

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

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 C 05/27/2009
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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 annual and complaint visit was conducted at this facility from May 20, 2009 through May 27, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documents as indicated. The census on the first day of the survey was ninety-nine (99). The survey sample totaled 21 residents (R1 through R21), which included 17 active and four (4) closed records. An additional 12 sub-sampled residents (SSR22 through SSR33) were included for observations and interviews.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	F157 1. Resident #R18 is no longer resides in the center. Resident #R12 remains in the center and has been reassessed for her incontinence and has been placed on a toileting plan. She is currently continent with toileting. Resident #R12 has been reviewed by the ICP team and a change in the resident continence status has been up dated in the plan of care. The current MDS of Resident R#12 reflects the resident's current continence status. Current residents with a change in condition have had their physicians notified of the change. 2. In-servicing by the Nurse Practice Educator shall be held on or before July 7, 2009 on "Physician Notification" for the licensed nursing staff. 3. Audits shall be completed at the rate of 10 per week over the next 90 days to determine compliance with physician and family notification this shall be the responsibility of the DON/designee. 4. The DON shall report to the QA committee and Administrator any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7-7-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chans, Jumbel</i>	TITLE NHA	(X6) DATE 7-1-09
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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 participation.

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F 157	<p>Continued From page 1</p> <p>resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed record review and interview, it was determined that the facility failed to notify the physician and/or family member regarding a significant change in condition for 2 residents (R12 and R18) out of 21 sampled. R12's continence status declined from being continent to being totally incontinent in a 3 month time period. R18 experienced an elevated temperature ranging from 100.1 to 101.7 for 6 days, requiring the administration of Tylenol to lower the temperature. Findings include:</p> <p>1. Cross refer to F315 The quarterly Minimum Data Set (MDS) assessment dated 9/10/08 and annual MDS assessment dated 12/8/08 indicated R12's cognitive skills for daily decision making were "independent-decisions consistent/reasonable" and that she had no short or long term memory problem. Although R12 had an unsteady gait and shortness of breath, she was able to transfer independently to/from the bed and wheelchair and on/off the toilet. R12 was continent/complete control of bladder (Coded 0).</p> <p>The MDS assessment dated 3/10/09 indicated R12's bladder control had declined to "frequently incontinent - of bladder, tended to be incontinent</p>	F 157		
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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157 Continued From page 2
 daily, but some control present (code 3)."

R12's ADL record for 01/09, indicated some bladder incontinence episodes on the 11-7 AM shift (12 times out of 31 days). In 2/09 her ADL record showed an increase of bladder incontinence, with 26 episodes on the 11-7 AM shift and 6 on the 3-11 PM shift. In 3/09, 4/09 and 5/09 her ADL record sheets showed that she became totally incontinent of bladder daily on all three (3) shifts.

R12's continence status declined from being continent to totally incontinent in a 3 month time period

In an interview with E24 (Nurse Practitioner) on 5/21/09 at approximately 1:00 PM, she stated that she was not informed of R12's increasing decline in incontinence.

2. Cross refer to F328
 R18 was admitted to the facility from the hospital on 1/28/09. According to the facility's "Nursing Admission Assessment" dated 1/26/09, R18 was admitted with a temperature of 97.4, had a PEG tube and was alert.

R18 developed a temperature of 101.7 degrees F (Fahrenheit) on 1/28/09 requiring administration of Tylenol to lower the fever. There was no evidence that the facility notified the physician, per facility policy, of R18's elevated temperature on 1/28/09. R18 continued to have an elevated temperature, ranging from 100.1 to 101.0 degrees F, on 2/4/09 through 2/8/09, a total of 5 days, again requiring Tylenol to lower the temperature. During this 5 day period, there was no indication in the nurse's notes that the

F 157

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	Continued From page 3 physician and/or the family member were notified of the elevated temperature. A nurse's note dated 2/8/09 and timed 3:00 PM stated, "... (family member) was in at 1-1:30 PM, stated that (R18) appears to be having some change of mental status and wish (sic) for (R18) to be sent to the ER... felt that (R18's) condition was deteriorating... order was obtained (E27-Medical Director/Attending Physician) to send resident to ER." Resident was admitted in the hospital for treatment and evaluation. Review of the hospital record revealed R18 required hospitalization for a UTI/fungemia (presence of fungi in the blood) and treatment with antibiotics. This finding was discussed with E2 (DON) on 5/26/09 and on 5/27/09.	F 157		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee records and the facility's abuse prohibition policy, it was determined that the facility failed to complete a thorough criminal background investigation in a timely manner. Findings include: Review of the facility documentation on 5/22/09 of twenty (20) sampled personnel by the State Investigative Administrator revealed that the	F 226	F226 1. Employee #9's file now contains the criminal background information. Employee files have been audited to determine that all information is in the files. 2. There will be in-servicing by the Social Service Director on or before July 7, 2009 for managers on "Abuse Prohibition". 3. Audits shall be completed on new hire files over the next 90 days to determine compliance. This shall be the responsibility of the HR manager. 4. The HR manager shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	7-7-09

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	Continued From page 4 criminal background investigation of E9 (therapist) for Long Term Care had not been completed. The Abuse Prohibition policy stated that the Center will screen potential employees for a history of abuse, neglect or mistreating residents.	F 226		
F 241 SS=E	483.15(a) DIGNITY 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, it was determined that the facility failed to ensure that 1 resident (R12) out of 21 sampled and 4 (SSR24, SSR25, SSR26 and SSR27) out 12 sub sampled residents were treated in a dignified manner during meal times. Additionally, the facility failed to ensure that 1 resident (R4) out of 21 sampled along with additional multiple residents were treated by staff with dignity and respect when entering residents' rooms. Staff were observed entering resident rooms without knocking and without waiting for residents to give permission to enter their rooms. Findings include: 1. On 5/20/09, SSR24, SSR28 and SSR33 were seated around a table in the 3rd floor lounge/dining area. At 12:05 PM, SSR28 and SSR33 were served their lunch meals and began to eat. SSR24 was not served his meal until 12:36 PM, 31 minutes later. E20 (CNA) confirmed the delay of SSR24's meal explaining that trays come up on the cart based upon the hallway in which a resident resides.	F 241	F241 1. Resident's # SSR27 and SSR28 no longer reside at the center. Other residents identified have been assessed during meals and are receiving their meals at the same time. Residents eating in the lounges have been assessed to determine compliance. Dietary department has reorganized the meal delivery carts to provide proper serving of meals by table. 2. In-servicing shall be completed by the NPE and FSD of nursing staff on or before July 7, 2009 on resident dignity with meal service. 3. Audits shall be completed at the rate of 3 per week over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. 4. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7-7-09

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F 241 Continued From page 5

F 241

The facility failed to ensure that SSR24 was treated in a dignified manner during the lunch meal. On 5/27/09, E2 (Director of Nursing) confirmed that residents who are seated at a table should receive their meals together.

2. On 5/20/09, lunch observations were done in the 4th floor lounge. There were 2 tables, one with 4 residents (table #1) and one with 2 residents (table #2).

At table #1, SSR31 was served her lunch tray at 12:15 PM. SSR26 received her lunch at 12:22 PM (7 minutes later) and SSR27 received his lunch at 12:23 PM (8 minutes later). SSR25 received his lunch tray at 12:31 PM, 16 minutes after the first tray arrived.

