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	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hillside LLC	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interview, it was determined that for one (R103) out of three residents reviewed for dignity, the facility failed to ensure that R103 was treated with dignity when staff did not wake the resident or obtain resident's permission before attempting to provide incontinence care. Findings include: Review of R103's clinical record revealed:8/19/25 - R103 was admitted to the facility with diagnoses including orthostatic hypotension and heart failure.8/25/25 - R103's admission MDS documented a BIMS score of 15, indicating an intact cognition. 8/26/25 - A facility incident report documented, [R103] reported that four days ago [8/22/25] a male aide came into his room and assaulted him by pulling down his underwear. [R103] then said it wasn't his underwear but it was his pants. [R103] unclear [sic] with this allegation and stated that he has been foggy since admitted from [hospital], medications have taken over his mind. [sic] The CNA who cared for [R103] that day was [E16, CNA] .8/26/25 - A follow up facility incident report documented, .[R103] said he was woken up by [E16] was [sic] trying to pull my underwear down to get them off .[R103] denied being touched inappropriately. [R103] said he didn't want [E16] to take care of him again. [R103] did not want the police called and wasn't fearful .8/29/25 - A facility incident report documented, Statement from [E16] .[E16] adamantly denied this allegation, stating that he did take care of [R103] but did not pull down his underwear or assault him .9/15/25 1:47 PM - Correspondence submitted by E2 (DON) to the State Agency documented, .[E16] was educated as to [sic] customer service explaining why you have entered the room and if you want check the patients for incontinence to let them know that .1/29/26 1:45 PM - During an interview, R103 stated, .I was asleep and felt tugging at my hip. [E16] said that I had to take my underwear off. [E16] did not touch me sexually or anything but he didn't announce himself and he didn't knock on the door .1/29/26 2:11 PM - During an interview, E2 stated, No follow up training was given to [E16] after the incident. [E16] only works every other weekend. When [E16] returned the resident was already discharged from the facility.1/30/26 2:30 PM - Findings were reviewed with E1, E2, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, it was determined that for three (second floor, third floor and fourth floor) of three shower rooms, the facility failed to ensure that adequate housekeeping and maintenance services were provided to maintain a clean, sanitary, and home-like environment. Additionally, the hallway carpet on all the units, and the floors of multiple residents' rooms were visibly soiled. Lastly, the facility also failed to ensure that resident care equipment was maintained in good repair and sanitary condition. Findings included: 1. 1/21/26 11:11 AM – During a tour of the second floor, the shower room was observed with cracked tiles, standing water on the floor, discolored walls and water dripping from the shower head. The handwashing sink was inaccessible due to multiple equipment including wheelchairs and mechanical lifts in the room. An area between the wall and the window was observed with a large amount black debris. During an interview, E13 (CNA) stated, A heater used to be there. But it was removed a while ago. The Surveyor asked E13 about access to the handwashing sink. E13 stated, We are not able to get to the sink because there is too much stuff in the way. 1/21/26 11:30 AM – During a tour of the third and fourth floor shower rooms, the floors were also observed with broken tiles, dripping shower heads and discolored walls. The handwashing sinks were also inaccessible because of the wheelchairs, and other equipment present. During an interview, the Surveyor asked E6 (CNA) about access to the handwashing sink. E6 stated, It's not easy to wash hands in there because of all of the stuff in the way. 1/21/26 12:00 PM - During a tour of all three units, hallway carpet and multiple residents' rooms were observed with visibly soiled areas. During an interview, C4 (ESD) stated, There was no schedule for carpet cleaning. We are getting schedules to deep clean the rooms and carpeted areas. 1/22/26 1:30 PM - During a tour of the three units, the hallway carpet and resident rooms continued to be visibly soiled. 1/22/26 1:45 PM - During a tour of the shower rooms on all three units, the rooms continued to be observed with clutter. 1/23/26 3:00 PM - During a tour of the three units, the hallway carpet and resident rooms continued to be visibly soiled. 1/23/26 3:15 PM - During a tour of the shower rooms on all three units, the rooms continued to be observed with clutter. 1/23/26 3:15 PM - Findings were confirmed with E1, E2, and E13. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference. 2. 1/27/26 10:42 AM - A plastic cushion, with five to six surface openings exposing the underlying permeable foam, was observed laying on a shower bed located in the fourth floor shower room. 1/28/26 1:33 PM - During an interview, E27 stated, That cushion has been like that for a while. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/29/26 9:15 AM - During an interview, E13 (Nurse Educator/IP) confirmed the openings on the shower bed cushion. The surveyor asked E13 how the shower bed cushion can be disinfected if the plastic is torn and has openings. E13 stated, I will have it removed. 1/30/26 9:00 AM - Finding was reviewed with E1 (NHA).