STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSIDE CENTER	**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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, review of the CDC (Centers for Disease Control) and the Centers for Medicare and Medicaid Services (CMS) COVID-19 guidelines, and facility policies, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to follow CDC and CMS guidelines for COVID-19 precautions to isolate R3 who was symptomatic with COVID-19 from R4, an asymptomatic resident. R3 had symptoms on 4/10/2020 including a fever of 102.6 F, [MEDICAL CONDITION] and a decreased oxygen saturation level and the facility failed to isolate and separate R3 from her roommate, R4 who was asymptomatic. The facility also failed to follow COVID-19 precautions to isolate a symptomatic resident (R1) away from an asymptomatic resident (R2), as they were in a shared room. R1 had a new onset of vomiting on 4/30/2020 and the facility failed to isolate and separate R1 from his roommate, R2 who was asymptomatic. Lastly, the facility's Cohorting Policy, dated 4/25/2020, was inconsistent with the 4/2/2020 CDC Guideline for cohorting. Findings include: 3/27/2020 - The facility's COVID-19 policy included: In addition to Standard Precautions, Contact and Droplet Precautions will be implemented for patients suspected or confirmed to have COVID-19 based on the Centers for Disease Control (CDC) guidance. Follow local public health and state regulations when applicable. This policy refers to a document called Special Circumstance COVID-19 Outbreak Intervention Tiers for confirmed patients or employees with COVID-19 which included to: Ensure patient has been placed in a private room with the door closed .Care for these patients with dedicated healthcare personnel (cohort staff) to minimize the risk of transmission and exposure to other patients and other health care workers, as much as able. 4/2/2020 - CMS and the CDC issued COVID-19 Long-Term Care Facility Guidance that included: Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status. When possible, facilities should exercise consistent assignment, or have separate staffing teams for COVID-19-positive and COVID-19-negative patients. 4/25/2020 - The facility's policy titled Cohorting Policy, stated, .Whenever a suspected COVID resident is tested , any roommate(s) should be also tested simultaneously, even if asymptomatic. This will allow for more effective cohorting based on results. Cohorting Strategy NOTE: All room changes related to coronavirus must be done in consultation with the CQS (Clinical Quality Specialist), who is responsible for ensuring that (Name of the Organization) cohorting policies are followed. Step 1 - First Positive Results When a patient's test returns positive, the patient must immediately be separated from COVID negative or untested roommate(s) per prior guidance . This policy was in conflict with the 4/2/2020 CDC Guideline, which indicated that long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status. In addition, the facility policy failed to include separating and isolating symptomatic residents from asymptomatic residents. 1. Review of R3's clinical records and the facility's Line Listing revealed the following: 10/9/2009 - R3 was admitted to the facility with [DIAGNOSES REDACTED]. 4/10/2020 8:00 AM - The COVID-19 Screen documented a new onset of fever at 102.6 F, [MEDICAL CONDITION] 132 beats per minute with irregular beats, and an oxygen saturation of 94% (normal range 95%-100%) on room air, which was a saturation decrease by 3% since the last saturation result. 4/10/2020 - The facility's Data Collection Line Listing for Respiratory Outbreak documented R3's onset of symptoms was on 4/10/2020 with a fever of 102.6 F, decreased oxygen saturation by 3%, and a heart rate greater than 100 beats per minute. In addition, droplet and contract precautions were indicated. There was lack of evidence that the facility isolated R3, after the above symptoms on 4/10/2020 and R3 continued to reside with R4 in the same room, despite that R4 was asymptomatic for COVID-19. 