At table #2, SSR32 was served her lunch tray at 12:23 PM. R12 received her tray 8 minutes later at 12:31 PM.

Each resident began to eat when they received their trays, so the other resident(s) at the table watched others eating while they awaited their meals.

3. During the tour on 5/20/09, E14 (certified nurses aide-CNA) was observed from 8:15- 8:25 AM going into several resident rooms delivering breakfast trays without knocking on the door or announcing herself.

4. On 5/21/09 a resident interview was conducted with R4 in the resident's room with the door closed. At approximately 9:45 AM, E16 (nurse)

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241 Continued From page 6
 entered R4's room without knocking and/or asking for R4's permission to enter. After E16 left the resident's room, R4 confirmed that she also had not heard the nurse knock before entering.

F 241

F 246 483.15(e)(1) ACCOMMODATION OF NEEDS
 SS=D
 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

F 246

F246

1. Resident's #R4 and SSR30 remains in the center. Both residents have their call bell within reach while in their rooms and are able to use the call bell. Current residents shall have their call bells within reach while in their rooms. 7-7-09
2. In-servicing shall be completed by the NPE on or before July 7, 2009 for nursing staff on placement of resident call bells.
3. Rounds shall be completed at the rate of 5 per week over the next 90 days to determine compliance; this shall be the responsibility of the DON/designee.
4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

This REQUIREMENT is not met as evidenced by:
 Based on observations during the initial tour, it was determined that the facility failed to ensure that two (R4 and SSR30) residents had reasonable accommodation of their needs. The facility failed to ensure that R4's and SSR30's call bells were within their reach. Findings include:

1. R4 was observed on 5/20/09 at 8:10 AM lying in bed. The cord to R4's call bell was observed tied to a raised side rail above her right shoulder, with the end of the call bell lying on the floor. When R4 was asked if she could reach her call bell, R4 was unable to lift her arms to reach the call bell.
2. SSR30 was observed on 5/20/09 at 8:38 AM in bed with bilateral bed bolsters in place. The call bell was observed lying on the floor inaccessible to the resident.

F 253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE
 SS=D
 The facility must provide housekeeping and

F 253

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 CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	Continued From page 7 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to provide maintenance services necessary to maintain an orderly interior. Findings include: Observations on 5/20/09 at 10:00 AM of resident room #405 revealed that the entry door was warped. This observation was repeated on 5/21/09 at 1:43 PM. An interview with E10 (Maintenance Director) on 5/26/09 at 9:25 AM confirmed that the door would be replaced.	F 253	F253 1. A replacement door for room 405 has been ordered, and has an estimated time of delivery of three to four weeks. At which time the door will be installed. Facility rounds have been completed to determine that all other doors are in good condition. 2. Rounds shall be completed at the rate of one every other week over the next 90 days to determine compliance; this shall be the responsibility of the maintenance director. 3. The Maintenance director shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7-7-09
78 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		

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F 278 Continued From page 8
to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review, it was determined that the Minimum Data Set (MDS) assessment for one resident (R15) out of 21 sampled, failed to accurately reflect the resident's status. Findings include:

Review of R15's quarterly MDS assessment, dated 10/8/08, revealed the assessment incorrectly coded R15 as needing "limited assistance" for transfers. R15's care plan, revised on 10/6/08, indicated that R15 required a "Mech (Mechanical) lift/2 (person) assist for all transfers." Therefore, the 10/8/08 quarterly MDS assessment should have coded R15 as needing "extensive assistance" for transfers.

F 278

- F278
1. Resident #15 has a current MDS that reflects the resident's current assistance with transfers. The quarterly MDS dated 10/8/08 did not have a significant corrected done due to another assessment having been completed. Current residents shall have their MDS's reviewed at their next care plan meeting to determine an accurate MDS.
 2. In-servicing shall be completed by the Regional Staff Development Coordinator on or before July 7, 2009 for staff completing any section of the MDS on MDS accuracy.
 3. Audits shall be completed at the rate of 1 per week to determine compliance over the next 90 days. This shall be the responsibility of the ADON/designee.
 4. The ADON shall report to the DON, Administrator, and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

7-7-09

F 279 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS
SS=D

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

F 279

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F 279	<p>Continued From page 9</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop care plans to meet residents' medical and nursing needs based on their comprehensive assessments for 2 (R2 and R12) out of 21 sampled residents. Findings include:</p> <p>1a. R2 was admitted to the facility with diagnoses including diabetes, obesity and coronary artery disease. On 4/30/09, the Resident Assessment Protocol Summary (RAPS) portion of the admission Minimum Data Set (MDS) assessment was completed. Review of the RAPS revealed the nutritional status was checked and indicated that a care plan was to be developed.</p> <p>The facility failed to develop a care plan for R2's nutritional status. On 5/21/09, findings were confirmed with E2 (Director of Nursing).</p> <p>1b. Additionally, based upon the 4/30/09 RAPS portion of the admission MDS assessment, a care plan for R2's functional ADL (Activities of Daily Living) was developed. However, the functional ADL care plan lacked any interventions other than</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> Resident # R2 has appropriate care plans in place to address the residents' ADL status. Resident #R12 has a care plan in place to address her continence status. Both residents have been reviewed by the ICP team. An audit of current residents with change in continence condition and new admissions is being completed to determine compliance with care planning. In-servicing shall be completed by the Nurse Practice Educator on or before July 7, 2009 for the licensed nursing staff on care planning. Audits shall be completed at the rate of 2 times per week for the next 90 days to determine compliance. This shall be the responsibility of the DON/designee. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance. <p>7-7-09</p>

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F 279 Continued From page 10
physical therapy (PT).

The facility failed to develop interventions other than PT for the functional ADL care plan for R2. On 5/21/09, findings were confirmed with E2.

2. Cross-refer to F315
Review of R12's clinical record revealed that the facility lacked a system/procedure to ensure that assessments were completed to evaluate the pattern of this resident's incontinent episodes and failed to evaluate the resident's ability to tolerate a toileting plan.

R12 was assessed as fully continent of bladder from 10/08 through 12/08. R12's annual MDS assessment dated 12/8/08 indicated that this resident was continent of bladder (coded 0). Three months later, her quarterly MDS assessment dated 3/10/09, indicated her bladder control declined to frequently incontinent (coded 3). The facility failed to identify this decline in bladder continence, failed to evaluate and care plan accordingly.

R12's ADL record for 01/09, indicated that she started to experience some bladder incontinent episodes on the 11-7 AM shift (12 times out of 31 days). In 2/09 her ADL record showed an increased in episodes of bladder incontinence with 26 times on the 11-7 AM shift and 6 times on the 3-11 PM shift. The 3/09, 4/09 and 5/09 ADL records showed that R12 became totally incontinent of bladder daily on all three shifts.

