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

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

STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: December 21, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A COVID-19 Focused Infection Control Survey and a complaint survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from December 17, 2020 through December 21, 2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility census on the first day of the survey was seventy-nine (79). The survey sample totaled eight (8) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		

Provider's Signature _____ Title _____ Date _____

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	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed December 21, 2020: F886.		

Provider's Signature _____ Title _____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. BUILDING _____ B. WING _____	C 12/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HILLSIDE LLC	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 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and a complaint survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from December 17, 2020 through December 21, 2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility census on the first day of the survey was severyt-nine (79). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this report are as follows: CDC - Center for Disease Control; CMS - Center for Medicare and Medicaid Services; CNA - Certified Nurse's Aide; COVID Testing - a test for COVID-19/Coronavirus - a respiratory illness that can be spread person to person; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; PPE - Personal Protective Equipment; RN - Registered Nurse.	F 000		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including	F 886		1/11/21

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

Electronically Signed | 01/12/2021

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 886	Continued From page 1 individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with	F 886		

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F 886	Continued From page 2 symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct the required COVID-19 testing every seven days for two (E3 and E4) out of four employees sampled. Findings include: 8/26/2020 - CMS memorandum regarding facility testing requirements indicated "for outbreak testing, all staff and residents should be tested and all staff and residents that tested negative should be re-tested every 3 days to 7 days..." The Division of Public Health (DPH) Testing Guidance for Long-Term Care Facilities (10/12/20) requires weekly testing of facility staff. The guidance for outbreak testing documented "Upon identification of a positive case, test immediately and then every 7 days." Review of testing data, work schedules and documentation provided by E1 (NHA) revealed	F 886	E3 and E4 are in compliance with the COVID-19 testing requ rements. A record review of employee CCVID-19 testing indicates that all employees are in compliance. Residents that were cared for by E3 and E4 had the potential to be affected by this deficient practice. The root cause of this deficient practice was that E1 inadvertently missed the testing requirement for E3 and E4. Currently testing requirement is every 3-7 days. A system is in place so that this deficient practice will not reoccur. This deficient practice will be corrected by a two-person review at the end of each day to ensure that each employee has been tested as required. The Employee	

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F 886	Continued From page 3 that the following discrepancies in testing: - E3 (RN) worked from 11/21/2020 through 11/30/2020 without being tested for COVID. - E4 (LPN) worked from 11/6/2020 through 11/17/2020 without being tested for COVID. During an interview on 12/17/2020 at 1:03 PM, E2 (DON) confirmed employees were not always tested every 3-7 days, E2 stated "sometimes there's vacations or holidays, we try to just have them come in the day after." These findings were reviewed during the exit conference on 12/21/2020 at 3:00 PM with E1 (NHA).	F 886	Testing Tracking Log is being reviewed daily by the NHA and DON. Both are signing off on the tracking log after each review. At the end of each week, compliance will be monitored by the QAPI Committee. Results of each weekly review will be conducted by the NHA and DON and reported to the QAPI Committee. These reviews will continue until COVID-19 testing has ended with the goal of 100% success with employee testing.	