

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

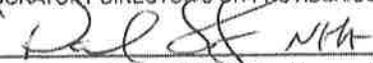
PRINTED: 04/29/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GILPIN HALL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 GILPIN AVENUE WILMINGTON, DE 19806</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>Revised Report following IDR request. Text changes made to F253, F329 and F428. No change to scope and severity.</p> <p>An unannounced annual recertification survey was conducted at this facility from March 7, 2016 through March 14, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 91. The Stage 2 survey sample size was 23.</p> <p>Abbreviations/definitions used in this 2567 are as follows:          NHA - Nursing Home Administrator;          DON - Director of Nursing;          ADON - Assistant Director of Nursing;          CNA - Certified Nurse's Aide;          EMR - Electronic Medical Record;          FSD - Food Service Director;          FMD - Facility Maintenance Director;          LPN - Licensed Practical Nurse;          MAR - Medication Administration Record;          MDS- Minimum Data Set (standardized assessment forms used in nursing homes);          POS - Physician Order Sheet;          PU - Pressure Ulcer/Sore - sore area of skin that develops when the blood supply to it is cut off due to pressure;          RN - Registered Nurse;          RNAC - Registered Nurse Assessment Coordinator;          TAR- Treatment Administration Record;          ALT- (alanine aminotransferase); measures amount of this enzyme found mainly in liver;</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X8) DATE <b>5/4/16</b>
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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 000	Continued From page 1 BP (Blood pressure) - the measure of the force of the blood against the walls of a blood vessel; BMP - set of eight tests that measure blood sugar and calcium levels, kidney function, and chemical and fluid balance; Blanchable - skin loses redness with pressure; cm-centimeter-unit of length; Divalproex - medication used to treat seizures, manic episodes related to bipolar disorder/manic depression and migraines; Erythema - a diffuse redness of the skin; Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed; Hyperlipidemia- high cholesterol &/or triglycerides (fat proteins) associated with increased risk for heart disease & stroke; Hypokalemia - low potassium; Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own; LFT's- liver function tests; enzyme testing to check liver function; Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non weight bearing assistance; Lipid profile or panel- blood tests for cholesterol & triglycerides (fat proteins); Locomotion - how a resident moves between locations; Milliequivalent/ meq - one thousandth of a chemical equivalent; Necrotic - dead; non-viable tissue; Nitro-Bid ointment - works by relaxing (widening) blood vessels allowing blood to flow more easily. This reduces the heart's workload and the amount of oxygen needed by the heart;	F 000			

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F 000	Continued From page 2 Non-blanchable - skin does not lose redness with pressure; Potassium Chloride ER (extended release) - medication used to prevent or to treat low blood levels of potassium (hypokalemia); Sacrum/sacral - large triangular bone at the base of the spine; Serum-filled blister - filled with clear fluid; Skin prep - a liquid film-forming dressing that, upon application to intact skin, forms a protective film; Sliding scale with insulin coverage - A dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher. Each sliding scale needs to be tailored to the individual, as each patient has unique circumstances and different insulin requirements; Slough - yellow, tan, gray, green or brown dead tissue; Supervision - oversight, encouragement or cueing; <- less than; >- greater than.	F 000			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/7/16 and 3/8/16 during Stage 1 review and during the environmental tour with E10 (FMD) and E11	F 253			