Review of R12's clinical record revealed that despite this continued decline in bladder continence, the facility failed to evaluate the

F 279

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

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 C 05/27/2009
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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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(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 279	Continued From page 11 pattern of this resident's incontinent episodes and the resident's ability to tolerate a toileting plan in a timely manner. Consequently, the facility failed to developed a care plan to address and/or implemented appropriate continent management interventions.	F 279	F281 1. Resident #R19 no longer resides at the center. Current residents MAR's have been audited to determine compliance with transcription. 2. In-servicing shall be held by the NPE for licensed staff on or before July 7, 2009 on transcription of medication orders. 3. MAR audits for transcription of orders shall be completed at the rate of 5 per week over the next 90 days to determine compliance. This shall be the responsibility of the DON/designee.	7-7-09
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of medication standards, and interview, it was determined that the facility failed to meet professional standards of quality for 1 resident (R19) out of 21 sampled. The facility failed to ensure the correct transcription of a physician order for Roxanol (Morphine) onto the medication administration record, they failed to ensure the discontinuance of medication orders for Xanax and Seroquel (antipsychotic) when new orders were written, and they failed to ensure clarification with the physician when an incomplete order was written for Xanax (for anxiety). The incomplete Xanax order was subsequently transcribed onto the MAR. Additionally, there were physician orders that lacked a date and time. Findings include: According to the www.guideline.gov "medication management guideline", risk reduction strategies for physician orders included, "... 2. Orders are dated and timed as written. 3. Orders include full name of medication, dose, route of	F 281	4. The DON shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.	

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

PRINTED: 05/27/2009
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 C 05/27/2009
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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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(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
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F 281 Continued From page 12

administration, time(s) of administration, related diagnoses/indications for use, and duration... 8. Nurse... will note all illegible, incomplete or otherwise questionable orders and immediately seek clarification from the prescriber before transcribing or dispensing the medication orders...". Risk reduction strategies for the transcription of medication orders included, "... 1a. Second nurse/authorized transcriber reviews the order transcription by verifying that the information in the MAR/TAR is the same as the order..."

1a. Review of R19's physician orders (po), dated 3/20/09, included Roxanol (Morphine) every 8 hours around the clock (ATC) and to continue with the previously written prn (as needed) order. The ATC order was transcribed correctly onto the 3/09 medication administration record (MAR), however, it was not carried over to the 4/09 MAR. Instead, the ATC Roxanol was documented in the preprinted prn Roxanol order with times handwritten in to administer the medication every 8 hours. The facility failed to follow the professional standard to transcribe orders exactly as written.

1b. On 3/22/09, R19 had a po for Xanax every 6 hours prn for anxiety. On 3/23/09, a po was written to change the Xanax to every 8 hours prn anxiety. The facility failed to discontinue the 3/22/09 order for Xanax every 6 hours on the MAR when the order was changed to every 8 hours on 3/23/09, so both orders were on the 3/09 MAR.

1c. R19 had an undated and untimed telephone po written for Seroquel at 8 AM and 5 PM daily (dated 4/3/09 on the MAR). On 4/4/09, a po was

F 281

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

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 C 05/27/2009
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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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(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
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F 281 Continued From page 13
 written to increase the Seroquel to 3 times per day. The facility failed to discontinue the 4/3/09 Seroquel order when the dose was changed on 4/4/09, so both orders were on the 4/09 MAR.
 1d. On 4/4/09, a po was written for "Xanax 0.25 mg prn." Although the order lacked frequency or how often the medication could be given, nursing transcribed the order as written, onto the 4/09 MAR. The facility failed to clarify the order and check the frequency with the prescribing physician.

F 281

F 309 483.25 QUALITY OF CARE
 =D
 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309

This REQUIREMENT is not met as evidenced by:
 Based on observation, record review and interview it was determined that the facility failed to ensure that three residents (R4, R15 and R17) out of 21 sampled, received care and services as per their plan of care. The facility failed to follow the plan of care for a two (2) person assist during transfers for R15 and R17, resulting in falls with injury. The facility failed to offload R4's heels per physician's orders. Findings include:

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

PRINTED: 05/27/2009
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 C 05/27/2009
--	--	--	---

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
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F 309 Continued From page 14

1. R15 was admitted to the facility on 2/13/08 and had diagnoses which included osteoporosis, a history of falls, strokes, and a right leg tibia fracture.

R15's care plan, dated 3/13/08 and entitled, "Potential for falls R/T (related to) fall risk score of 11" (10 or greater=High Risk) included the intervention, "Assist of 2 staff for all transfers."

Review of R15's nurse's notes, dated 10/4/08 and timed 12 PM stated, "Resident was using the bathroom... helping her off the toilet her knees gave way... lowered... to the floor..." A second nurse's note, dated 10/4/08 and timed 6:20 PM stated, "... complained that her L (left) leg was in pain... MD was aware & ordered her to go to the ER for follow-up."

The left tibia-fibula x-ray report, dated 10/4/08, stated that it was uncertain as to whether the trauma was new or old.

During an interview with E2 (DON) and E23 (CNA) on 5/27/09, the facility's incident Report, dated 10/4/08, was reviewed. E2 confirmed that R15 had been transferred alone by E23 when a two person transfer should have been done. E23 stated that she did not know the care plan listed R15 as a two person assist.

2. R17 was admitted to the facility on 8/5/04 and had diagnoses which included stroke with right sided weakness, aphasia (impairment of speech), hypertension, coronary artery disease and was not ambulatory. R17's quarterly Minimum Data Set (MDS) assessment, dated 4/10/09, identified that the resident required extensive assistance

F 309

F309

1. Resident #R4 remains in the center and continues to have heels floated when in bed. Resident's #R15 and R17 remain in the center and R#15 has been assessed as needing a total lift and R17 has been assessed as needing a gait belt transfer. All three residents have been reviewed by the ICP team and their plans of care have been up dated to reflect their current status. Current residents have had new lift assessment completed to ensure the proper lift is used. New residents have a lift assessment completed upon admission. Current and new residents at risk for skin breakdown on their heels shall have appropriate pressure reduction.

2. Nursing staff shall be in-serviced by the NPE on or before July 7, 2009 on floating of heels, and center no lift program. Licensed nurses shall be in-serviced by the NPE on completion of lift assessments on or before July 7, 2009.

3. Rounds shall be completed at the rate of 5 per week over the next 90 days to determine compliance with floating of heels and proper lift usage. This shall be the responsibility of the DON/designee.

4. The DON shall report to the administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

7-7-09

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

PRINTED: 06/22/2009
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 C 05/27/2009
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HILLSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH BROOM STREET WILMINGTON, DE 19805
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(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 309 Continued From page 15
from facility staff for transfers during the seven (7) day look back period. A care plan, revised on 2/12/09 and entitled, "Resident has potential for falls..." included the intervention, "Make sure 2 assist for transfers to prevent injury."

A nurse's note, dated 4/4/09 and timed 9:00 PM, stated that R17 had a fall while transferring from her wheelchair to bed and did not have any visible injuries at this time. A nurse's note, dated 4/5/09 and timed 7 AM to 3 PM shift, stated that R17 complained of back pain and that her left hand appeared swollen. The physician was notified and X-rays of the left hand and lumbar and thoracic spine were ordered. The X-rays were obtained on 4/5/09 and revealed that there were no fractures.

Review of the facility's "Patient Fall Investigation Form," dated 4/8/09, revealed that E25 (CNA) had transferred R17 from the wheelchair to bed by herself, at which time R17 lost her balance and fell on her buttocks. The facility failed to follow R17's plan of care for a two (2) person assist during transfer resulting in the resident's fall.

