STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. Building B. Wing	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hillside LLC	810 South Broom Street Wilmington, DE 19805

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46134 Based on record review of one (R1) out three residents sampled for care plans, the facility failed to implement a care plan for R1's use of oxygen. Findings include: 10/12/23 - R1 was admitted to the facility with diagnoses including acute respiratory failure with hypoxia (not enough oxygen reaching body tissues). R1's physician's orders included oxygen at 2-3 liters continuously every shift via nasal cannula (medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels). 11/17/23 10:30 AM - A review of R1's care plans failed to show evidence of a care plan for the use of oxygen. The facility failed to implement a care plan for R1's continuous use of oxygen. Findings were reviewed with E1 (NHA), E2 (DON) E5 (Staff Educator) and E4 (Regional Clinical Consultant) on 11/17/23 at 5:00 PM.

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

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

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NAME OF PROVIDER OR SUPPLIER: Complete Care at Hillside LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 810 South Broom Street Wilmington, DE 19805	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46134 Based on interview and record review it was determined that for one (R1) out of three residents reviewed for care, the facility failed to ensure that R1 received treatment and care in accordance with professional standards of practice and physician orders. On the evening of 11/14/23 R1 had a change in condition and became unresponsive in the facility and was transported to an acute care hospital without a nursing assesment including vital signs. Findings include: A review of R1's clinical record revealed: 10/12/23 - R1 was admitted to the facility with multiple diagnoses including acute respiratory failure with hypoxia, anemia, high blood pressure, diabetes and congestive heart failure, and R1 took daily medications to address those diagnoses. 10/12/23 - A physician's order was written for low blood sugar protocol: if the resident became symptomatic and was difficult to arouse or unconscious . remain with patient., monitor vital signs, perform blood glucose, if blood glucose is above 70, notify practitioner of symptoms. If blood glucose equal to or below 70 immediately administer Glucagon (medication to raise blood sugar) . 10/12/23 - A Physician's order was written for Do Not Resuscitate (DNR). 10/16/23 - A Physician's order was written for oxygen at 2-3 L/min via nasal cannula continuously. 11/14/23 1:30 PM - A progress note was written by E8 that revealed that R1's vital signs assessment, including blood pressure (121/78), pulse (80), temperature (97 F), respirations (18) blood sugar (123) and pulse ox (97%) were all within normal limits. 11/15/23 12:12 AM - A progress note was written by E3 (RN Supervisor) that revealed that at about 10:30 PM on 11/14/23 a CNA reported to her that R1 was not waking up; E3 rushed to R1's room, and R1 was found unresponsive. E3 attempted to get R1's blood pressure, but the blood pressure machine signaled error for the blood pressure reading. E3 then called 911 to send R1 to the hospital. 11/17/23 3:00 PM - During an interview, E3 stated that she checked on R1 at the beginning of her 3-11 shift, when R1 was sitting in the chair, and R1 interacted verbally with E3. At 5:00 PM, E3 gave R1 her 5:00 PM oral medications. E3 stated that she next saw R1 at 9:00 PM to administer R1 her bedtime medications, but that R1 was too sleepy to take the oral medications. Later in the evening, the CNA told E3 that R1 was not waking up, E3 then tried to get R1's blood pressure but could not as the machine kept saying error. E3 stated that R1's pulse ox was low and her pulse was very weak, so E3 called 911. E3 stated that she knew R1 was a DNR, but she decided to call 911 because R1 needed help with her breathing. E3 stated that she did not utilize the facility's Emergency Cart. Observations to the three Emergency Carts in the facility revealed that each cart had the folllowing equipment to use in an emergency situations: - Oxygen delivery supplies, including a non-rebreather mask (mask used to deliver a higher concentration of oxygen) to use when a person with nasal cannula oxygen needs additional oxygen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Manual blood pressure measuring equipment to be able to obtain a blood pressure without the use of a machine. Review of facility documentation on the evening of 11/14/23 revealed the lack of assessments for blood pressure, pulse, blood sugar, temperature and lung sounds after R1 was found unresponsive. Findings were reviewed with E1 (NHA), E2 (DON) E5 (Staff Educator) and E4 (Regional Clinical Consultant) on 11/17/23 at 5:00 PM.