breakfast observation on the 2nd Floor, E16 (Cook) served the residents in the dining/TV room, took off her used gloves, tossed them into the trash can, walked down the South Hall, put on new gloves and continued to plate food for residents in that hall. E16 failed to wash her hands between glove changes. At 8:30 AM, E16, again, took off the used gloves, tossed them in the trash can, walked down the North Hall, put on new gloves and continued to plate food for residents in that hall. E16 failed to wash her hands between glove changes.</p> <p>2. On 11/24/15 at 8:27 AM, during a breakfast observation on the 2nd Floor, E16 served the residents in the dining/TV room, took off her used gloves, tossed them into the trash can, then helped to push the steam table down the South Hall. E16 put on new gloves and then plated food for the residents in that hall without washing her</p>	F 371	<p>napkins for distribution. E20 was educated on handling of clean utensils. E21 as educated to wear gloves when removing saran wrap from beverage containers.</p> <p>B. A sanitation/food safety audit was performed to identify other potential areas of deficient practices (attachment 20 & 21). Further deficient practices were corrected immediately.</p> <p>C. Identified areas of deficient practice were related to the dietary staff not following policies. Education was provided to the dietary department on related deficiencies. No policy changes were needed. FSD (Food Service Director)/designee will inservice dietary staff by 1/8/16 on hand washing with glove changes, handling contaminated and clean utensils (attachments 22-29, attachment 23 is sample competency). Sanitation/food safety audits will be conducted to</p>		

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F 371	<p>Continued From page 19</p> <p>hands prior to putting on new gloves. At 8:31 AM, E16 took her used gloves off in the North Hall and replaced them with new gloves without washing her hands between the glove changes.</p> <p>In an interview on 11/24/15 at 8:38 AM, E16 confirmed the findings.</p> <p>Findings were reviewed on 11/24/15 at 8:59 AM with E6 (FSD) and at 9:00 AM with E2 (DON).</p> <p>3. During lunch service to the halls on the 3rd floor on 11/18/15 from 11:50 AM to 12:30 PM, E18 (dietary aide) was observed changing her disposable gloves 2-3 times without washing her hands between glove changes. She was plating foods.</p> <p>Findings were reviewed with E1 (NHA) and E2 during the exit conference on 11/24/15 at approximately 4:45 PM.</p> <p>Observations during the full kitchen tour on 11/18/15 between 9:30 AM and 11:45 AM with E6 (FSD) and E7 (regional FSD) revealed the following:</p> <p>5. E11 (dietary aide) cleaned a ladle using the hand sink and then went to serve food. According to E6, E11 was trying to wet the paper towel to clean the ladle. Using water without sanitizer and a paper towel to clean a food contact surface contaminates the utensil.</p> <p>6. E11 picked up a styrofoam cup with her bare hand while asking E10 (dietary aide) to scoop up some tater tots into the cup. E10, with her gloved hand touched E11's bare hand when she touched</p>	F 371	<p>ensure deficient practices are not recurring (attachments 30 & 31).</p> <p>D. FSD/designee will complete audits to verify safe food handling and sanitation policies are followed. These will be completed weekly x 3 until 95% success over 3 consecutive evaluations is reached. Then monthly x 3 until 95% success over 3 consecutive evaluations is reached. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>	

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F 371	Continued From page 20 the cup. After filling the styrofoam cup, E10 went back to handling food on the trayline, however, she did not wash her hands and applied new gloves. 7. E13 (FMD) with an overgrown beard was working on the dishwashing room hand sink without a beard restraint. E13's beard touched the sink surface several times. Findings were confirmed with E6 and E7 on 11/18/15 at approximately 12:00 PM. The third floor dining observation on 11/18/15 between 11:50 AM and 12:15 PM with E6 and E7 revealed the following: 8. E21 removed the saran wrap while touching the food contact part of the beverage dispenser without using gloves. 9. On 11/18/15 at 3:10 PM observed improper storage of clean eating utensils. The utensils were stored with the food contact sides facing up. 10. 11/18/15 at 3:15 PM, E20 picked up clean kitchen utensils with his bare hands. He also hugged the clean utensils against his body and in direct contact with his dirty apron, thus contaminating the clean utensils. Findings were confirmed by E6 on 11/18/15 at approximately 3:30 PM. Findings were reviewed with E1 and E2 during the exit conference on 11/24/15 at approximately 4:45 PM.	F 371			
F 502	483.75(j)(1) ADMINISTRATION	F 502	A. The lab was obtained for R64. Results were within normal limits and reported to the medical practitioner.	1/8/16	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/24/2015
NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH BROOM 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 502 SS=D	<p>Continued From page 21</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to obtain laboratory (lab) services to meet the needs of one (R64) out of 48 sampled stage 2 residents. Findings include:</p> <p>Review of physician orders for R64, dated 9/24/15, included a Vitamin B-12 level and other lab tests to be done with the next lab draw.</p> <p>Review of lab results in the clinical record revealed that the labs ordered on 9/24/15 were drawn on 10/5/15, however, there was no B-12 level.</p> <p>Review of the facility's lab log on 10/5/15 for R64 lacked the B-12 level.</p> <p>Findings were confirmed with E15 (LPN) on 11/24/15 at approximately 11:30 AM.</p> <p>E14 (LPN) called the lab on 11/24/15 at approximately 11:35 AM to see if a B-12 was done on or after 10/5/15 and confirmed to the surveyor that a B-12 level was not done.</p> <p>The facility failed to obtain lab services to meet the needs of R64.</p>	F 502	<p>B. Other residents have the potential to be affected by the deficient practice and November lab orders were reviewed to determine compliance with deficient practice.</p> <p>C. No policy change was needed. In-service by Nurse Practice Educator (NPE) will be provided by 1/8/16 on obtaining laboratory services as ordered (attachment 4).</p> <p>D. Random audits of 10% of current census will be conducted by DON/designee to verify labs are obtained as ordered and physician notified accordingly (attachments of example audits 32-36). Audits will be conducted monthly until 100% success is obtained for 3 consecutive evaluations. All findings will be reported to the Quality Assurance and Improvement Process Committee for data evaluation and recommendations as needed.</p>	



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: November 18, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced bi-annual survey was conducted at this facility from November 18, 2015 through November 24, 2015. 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 91. The Stage 2 survey sample size was 48.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed November 24, 2015 F241; F253; F256; F258; F309; F323; F362, F371 and F502.</p>	<p>Cross reference to CMS 2567 survey report.</p> <p>Date survey completed 11/24/15</p> <p>F242, F253, F256, F258, F309, F323, F362, F371, F502</p>	<p>1/8/16</p>

Provider's Signature Gene Ketterman Title Administrator Date 1/7/16