During an interview with E2 (DON) on 5/26/09 at 1:45 PM, E2 confirmed that E25 transferred the resident by herself and failed to follow the resident's plan of care.

3. R4 was admitted to the facility on 3/7/07 and had diagnoses that included rheumatoid arthritis, osteoarthritis, degenerative joint disease and congestive heart failure.

R4's annual MDS assessment, dated 2/23/09, identified that the resident required extensive assistance of two (2) persons for bed mobility and that she did not ambulate. The 2/23/09 Resident

F 309

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

PRINTED: 05/27/2009
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 C 05/27/2009
--	--	--	---

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 309	<p>Continued From page 16</p> <p>Assessment Protocol Summary (RAPS) triggered R4 as being at risk for the development of pressure ulcers. Review of R4's 5/09 monthly physician order sheet revealed an order, "Offload heels at all times."</p> <p>Observations on 5/20/09, 5/21/09 and 5/26/09 revealed that R4's heels were not offloaded while in bed and were in direct contact with the mattress. The facility failed to offload R4's heels at all times as per physician's orders.</p> <p>Findings were reviewed with E2 (DON) on 5/26/09 at 1:45 PM. E2 later informed the surveyor that additional pillows had been obtained to aide in the offloading of R4's heels.</p>	F 309		
F 315 =G	<p>483.25(d) URINARY INCONTINENCE</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility policy and procedures, it was determined that the facility failed to ensure that one (1) resident (R12) out of 21 sampled, who was incontinent of bladder received appropriate treatment and services to restore or improve normal bladder function to the extent possible.</p>	F 315		

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

PRINTED: 06/22/2009
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 C 05/27/2009
--	--	--	---

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 315 Continued From page 17

The facility failed to re-assess R12's continence status when she had a decline, failed to have a procedure and a system in place to ensure that appropriate interventions were developed, implemented and monitored. As a result, R12's continence status declined from continent to totally incontinent in a 3 month time period. Findings include:

The facility's policy entitled "Continence Management" was reviewed.

R12 had diagnoses that included chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure (CHF), depression, bipolar disorder, Stage III (moderate) chronic kidney disease, and overactive bladder. R12's prescribed medications included 2 mg of Detrol (for overactive bladder) LA (long acting) capsule, Lisinopril 2.5 mg. and Lasix (diuretic) 40 mg tablet daily for hypertension/CHF.

According to R12's quarterly Minimum Data Set (MDS) assessment dated 9/10/2008 and annual MDS assessment dated 12/8/2008, R12's cognitive skills for daily decision making were "independent-decisions consistent/reasonable" and she had no short or long term memory problem. R12 had unsteady gait, shortness of breath and used the wheelchair as her primary mode of locomotion. She was able to transfer independently to/from bed and wheelchair and on/off the toilet. R12 was continent/complete control of bladder (Coded 0).

A quarterly MDS assessment dated 3/10/2009 indicated R12's bladder control had declined from continent daily (code 0) to "frequently incontinent (code 3) - of bladder, tended to be incontinent

F 315

F315

1. Resident #R12 remains in the center and has been reassessed for urinary incontinence, the ICP team has reviewed the resident's plan of care and changes have been made to reflect the resident's current continence and toileting program. The resident has an individualized toileting program in place. Audits of residents with urinary incontinence has been completed to determine no other residents have been affected. 2-7-09
2. In-servicing shall be completed by the NPE for the nursing staff on or before July 7, 2009 on Urinary incontinence assessment, and development of individualized toileting programs.
3. Audits shall be completed biweekly for the next 90 days to determine any residents with a change in incontinent status. Residents shall be monitored for changes in condition requiring assessment. This shall be the responsibility of the DON/designee.
4. The DON shall report to the QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

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

PRINTED: 06/22/2009
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 C 05/27/2009
--	--	--	---

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 315 Continued From page 18

daily, but some control present." In addition, R12 was assessed to have a short term memory problem.

Review of R12's CNA (Certified Nurse's Aide) "Activity of Daily Living Flow Record (ADL)" for 10/08, 11/08 and 12/08 indicated that R12 was fully continent of bladder daily. Her ADL record for 01/09, indicated that she started to experience some bladder incontinent episodes on the 11-7 AM shift (12 out of 31 days). The 2/09 ADL record showed increased episodes of bladder incontinence, with 26 episodes on the 11-7 AM shift and 6 on the 3-11 PM shift. The 3/09, 4/09 and 5/09 ADL record showed that R12 was totally incontinent of bladder daily on all three (3) shifts.

The facility initiated a care plan on 7/21/08, last revised on 3/11/09, for "Verbal aggression...yelling at staff/residents" which included the intervention, "Assess and manage unmet needs such as pain...toileting..." An interview with E15 (CNA) on 5/27/09 revealed that R12 refused to be toileted, and yelled at staff.

Review of the clinical record revealed that the facility lacked a system/procedure to ensure that assessments to evaluate R12's incontinent episodes and ability to tolerate a toileting plan were implemented in a timely manner. In addition, the facility failed to develop a care plan to address R12's incontinence and failed to implement appropriate continent management protocols and interventions.

This finding was confirmed by E2 (DON), E4 (Staff development) and E22 (LPN) on 5/21/09 at approximately 10:15 AM.

F 315

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 C 05/27/2009
--	--	--	---

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 315 Continued From page 19

F 315

Additionally, in an interview with E24 (Nurse Practitioner) on 5/21/09 at approximately 1:00 PM, E24 stated that she had not been informed of R12's increasing incontinence. E24 stated the resident went on hospice care on 1/21/09 for her diagnosis of congestive heart failure/oxygen treatment and had come off hospice on 4/14/09. She also stated that R12 had, "complaints of pain and had drug and attention seeking behavior." Clinically the medications are not making her incontinent. R12 was taking Detrol LA for her overactive bladder and that she can be maintained with a toileting schedule. The administration of the Lasix can be timed to minimize impact of incontinence" and "the need to diurese". Additionally, according to the result of a Renal consult by a nephrologist, dated 12/29/08, her "Chronic Kidney disease stage III" was stable.

Subsequently, on 5/26/09, as per E8 (LPN), the facility started to re-assess R12's continence status to evaluate her pattern of incontinent episodes and to attempt to restore her bladder function. E8 stated that she needed and can be coached and encouraged.