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46134 Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for Staffing, the facility failed to provide competent nursing care that included assessments and interventions for a resident who experienced a change in respiratory condition. Findings include: A review of R1's clinical record revealed: 10/12/23 - R1 was admitted to the facility with multiple diagnoses including acute respiratory failure with hypoxia, anemia and congestive heart failure. R1 was hospitalized from 10/9/23 - 10/12/23 which included the treatment of respiratory wheezing, and R1 was started on oxygen at that time. 10/12/23 - A Physician's order was written for Do Not Resuscitate. 10/16/23 - A Physician's order was written for Oxygen at 2-3 L/min via nasal cannula continuously. 11/9/23 - A Physician's order was written for 02 sats to keep oxygen saturation greater than or equal to 92%. Every Shift. 11/14/23 1:30 PM - A progress note was written by E8 that revealed that R1's blood pressure, and breathing were within normal limits and that R1's pulse ox measured 97% with oxygen being supplied by nasal cannula (plastic tubing with prongs that are placed at the nasal openings). 11/15/23 12:12 AM - A progress note was written by E3 (RN) that revealed that at about 10:30 PM a CNA reported to her that R1 was not waking up; E3 rushed to R1's room and R1 was not responsive. E3 attempted to get R1's blood pressure, but the blood pressure machine signaled error for the blood pressure reading. E3 then called 911 to send R1 to the hospital. 11/16/23 9:10 AM - Observations were made to the Emergency Carts on the three floors of the facility. Emergency respiratory supplies (non-rebreather masks) and manual blood pressure equipment were present on every cart. 11/16/23 3:10 PM - During an interview, E3 stated that when she was assessing R1, she could not get a blood pressure using the blood pressure machine. E3 stated that she was able to feel that R1 had a weak pulse, and R1 was still breathing, so E3 called 911 for additional emergency support. E3 stated that she did not utilize the facility's Emergency Cart prior to R1 leaving the facility.When E3 was questioned about her facility orientation and the use of the facility's Emergency Cart, E3 stated that she was aware of the contents of the Emergency Cart but that her orientation did not include a hands-on practical use of the facility Emergency Cart. E3 also stated that she had two new resident admissions on her 3-11 shift on 11/14/23. E3 stated that she has been a nurse for three months. 11/17/23 - A review of the staffing schedule for 11/14/23 revealed that E3 was the only RN in the building on the 3-11 shift. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/17/23 4:00 PM - During an interview, E1 stated that the facility did not have a policy/procedure for the role of Registered Nurse Supervisor. E1 stated that during a work shift, if there are multiple RNs scheduled, that the RN with the most seniority would assume the RN Supervisor role for the building. If there was only one RN only on a shift, that RN would assume the role of RN Supervisor for the building. A review of the facility's Assessment Tool revealed: Other, 1.7 - Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs . We have daily discussions on unit-by-unit staffing . The conversation is revisited throughout the day based on planned admissions as well. E3, as the RN supervisor on the night of 11/14/23 and during R1's significant change in condition, did not receive complete training by the facility prior to E3 independently providing services to residents in her role of an RN supervisor. 11/17/23 - A review of facility documentation revealed a lack of evidence that R1 was provided any additional assessments or respiratory interventions, specifically in the form of a manual blood pressure assessment or the placement of a non-rebreather mask, which would have supplied a higher oxygen flow to support R1's respiratory comfort. 11/17/23 10:00 AM - During an interview, E5 (RN Staff Educator) stated that the facility's nursing orientation process does not include a hands-on practical review of the facility's emergency cart and the use of the equipment that the cart contains. Findings were reviewed with E1 (NHA), E2 (DON) E5 (Staff Educator) and E4 (Regional Clinical Consultant).