4/11/2020 - R3's specimen for COVID-19 testing was obtained. 4/12/2020 - The laboratory results documented that R3 was positive for COVID-19. Although R3 was confirmed positive for COVID-19, there was lack of evidence that R3 was separated from R4, her roommate. 4/12/2020 through 4/23/2020- Multiple Progress Notes by various disciplines, including medical practitioners, nurses, and Social Service staff documented that R3 was provided ongoing medical care and services, including [MEDICATION NAME] (a medication to prevent or treat [DIAGNOSES REDACTED]) and a Z pack (antibiotic), however, R3's condition worsened. 4/24/2020 12:30 PM - A Progress Note by E1 (NHA) documented that the decision was made by R3's Power of Attorney, FM2, to change R3's code status from a Full Code to a Do Not Resuscitate (DNR) and to discontinue the treatment with [MEDICATION NAME] and Z Pack. The plan was to arrange for hospice care. 4/25/2020 1:54 PM - A Progress Note by E10 (LPN) documented an assessment by a hospice nurse and medication orders were obtained. 4/26/2020 5:07 PM - A Progress Note by E11 (RN) documented that R3 was found unresponsive without a pulse, respirations, or a heartbeat. R3 was pronounced dead at 4:45 PM. 5/4/2020 1:45 PM - An interview with E1 (NHA) and E2 (DON) revealed that R3's symptoms were consistent with COVID-19 on 4/10/2020, the facility implemented droplet and contact precautions and isolation by pulling the privacy curtain between R3 and R4. E1 and E2 confirmed that R3 and R4 remained in the same room, although R4 was asymptomatic for COVID-19 on 4/10/2020 and R3 was confirmed COVID-19 positive on 4/12/2020. E1 and E2 stated their understanding was that there was no need to isolate and separate R3 from R4 as there was a privacy curtain between them and the door was kept closed since R3 initially presented with symptoms on 4/10/2020. 2. Review of R4's clinical records and the facility's Line Listing revealed the following: 5/30/2013 - R4 was admitted to the facility with [DIAGNOSES REDACTED]. 4/10/2020 through 4/11/2020 - Multiple progress notes by various nurses revealed that R4 was asymptomatic for COVID-19. Despite the fact R4's roommate, R3 had multiple symptoms consistent with COVID-19 on 4/10/2020, R4, who was asymptomatic continued to be in the same room as R3. 4/12/2020 - The facility's Data Collection Line Listing for Respiratory Outbreak documented on 4/12/2020 that R4 had an onset of fever, which was 99.6 F and a decreased oxygen saturation by 3% and that droplet and contract precautions were indicated. 4/19/2020 12:26 PM - The COVID-19 Screen documented a new onset of [MEDICAL CONDITION] a heart rate of 113 per minute, oxygen saturation of 83% on room air and worsening confusion. 4/19/2020 - R4's COVID-19 test sample was obtained. 4/20/2020 - R4's COVID-19 test result confirmed that R4 was positive for COVID-19. 4/19/2020 through 4/21/2020 - Multiple Progress Notes by various disciplines, including medical practitioners, nurses, and Social Service staff documented that R4's condition worsened as the facility provided ongoing monitoring and care and services. 4/21/2020 - an order for [REDACTED]. 3. Review of R1's clinical records and the facility's Line Listing revealed the following: 5/16/2019 - R1 was admitted to the facility with [DIAGNOSES REDACTED]. 4/29/2020 - A Progress Note by E5 (Nurse Practitioner-NP) documented that R1 offered complaints of gastrointestinal reflux, was belching upon assessment and denied vomiting or diarrhea. R1 was ordered to start a medication to treat GERD. 4/30/2020 00:43 AM - The COVID-19 Screen completed by E9 (LPN) documented that R1 had a new indicator of gastrointestinal symptoms (vomiting). 4/30/2020 10:08 AM - A Progress Note by E6 (LPN) documented that R1's specimen for COVID-19 testing was obtained. 4/30/2020 12:14 PM - A Progress Note by E2 (DON) documented, Resident was tested for COVID-19 this morning secondary to triggering on his assessment for vomiting. Swab sent to lab. 4/30/2020 - The facility's Data Collection Line Listing for Respiratory Outbreak documented that R1 had a new onset of vomiting on 4/30/2020 and droplet and contact precautions were implemented. There was lack of evidence that the facility isolated R1, after R1 had a symptom consistent with COVID-19 and pending COVID-19 testing results. 4/30/2020 2:45 PM - A joint