F 328 483.25(k) SPECIAL NEEDS
SS=G

F 328

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

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

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 C 05/27/2009
--	--	--	---

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 328 Continued From page 20

F 328

This REQUIREMENT is not met as evidenced by:
Based on closed record review and interview, it was determined that the facility failed to ensure that one (1) resident (R18) out of 21 sampled, received proper treatment and care for enteral fluids. The facility failed to have a system in place to ensure that R18 received a sufficient amount of fluids based on her individual needs to prevent dehydration. R18 experienced symptoms of an elevated temperature that ranged from 100.1 to 101.7 for 6 days and was given Tylenol to lower the temperature. At the request of a family member, R18 was admitted to the hospital for treatment and evaluation due to a change in mental status. R18 was found to have an elevated BUN (nitrogenous end product of metabolism) of 208 (normal range is 8-22 mg/DL) and an elevated creatinine (measures kidney function) of 3.4 (normal range is 0.5-1.0 mg/DL). R18 was diagnosed with Pre-renal azotemia (most common form of acute renal failure) requiring intravenous fluid after which her BUN and creatinine returned to normal. In addition, she was also diagnosed with UTI (urinary tract infection)/fungemia (fungus in the blood) and was treated with antibiotics. Findings include:

R18 was admitted to the facility from the hospital on 1/26/09 with diagnoses of hemorrhagic cerebral-vascular accident, hypertension and GI (gastrointestinal) bleed. According to the "Nursing Assessment/Admission" dated 1/26/09, R18 was admitted at 4:30 PM. She was alert, had paralysis of the left arm/left leg and had a PEG (percutaneous endoscopic gastrostomy)

F328

1. Resident #18 no longer resides at the center. Current residents receiving tube feedings have been assessed by the dietician and are receiving adequate fluids per physician's orders. Residents receiving enteral feedings are assessed by nursing staff to ensure adequate hydration with administration of feedings. The physician shall be notified with any change in the resident's status.
2. In-servicing for licensed nursing staff shall be completed by the Nurse Practice Educator on or before July 7, 2009 on Enteral Protocol and Hydration.
3. Weekly audit by the dietician shall be completed to determine compliance over the next 90 days.
4. The dietician shall report to the administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

7-7-09

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

PRINTED: 05/27/2009
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 C 05/27/2009
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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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(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
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F 328 Continued From page 21 F 328

tube. R18's cognition was severely impaired, she was incontinent of bladder and was totally dependent on staff for activities of daily living (ADL).

The facility initiated a care plan dated 1/27/09 for "Resident exhibits or is at risk for dehydration as evidenced by medications (diuretics), tube feeding". The interventions included "Monitor for signs/symptoms of dehydration (increased temp, decrease output, mental status change)...H2O flushes as ordered, Dietitian to evaluate estimated fluid needs, tube feeding as ordered". Another care plan was initiated on 1/27/09 on "Resident is at risk for UTI due to urinary incontinence." The interventions included "Tube feeding as ordered with H2O (water) flushes" and "Observe for s/s of UTI such as ...or increase in temperature."

Review of R18's clinical record revealed the following:
A "Physician Order Sheet and Interim Plan of Care" dated 1/26/09 and timed 7:00 PM had 5 medications that included the antihypertensive/diuretic HCTZ (hydrochlorothiazide) 12.5 mg. and antacid reflux Nexium 40 mg. Also included was an order for "TF (tube feeding)- Promote with fiber 240 mls. 5 x/day". There was no documented evidence that this was started or given. This "Physician Order Sheet and Interim Plan of Care dated 1/26/09, was signed by E27 (Medical Director/attending physician) on 1/27/09. A second physician's order was received on 1/26/09 (at an unknown time) which stated to "Change Promote with fiber to Jevity 1.5 with fiber. Infuse at 70 cc/hr. 100 mls H2O (water) flushes every 4 hrs. This change in TF orders failed to note over how long a time

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

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 C 05/27/2009
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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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(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
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F 328 Continued From page 22
period it was to run in 24 hours and it was noted on 1/27/09 (no time documented). The "Enteral Protocol" sheet was signed by E27 (Medical Director/attending physician) on 1/27/09. A nurse's note dated 1/26/09 and timed 11:00 PM stated, "Jevity 1.5 at 70 cc/hr with 100 ml flushes every 4 hours initiated, however this to be clarified including MD in attendance". This order was transcribed on the 1/09 MAR as "Jevity 1.5, 70 ml/hr x 24 hrs? (Subject to clarification on 1/27/09)." Also transcribed was "Flush tube with 100 ml water every 4 hours."

Another "Enteral Protocol" sheet was initiated and signed by E27 on 1/27/09. The physician's order stated, "Jevity 1.5 with fiber via pump" at a rate of "70 ml/hour". The order included "Flush tube with 150 ml of water every 4 hours"; "Flush tube with 30 ml of water before and after each medication pass"; "Flush tube with 5-10 ml of water between each medication". This was also written on the printed Physician Order Sheet (POS). The 11-7 AM shift nurse had initialed on 1/27/09 that the chart was checked to see that the order was properly transcribed. However, the dated hours of delivery per day and the total nutrient to be administered was again missing. Included in the POS under the "Enteral Protocol" order was "Record Amount Consumed 25-50-75-100% in ML".

On the 1/09 MAR, the tube feeding nutrient order on 1/27/09 remained as it was previously written and without the hours of delivery. No documented clarification was obtained. In addition the water flushes remained as 100 ml water q 4 hours" on the 1/09 MAR instead of "150 ml of water every 4 hours" as ordered.

F 328

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

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 C 05/27/2009
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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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(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 328 Continued From page 23

The 1/26/09 MAR, failed to indicate the time the tube feeding, including the prescribed flushes, were initiated and/or administered. The 1/27/09 and 1/28/09 MAR indicated that the Jevity 1.5 was infused on the 7-3 PM shift, but there was no specific time indicated that the nutrient should be delivered. Additionally, nursing staff continued to sign off for the 100 cc water flushes every 4 hours on 1/27/09 and 1/28/09 (1200cc) instead of 150 cc (1800 cc) as ordered. The enteral protocol order "Flush tube with 30 ml of water before and after each medication pass" and "Flush tube with 5-10 ml of water between each medication" failed to be transcribed onto this MAR and therefore, there was no evidence they were even given. In addition, on 1/28/09, there was no documentation that the chart had been checked by the 11-7 AM shift nursing staff member to see that the order was properly transcribed.

E28's (Registered Dietitian) Nutritional Assessment dated 1/27/09 estimated R18's fluid needs as 1732 cc./day. E28 recommended to the attending physician to change the TF to 55 cc/hr x 20 hrs. (836 cc free water daily) with flushes of 150 cc every 4 hours to meet her daily free water requirement with an "effective date: 1/28/09 12:32". This change was entered onto the "Enteral Protocol" sheet, dated 1/28/09 as "Jevity 1.5 cal via PEG pump at 55 mls per hour. Hours per day 20, Down time 10 AM-2 PM...Flush 150 ml of water every 4 hours. Total volume of flush 900 ml/24 hrs (excluding medication flushes). Total volume of nutrient + flush = 2000 ml/24 hrs. Flush tube with 50 ml of water before and after each medication pass" and "Flush tube with 5 ml of water between each medication." This "Enteral Protocol" sheet was signed by a nursing staff member on 1/29/09 at 3:00 AM, however,

F 328

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

PRINTED: 06/22/2009
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 C 05/27/2009
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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
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F 328 Continued From page 24
there was no physician's signature obtained.

Subsequently, the new tube feeding orders were transcribed onto the 01/09 and 02/09 MAR. On the 01/09 MAR, the new enteral feeding of Jevity 1.5 cal at 55 cc/hr x 20 hrs, total of 1100cc nutrient/24 hrs was initiated on 1/29/09 at 2:00 PM with a downtime at 10:00 AM. The MAR dated 1/30/09 failed to indicate the time the tube feeding nutrient was started and when it was held for the downtime. The MAR on 1/29/09 and 1/30/09 failed to indicate that the 150 cc every 4 hours water flushes were done consistently (6 flushes/900cc were missed) as recommended. In addition, the water flushes between medication pass and water flushes between each medication was not carried over to the 1/09 MAR from 1/28/09 through 1/31/09. It failed to indicate that the 50 cc water flushes between each medication pass in the 2 shifts for 4 days (800cc) were done (excluding flushes between each medication).