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that for three (R55, R98 and R105) reviewed for care plans, the facility failed to provide care that meets the professional standards of care. For R55 and R105, an LPN completed R55's and R105's admission assessments in violation of the State Board of Nursing Scope of Practice. For R98, there was no evidence of an RN providing discharge education. Additionally, for R105, there was no evidence that an RN completed post fall assessments and documentation. Delaware State Board of Nursing – RN, LPN and NA/UAP Duties 2024. admission Assessments * - RN. * = Once a care plan is established, the LPN may do assessments. Post Fall Assessment & Documentation ^ - RN .^ = RN must do initial fall assessment; LPN can do subsequent assessments. Discharge Process (RN must do initial teaching) **. ** = LPN can reinforce discharge teaching/plan. RN must do all initial assessments. Review of R55's clinical record revealed: 11/22/25 – R55 was admitted to the facility. 11/22/25 – E15 (LPN) completed the Nursing Admission/ Readmission/Annual/Sig Change Assessment in R55's EMR (electronic medical record). 11/22/25 – E15 completed R55's Lift/Transfer/Reposition evaluation, AIMS assessment, PHQ9 evaluation and bedrail evaluation in R55's EMR. An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R55. 2. Review of R98's clinical record revealed: 11/11/25 – R98 was admitted to the facility. 11/19/25 – R98 was discharged from the facility. 1/26/26 10:32 AM – A review of R98's Discharge Plan Documentation revealed E17 (Social Work Assistant) and E18 (nursing clerical assistant) documented all aspects of R98's discharge to home plan. The facility lacked evidence of any licensed personnel reviewing R98's Discharge Plan documentation. 1/27/26 9:57 AM – A review of R98's EMR progress notes revealed no evidence that an RN provided discharge education prior to R98's discharge. E19 (Social worker) documented in R98's EMR progress notes, Pt (patient) is discharging per choice. He was informed that he can and should stay and he declined. He was educated on the risks of not completing rehab. 1/28/26 2:10 PM – During an interview, E18 stated, I sign at the bottom of the discharge plan because I am the one printing it out. The nurses should write a note about the discharge and the education given. The resident/family gets a copy, we (the facility) keep a signed copy that goes in the paper chart and I mail a copy to the PCP (primary care provider). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility lacked evidence that an RN provided R98 any discharge education. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference. 3. Review of R105's clinical record revealed: 6/27/25 - R105 was admitted to the facility with diagnoses including breast cancer and dementia. 6/27/25 7:15 PM - E24 (LPN) completed a Nursing Admission/Readmission/Annual/Significant Change Assessment form in R105's EMR. 6/27/25 7:15 PM - E24 entered a System Note in R105's clinical record documenting that an admission nursing assessment was completed. 7/8/25 10:45 AM - A facility fall incident report documented, .[R105] found lying on her side in front of her wheelchair .Immediate Action Taken: Neurocheck in effect. Assessment done. Lump noted on left side of [R105's] head .Person Preparing Report: [E23, LPN] . 7/8/25 - A facility document titled, Neurological Evaluation Flow Sheet noted that E23 completed an initial neurological assessment for R105 at 10:45 AM. 1/29/26 11:32 AM - During an interview, E21 (Corporate Educator) stated, The nurse who is assigned to the resident will do the post fall assessment and any other assessment prompted by entering a change in condition note [in the EMR]. 1/29/26 12:00 PM - Review of a facility staffing document dated 7/8/25 noted that E23 was assigned to R105 at the time the fall occurred. 1/29/26 12:15 PM - During an interview, E23 stated, I don't remember the resident but if I was assigned to a resident that fell and hit their head, I would do a full body assessment and the neuro checks for the shift. 1/29/26 1:00 PM - Review of R105's EMR lacked evidence that an RN completed R105's admission assessment or post fall assessment. 1/30/26 9:00 AM - Finding was reviewed with E1 (NHA). 1/30/26 2:30 PM - Findings were reviewed with E1, E2 (DON), E13 (Nurse Educator/IP) and E21.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, it was determined that for one (R99) out of two residents reviewed for activities of daily living, the facility failed to ensure the dependent resident received his scheduled bathing/showers. Findings include: Review of R99's clinical record revealed: 8/19/25 - R99 was admitted to the facility. 8/19/25 - R99 was care planned for ADL self-care performance deficit related to a stroke. An intervention was that R99 was totally dependent on staff to provide bath/shower. 8/21/25 - R99 was care planned that it was . important that he has the opportunity to engage in daily routines that are meaningful and relative to his preferences. An intervention for R99 was .very important for [R99's name] to choose how he [was] bathed. He prefers a shower or bed bath. Review of R99's Documentation Survey Reports from 8/19/25 through 9/4/25 revealed that he was scheduled to be showered or bathed every Wednesday and Saturday evening shift and as needed. Out of five scheduled shower/bathing opportunities documented, R99 received bathing two times and refused bathing one time. Review of R99's progress notes lacked evidence of the reason for no bathing provided on 8/30/25 and 9/3/25. 1/30/26 11:50 AM - E13 (NE/IP) confirmed the finding. 1/30/26 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (NE/IP), E20 (ADON) and E21 (CE).