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) observation with E2 (DON), on the 4th Floor Nursing Unit revealed that R1 was in a semi-private room with the door closed and had signage for droplet and contact precautions posted on the door. During an interview, E2 revealed that R1 was symptomatic with one episode of vomiting on 4/30/2020, thus, isolation was implemented, COVID-19 testing was obtained and the facility was awaiting results. E2 stated that R1's roommate, R2, was asymptomatic for COVID-19, however, R2 was also being tested for COVID-19. E2 stated that R1 was evaluated by E5 (NP) earlier today for an episode of vomiting, assessed it [MEDICAL CONDITION] treatment was ordered. 4/30/2020 3:45 PM - An interview with E7 (LPN), who was assigned to R1 and R2 during the day shift on 4/30/2020, revealed that both residents were on isolation with droplet and contact precautions. E7 verbalized that R1 had no further episodes of vomiting during day shift on 4/30/2020. E7 stated that R2 was asymptomatic for COVID-19. 4/30/2020 4:30 PM - A meeting was conducted with E1 (NHA), E2 (DON), E3 (ADON), and E4 (NPE). The surveyor advised, after consultation with her supervisor, DHCQ1, that the facility must separate and isolate R1, who was symptomatic with vomiting earlier today. E1 refused to move R1 and stated that she would be contacting her corporate leadership. 4/30/2020 4:47 PM - E1 (NHA) stated to the surveyor that the facility will move R2 to an empty semi-private room. 4/30/2020 6:30 PM - A joint observation with E2 (DON) revealed that R2 remained in the empty semi-private room and no longer had a roommate. 5/3/2020 5:35 PM - The laboratory results documented that R1 was negative for COVID-19. 4. Review of R2's clinical records and the facility's Line Listing revealed the following: 6/16/2019 - R2 was admitted to the facility with [DIAGNOSES REDACTED]. 4/30/2020 - The facility's Data Collection Line Listing for Respiratory Outbreak documented that R2 was R1's roommate and R2 lacked symptoms consistent with COVID-19, however, R2 was on droplet and contact precautions and the results of R2's COVID-19 test were pending. There was lack of evidence that the facility separated R2 from R1, when the facility identified R1's vomiting as a symptom consistent with COVID-19 and was awaiting results of the COVID-19 testing. 4/30/2020 10:22 AM - A Progress Note by E2 (DON) documented that R2's FM1 was contacted about R2's COVID-19 testing. E2 informed FM1 that R2's roommate, R1, triggered on his COVID-19 assessment, thus, the facility was also testing R2. FM1 requested that R2 be moved out of the current room into another room. The note documented that E2 educated FM1 on the cohorting and exposure, however, FM1 stated that she was not comfortable with this. The plan was to have E8 (MD) call FM1 to provide her additional education regarding the COVID-19 virus. 4/30/2020 12:10 PM - A subsequent Progress Note by E2 (DON) documented that E8 (MD) spoke with FM1 per E2's (DON) request, to give FM1 an update on the COVID-19 guidelines. 4/30/2020 5:12 PM - A Progress Note by E1 (NHA) documented that R2's emergency contact (FM1) was notified that R2's room was changed. 4/30/2020 6:30 PM - A joint observation with E2 (DON) revealed that R2 was relocated to an empty semi-private room, where R2 was isolated with droplet and contact precautions. 5/3/2020 5:35 PM - The laboratory results documented that R2 was negative for COVID-19. 5/7/2020 2:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference. The surveyor advised E1 that the Division of Health Care Quality was advising the facility to revise the policy titled Cohorting Policy, dated 4-25-2020, to be consistent with the CDC COVID-19 Guideline. The revised policy was forwarded to the Division as requested.