In an interview with E28 on 5/26/09, she stated that she was "not sure" how to ascertain that this resident did in fact receive the volume ordered.

R18's Physician Order Form (POS) dated 2/01/09 included the order "Record Amount Consumed 25-50-75-100% in ML (cc)".

Review of the nurse's notes from 1/26/09 through 2/8/09 lacked documentation of tube feedings and water flushes consumed per shift. The CNA ADL Flow Record did not indicate number/amount of saturation of bladder incontinent episodes from 1/26/09 through 2/8/09. Although the facility had a policy and procedure on "Intake and Output", an interview with E2 (DON) on 5/26/09 revealed that the facility did not use Intake and Output sheets.

F 328

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

PRINTED: 05/27/2009
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 C 05/27/2009
--	--	--	---

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 328	<p>Continued From page 25</p> <p>The facility failed to have a system in place or procedure to determine amount of tube feeding administered including flushes, number of incontinent episodes (amount of urine saturation), in order to evaluate and monitor this resident's fluid deficit/imbalance.</p> <p>R18 developed a 101.7 degrees F (Fahrenheit) temperature on 1/28/09 and was given Tylenol to lower the fever. R18 continued to have a temperature from 2/4/09 through 2/8/09, a total of 5 days, with temperatures ranging from 100.1 to 100.7 degrees F requiring administration of Tylenol. During this period, there was no indication in the nurse's note that the physician was aware and/or notified.</p> <p>A nurse's note dated 2/8/09 and timed 3:00 PM stated, "... (family member) was in at 1-1:30 PM, stated that (R18) appears to be having some change of mental status and wish (sic) for (R18) to be sent to the ER...felt that (R18's) condition was deteriorating...order was obtained (E27) to send resident to ER."</p> <p>Review of R18's hospital clinical record dated 2/8/09 revealed an elevated admitting BUN of 208 (normal range is 8-22 mg/DL) and an elevated creatinine of 3.4 (normal range is 0.5-1.0 mg/DL). According to the hospital's Discharge Summary dated 2/17/09, R18 was found to be in pre-renal Azotemia/acute renal failure and was treated with IV (intravenous) fluid hydration and her laboratory blood results improved upon discharge to normal. In addition, the resident was found to have a "UTI/fungemia" and was treated with antibiotics.</p> <p>R18 was discharged to another nursing home on 2/17/09.</p>
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F 328	
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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 C 05/27/2009
--	--	--	---

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
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F 363 SS=B 483.35(c) MENUS AND NUTRITIONAL ADEQUACY

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, weekly menu review and Food Committee meeting minutes, it was determined that the facility failed to follow the menu that was posted throughout the facility on two days (5/21/09 and 5/27/09) during the survey. Findings include:

Observations of daily menus posted throughout the facility on 5/21/09, revealed that "Veal Patty" was listed as an entree option for lunch. The Week 2 cycle menu was reviewed and found to list "Creamed Chipped Beef" instead of veal for lunch that day. Lunch time meal observations in the third floor dining room revealed that creamed chipped beef was served and not veal. During an interview with E11 (Dietary Director), on 5/22/09, he stated that the Activities Department posts the menu and they did not receive the change in the entree item.

Review of Food Committee meeting minutes, dated 1/4/09 and 2/15/09, revealed that residents requested that all veal be removed from facility menus and be replaced with creamed chipped beef.

Observations of daily menus posted throughout

F 363

F363

1. Menus are posted daily to reflect the current meals being served. Menus were changed at the request of Resident Council and the wrong menu was posted on the day in question. The residents did receive the "Creamed Chipped Beef" as they had requested. 7-7-09

2. The FSD or designee shall be responsible for posting the accurate daily menus.

3. The FSD/designee shall complete audits at the rate of 3 per week over the next 90 days to review the menu prior to posting to insure accuracy.

4. The FSD shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.

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

PRINTED: 06/22/2009
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 C 05/27/2009
--	--	--	---

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 363 Continued From page 27
the facility on 5/27/09, revealed that "Veal Parmesan" was listed as an entree option for dinner, however, the Week 3 cycle menu listed "Creamed Chipped Beef" instead of veal for dinner that day. In an interview with E19 (Activities Director) on 5/27/09, E19 stated that the Activities Department posted the daily menus throughout the facility and that the menus were provided by the Dietary Department. E19 stated that she had not been given updated menus.

F 363

F 364 483.35(d)(1)-(2) FOOD
SS=D

F 364

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

F364

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and document review, it was determined that the facility failed to serve food that was palatable and at acceptable temperatures for one resident, (R4) of 21 sampled. Findings include:

1. Resident #R 4 remains in the center and is receiving her meal trays in the appropriate time to maintain adequate temperatures. Rounds have been completed to determine timely tray passes. No other issues were identified
2. Regional FSD and center FSD shall in-service nursing staff on timely passing of meal trays on or before July 7, 2009.
3. Audits shall be completed by the FSD at the rate of 3 per week over the next 90 days to determine compliance with tray pass.
4. The FSD shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

7-7-09

During an interview with R4 on 5/21/09, she stated that the hot cereal that is served at breakfast is not as warm as she would liked. R4 stated that staff served the meals beginning at the opposite end of her hall so that by the time she receives her tray, the food cooled down since she is the last to be served on the hall.

Breakfast tray service was observed on 5/22/09 on the fourth floor. R4 was served her meal at 7:45 AM, 29 minutes after it had arrived on the unit. The oatmeal was immediately removed

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 C 05/27/2009
--	--	--	---

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 364	Continued From page 28 from the tray by the surveyor who checked the temperature and tasted it. The oatmeal temperature was found to be 121 degrees F and tasted lukewarm and was determined to be unpalatable. A log that recorded the time that the meal cart was delivered to the fourth floor was reviewed and revealed that the cart arrived at 7:16 AM. The facility failed to serve R4's breakfast tray in timely manner causing the food to cool down.	F 364	F371	
F 371 SS=F	483.35(i) SANITARY CONDITIONS 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 conditions This REQUIREMENT is not met as evidenced by: Based on observations with E11 (Dietary Director) in the kitchen on 5/20/09 and in the dining room on 5/20/09 and 5/21/09, it was determined that the facility failed to protect food during preparation, storage and distribution. Findings include: 1. Observations were made during lunch service in the third floor dining room on 5/20/09 and 5/21/09. On 5/20/09, at 12:05 PM, E21 (Dietary Aide) was observed serving salad with a gloved hand. After	F 371	1. No negative resident outcome reported as a result of this deficient practice. 2. The FSD and Regional FSD will in-service staff on use of gloves and hand washing, pot and pan washing and drying; and storage of spice containers on or before July 7, 2009. The FSD/designee shall schedule preventive maintenance on the juice machine; machine was serviced on 5/28/09. 3. Audits shall be completed weekly on the above items to determine compliance over the next 90 days. 4. The FSD shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.	7-7-09

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 C 05/27/2009
--	--	--	---

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 371 Continued From page 29
handling the salad, E21 was observed opening the refrigerator with the same gloved hand, then going back to continue serving salad without changing her gloves.

On 5/21/09, at 12:10 PM, E21 was observed serving rolls with a gloved hand and then opening drawers and the food warmer with the same gloved hand. E21 then went back to handling rolls without changing gloves.

2. Observations at 8:25 AM of the ready-to-use rack revealed three (3) stacks of steam table pans were dripping wet. On 5/26/09 at 1:13 PM, an interview with E11 at 1:13 PM confirmed that additional racks were to be ordered to facilitate air drying.

3. Observations at 8:25 AM of the ready-to-use rack revealed that a stack of two steam table pans were soiled with white sticky debris.

4. Observations on 5/20/09 at 8:38 AM revealed that the juice machine was dripping and causing a splash. An interview with E11 on 5/20/09 at 8:40 AM confirmed that the juice machine was to be scheduled for repair on 5/20/09. This observation was repeated on 5/26/09 at 7:00 AM.

5. Observations at 8:50 AM of sixteen (16) spice containers stored on a wall shelf revealed that the lids of two (2) containers were open to splash and dust.

F 371

F 445 483.65(c) INFECTION CONTROL - LINENS
SS=D
Personnel must handle, store, process, and

F 445

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 C 05/27/2009
--	--	--	---

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 445	<p>Continued From page 30</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tours and review of the facility's linen handling policy, it was determined that the facility failed to store soiled linens to prevent the spread of infection. Findings include:</p> <p>Observations on 5/20/09 at 9:38 AM of resident room #412 revealed that two (2) wash cloths were stored on the restroom floor. Additionally, observations on 5/21/09 at 2:15 PM revealed that a wash cloth and towel were stored on the restroom floor of resident room #208. Review of the facility's Linen Handling Policy revealed that soiled linen should be placed directly in a covered container at the location where it is used.</p>	F 445	<p>F445</p> <ol style="list-style-type: none"> Item identified has been corrected. Rounds were completed to determine that this incident no longer occurs. In-servicing shall be completed by the NPE for facility staff on handling of linens on or before July 7, 2009. Random rounds shall be completed 3 times per week over the next 90 days to determine compliance; this shall be the responsibility of the Housekeeping Director/designee. The Housekeeping Director shall report to the Administrator and QA committee monthly any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance. 	7-7-09
F 514 SS=E	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 514		

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 C 05/27/2009
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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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(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 514 Continued From page 31

Based on observation, record review and interview it was determined that the facility failed to ensure that four (4) out of 21 sampled residents' (R2, R6, R14 and R17) clinical records were maintained in accordance with accepted professional standards and practices that were complete and accurately documented. Findings include:

1. R17's quarterly Minimum Data Set (MDS) assessments, dated 10/3/08, 1/5/09 and 4/10/09, revealed that the resident was incontinent of bowel and bladder. Review of R17's Activity of Daily Living Flow records from 10/1/08 through 5/21/09 also indicated that the resident was incontinent. Nurse's notes, dated from 1/16/09 through 5/8/09 inaccurately documented that this resident was continent of bowel and bladder.

In an interview with E29 (CNA) on 5/26/09 at 1:15 PM, E29 stated that she has cared for R17 since her admission to the facility and that R17 will at times be continent of bowel, however she has never been continent of bladder, despite attempts to toilet her. Interview with E2 (Director of Nursing) on 5/26/09 at 1:45 PM, confirmed that the nurse's notes contained inaccurate information regarding R17's continence status.

2. R14 had a physician's order, dated 4/2/09, to discontinue the use of a bed alarm due to R14's refusal to have the alarm. During an interview on 5/27/09, R14 stated that she refused the alarm because the noise upset her. Observations made during the survey confirmed that there was no bed alarm on the bed.

Review of the Activity of Daily Living Flow Records for 4/09 and 5/09 revealed that staff

F 514

F514

1. Resident # SSR 28 and R6 no longer resides in the center. Resident R2, R14, and R17 remain in the center. Resident # 2 no longer has a pressure ulcer, R17's documentation has been reviewed and has corrected documentation related to the resident's incontinent status, and R14's documentation has been corrected by removing the resident's bed alarm from the ADL flow record. Clinical records have been reviewed to determine compliance.
2. In-servicing shall be completed by the NPE on or before July 7, 2009 for licensed and non licensed nursing staff on documentation.
3. Daily audits shall be completed for the next 90 day of clinical records to determine compliance. This shall be responsibility of the DON/designee.
4. The DON shall report to the Administrator and QA committee any variances in the data collected. The QA committee shall assess and evaluate the data and provide recommendations to obtain and maintain compliance.

7-7-09

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 C 05/27/2009
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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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(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
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F 514 Continued From page 32
continued to document that the bed alarm placement and function were checked each shift.

On 4/2/09, the facility failed to note that the the bed alarm was discontinued on the Activity of Daily Living Flow Records and inaccurately recorded that the bed alarm was on the bed and functioning from 4/2/09 through 5/27/09. On 5/27/09, findings were confirmed with E2 (Director of Nursing).

3. On 4/24/09, R2 was admitted to the facility with a stage II pressure ulcer (PU) on the left buttocks. Measurements were noted on the Admission Nursing assessment. Review of the record revealed it lacked evidence of weekly skin integrity sheets. The 5/09 Treatment Assessment Record (TAR) stated that the PU treatments were discontinued on 5/7/09. In an interview on 5/22/09, E7 (LPN) confirmed that R2's PU was healed on 5/7/09.

The facility failed to have evidence that weekly skin integrity sheets recorded the status of the PU. On 5/21/09, the findings were confirmed with E6 (RN) and E7.

4. On 5/21/09, R6's record was reviewed and revealed that the 5/09 Treatment Administration Record (TAR) incorrectly contained the skin integrity sheet for SSR28.

The facility failed to maintain an accurate and organized clinical record for R6 and SSR28. On 5/21/09, the findings were confirmed by E6.

F 514

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM TO SNFs AND NFs	PROVIDER # 085013	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	LTC RESIDENTS PROTECTION LTC SURVEY COMPLIANCE 5/27/2009 JUL 01 2009 Director's Office
PROVIDER OR SUPPLIER WILMSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 810 SOUTH BROOM STREET WILMINGTON, DE		

DEFICIENCY ID	SUMMARY STATEMENT OF DEFICIENCIES
170	<p>483.10(i)(1) MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on group and staff interviews, it was determined that the facility violated a resident's right of privacy in written communication. Findings include:</p> <p>A group interview conducted on 5/21/09 at 10:30 AM revealed that SSR23 had received opened mail. An interview with E12 (Social Services) on 5/21/09 at 2:20 PM confirmed that the business or activity office may have opened SSR23's mail. On 5/26/09 at 8:50 AM, E13 (Business Manager) confirmed that the business office had opened the mail containing SSR23's bills.</p>

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 for the above isolated deficiencies pose no actual harm to the residents.



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STATE SURVEY REPORT

LTC Residents Protection
JUL 0 1 2009
Director's Office

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced annual and complaint visit was conducted at this facility from May 20, 2009 through May 27, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The census on the first day of the survey was ninety-nine (99). The survey sample totaled 21 residents (R1 through R21), which included 17 active and four (4) closed records. An additional 12 sub-sampled residents (SSR22 through SSR33) were included for observations and interviews.

- 3201 Skilled and Intermediate Care Nursing Facilities
- 3201.6.0 Services To Residents
- 3201.6.1 General Services
- 3201.6.1.1

The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and

Provider's Signature David J. [Signature] HHA Title Administrator Date 6-26-09



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>psychosocial needs.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 5/27/09, F157, F246, F253, F281, F309, F315, F328, F364, and F445.</p>	<p>Refer To: F 157, F246, F 253, F281, F 309, F 315, F 328, F 364, F 445. 7-7-09</p>
3201.6.5	Nursing Administration	
3201.6.5.6	<p>A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.</p> <p>This requirement is not met as evidenced by:</p>	
3201.6.5.7	<p>Cross-refer to CMS 2567-L, survey date completed 5/27/09, F279 examples #1a and #1b.</p> <p>The assessment and care plan for each</p>	<p>Refer To: F279 examples #1a and #1b. 7-7-09</p>



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AND SOCIAL SERVICES**

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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.7.0 3201.7.5 3201.7.5.1	<p>resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 5/27/09, F279 example #2.</p> <p>Plant, Equipment and Physical Environment Kitchen and Food Storage Areas Facilities shall comply with the Delaware Food Code.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on dietary observations during the survey, it was determined that the facility failed to comply with the following sections: 3-304.15 (A), 3-305.11 (A) (2), 4-501.11 (A), 4-601.11 (B), and 4-903.11 (B) (1) of the State of Delaware Food Code. Findings include:</p>	<p>Refer to: F279 example #2.</p> <p style="text-align: right;">7-7-09</p>

David J. [unclear] 1-7609



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F371.</p> <p>3-302.15 Gloves, Use Limitation.</p> <p>(A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F371 example #1</p> <p>3-305.11 Food Storage.</p> <p>(A) Except as specified in 11 (B) and (C) of this section, Food shall be protected from contamination by storing the Food:</p> <p>(2) Where it is not exposed to splash, dust, or other contamination.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F371 example #5.</p>	<p>Refer to: F371. 7-7-09</p> <p>Refer to: F371 example #1. 7-7-09</p> <p>Refer to: F371 example #5. 7-7-09</p>

Dina Hume 4-26-09



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>4-501.11 Good Repair and Proper Adjustment.</p> <p>(A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F371 example #4.</p> <p>4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.*</p> <p>(B) The Food-Contact Surfaces of cooking Equipment and the pans shall be kept free of encrusted grease deposits and other soil accumulations.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F371 example #3.</p> <p>4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.</p> <p>(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section</p>	<p>Refer to: F371 example #4. 7-7-09</p> <p>Refer to: F371 example #3. 7-7-09</p>

R. J. Lumberton 6-2-6-09



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AND SOCIAL SERVICES**

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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>and shall be stored:</p> <p>(1) In a self-draining position that allows air drying.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F371 example #2.</p> <p>Records and Reports</p> <p>There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the following:</p> <p>Nursing notes, which shall be recorded by each person providing professional nursing services to the resident, indicating date, time, scope of service provided and signature of the provider of the service. Nursing notes shall include care issues, nursing observations, resident change of status and other significant events.</p> <p>Cross refer to CMS 2567-L survey date completed 5/27/09, F514 example #1.</p>	<p>Refer To: F371 example #2. 7-7-09</p> <p>Refer to: F514 example #1. 7-7-09</p> <p><i>D. J. ...</i></p>



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.10.1.15	<p>CNA flow sheets.</p> <p>Cross refer to CMS 2567-L survey date completed 5/27/09, F514 example #2.</p>	<p>Refer to: F514 example #2 7-7-09</p>
3201.10.8	<p>Reportable incidents are as follows:</p>	<p>3201 10 8 42</p>
3201.10.8.4	<p>Significant injuries.</p>	
3201.10.8.4.2	<p>Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 48 hours.</p> <p>This requirement is not met as evidenced by:</p> <p>R16 had an accident with injuries on 4/28/09. Review of the incident report, dated 4/29/09, revealed that R16 was found on the floor with a cut and bleeding tongue and was sent to the emergency room for treatment of her injuries. There was no evidence that an incident report was sent to the Division of Long Term Care. Findings were confirmed by the Director of Nursing on 5/27/09.</p>	<p>1. Resident R 16 remains in the center. Current incident reports are reviewed by the Director of Nursing to determine needs for reporting. All reportable incidents are being reported within set timeframe of regulations.</p> <p>2. Licensed nursing staff shall be in-serviced on or before 7/7/09 on incident and accident reporting.</p> <p>3. Weekly audits of center incident reports will be completed over the next 90 days to determine compliance. This is the responsibility of the Director of Nursing or designee.</p> <p>4. Results of the audits will be reported monthly to the QI meeting for compliance</p>
16 Del. C.	<p>Patient's rights.</p>	



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NAME OF FACILITY: Hillside Center

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
Chapter 11, § 1121	<p>It is the intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:</p> <p>(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F241 examples #1 and #2.</p> <p>(11) Every patient and resident may associate and communicate privately and without restriction with persons and groups of the patient's own choice (on the patient's or</p>	<p>Refer to: F241 examples #1 and #2. 7-7-09</p> <p><i>David I. Lemire 6-26-09</i></p>



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del. C., Chapter 11, § 1141	<p>resident's own or their initiative) at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F170.</p> <p>(14) Every patient and resident has the right of privacy in the patient's or resident's own room, and personnel of the facility shall respect this right by knocking on the door before entering the patient's or resident's room.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L survey date completed 5/27/09, F241 examples #3 and #4.</p> <p>Criminal background checks.</p> <p>(c) No employer who operates a nursing home or a management company or other business entity that contracts to operate a nursing home</p>	<p>Refer to: F170.</p> <p>Refer to: F241 examples #3 and #4. 7-7-09</p> <p><i>Plan, Summary 6-26-09</i></p>



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del. C., Chapter 11, § 1162	<p>may hire any applicant without obtaining a report of the person's entire criminal history record from the State Bureau of Identification and a report from DHSS regarding its review of a report of the person's entire federal criminal history pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 5/27/09, F226.</p> <p>Nursing staffing.</p> <p>(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential</p>	<p>Refer to: F226.</p> <p>7-7-09</p>

Handwritten signature
4-26-09



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STATE SURVEY REPORT

NAME OF FACILITY: Hillside Center

DATE SURVEY COMPLETED: May 27, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.</p> <p>This requirement is not met as evidenced by:</p> <p>Observations during the initial tour on 5/20/09 revealed that E26 was not wearing a nametag prominently displaying one's full name and title. Additionally, E27 was not wearing a nametag on 5/21/09.</p>	<p style="text-align: center;">7-7-09</p> <p>16 De1 C., Chapter 11, 1162</p> <ol style="list-style-type: none"> 1. The two employees identified are now in compliance. All current facility staff have name badges. 2. Inserviceing for Facility staff should occur on or before 7/7/09 on wearing name badges. 3. Monthly audits will be conducted over three months to determine compliance. The Human Resources manager or designee will conduct audits to monitor compliance. 4. The Human Resources Manager will review the results of the audit at our monthly QI meetings.