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F 253	<p>Continued From page 3</p> <p>(Head of Housekeeping) on 3/9/16 between 1:30 PM and 2:15 PM , it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 10 (204, 239, 247, 225, 256, 304, 305, 348, 356, 358) out of 31 rooms surveyed. Findings include:</p> <p>The following observations were made during Stage 1 review on 3/7/16 and 3/8/16 and during the environmental tour on 3/9/16:</p> <p>Room 204</p> <ul style="list-style-type: none"> <li>- Ceiling light inside bedroom door was out;</li> <li>- Rubber pads around edge of bathroom door torn;</li> <li>- Window curtains were torn.</li> </ul> <p>Room 239</p> <ul style="list-style-type: none"> <li>- Pink basin with the resident's name written on it was stored on floor;</li> <li>- A clear plastic urinal was stored on the bathroom floor next to drawer cart;</li> <li>- Sink back molding was separating;</li> <li>- Tiles in bathroom above toilet stained and bulging.</li> </ul> <p>Room 247</p> <ul style="list-style-type: none"> <li>- Privacy curtain facing inside room stained.</li> </ul> <p>Room 255</p> <ul style="list-style-type: none"> <li>- Stained ceiling tiles in bathroom;</li> <li>- Pink basin stored on floor under the sink.</li> </ul> <p>Room 256</p> <ul style="list-style-type: none"> <li>- Three (3) stained ceiling tiles above the window in the left side of the room;</li> <li>- One (1) stained ceiling tile to the left of the window in the corner;</li> </ul>	F 253	<p>1.1 Ceiling lights, rubber pads on bathroom doors, tom curtains, ceiling tiles, privacy curtains, door latches, scraped walls, door latches, screen doors, toilet tank lid, leaking spigot, lower screen clips, and sink drain were all repaired prior to the end of the survey. Pink basins and urinal were removed from floor prior to the end of survey. Privacy curtain was cleaned prior to the end of the survey. Nebulizer was covered and oxygen concentrator was cleaned prior to the end of the survey. Floors, walls, and debris were cleaned prior to the end of the survey. (Completed work orders attached.)</p> <p>1.2 Wall repairs were completed 5/3/16 and sink back molding was repaired 4/27/16 after the completion of the survey once appropriate parts were received. (Completed work orders attached.)</p> <p>2.1 Ceiling lights, rubber pads on bathroom doors, tom curtains, ceiling tiles, privacy curtains, door latches, scraped walls, door latches, screen doors, toilet tank lid, leaking spigot, lower screen clips, and sink drain were all repaired prior to the end of the survey. Pink basins and urinal were removed from floor prior to end of survey. Privacy curtain was cleaned prior to the end of the survey. Nebulizer was covered and oxygen concentrator was cleaned prior to the end of the survey. Floors, walls, and debris were cleaned prior to the end of the survey. (Completed work orders attached.)</p> <p>2.2 Wall repairs and sink back molding were repaired after the completion of the survey once appropriate parts were received. (Completed work orders attached.)</p> <p>3. Housekeeping and Maintenance staff will be in-serviced by Housekeeping Supervisor on all referenced findings in resident rooms and instructed to report like observations. Facility Manager or designee will inspect 5 rooms per day using the "F253 Housekeeping and Maintenance Checklist" (attachment # 1), until correction process is complete, then incorporate referenced items into Monthly Environmental Checklist. (continued on next page)</p>	5/3/16	

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F 253	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- Scraped wall on right side of bed;</li> <li>- Entry door not latching when shut;</li> <li>- Screen door with loud slamming noise when released.</li> </ul> <p>Room 304</p> <ul style="list-style-type: none"> <li>- Observed nebulizer on bed side table with attached tubing and face mask sitting on top of it uncovered. E9 (LPN) confirmed the mask was uncovered on 3/7/16 at 10:20 AM;</li> <li>- Rubber pads around edge of bathroom door torn.</li> </ul> <p>Room 305</p> <ul style="list-style-type: none"> <li>- Toilet water tank lid at top had long crack;</li> <li>- Rubber pads around edge of bathroom door torn;</li> <li>- Floors in bedroom, especially corners of the room were dirty and debris present;</li> <li>- Walls in bedroom by recliner were dirty;</li> <li>- Oxygen concentrator was dirty.</li> </ul> <p>Room 348</p> <ul style="list-style-type: none"> <li>- Water leaks out of cold water spigot when hot or cold water was turned on.</li> </ul> <p>Room 356</p> <ul style="list-style-type: none"> <li>- Lower section of screen on screen door is askew with missing clip on one side.</li> </ul> <p>Room 358</p> <ul style="list-style-type: none"> <li>- Bathroom sink is slow draining.</li> </ul> <p>All findings were reviewed and confirmed with E10 and E11 on 3/9/16 between 1:30 PM and 2:15 PM during the stage 2 environmental tour.</p> <p>All findings were reviewed with E1 (NHA) and E2 (DON) on 3/14/16 at approximately 4:15 PM.</p>	F 253	<p>(F253 continued)</p> <p>4. Facility Manager or designee will inspect 5 rooms per day using "F253 Housekeeping and Maintenance Checklist" form until 3 consecutive days are 100% compliant. Thereafter, Facility Manager or designee will inspect 5 rooms per week until 3 weeks are 100% complaint. Once 3 weeks are 100% complaint, the monitoring will conclude. Result of the inspections will be reported to QAPI.</p>

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F 272 SS=D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:            Identification and demographic information;            Customary routine;            Cognitive patterns;            Communication;            Vision;            Mood and behavior patterns;            Psychosocial well-being;            Physical functioning and structural problems;            Continence;            Disease diagnosis and health conditions;            Dental and nutritional status;            Skin conditions;            Activity pursuit;            Medications;            Special treatments and procedures;            Discharge potential;            Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and            Documentation of participation in assessment.</p>	F 272	<p>1.1 MDS for R58 for Section G0110 (E) and (F) regarding locomotion on the unit and off the unit, will be corrected to reflect actual condition.</p> <p>1.2 MDS for R72 for Section M has been modified regarding skin condition to reflect actual condition.</p> <p>2.1 RNAC will review the current MDS for all residents Section G0110 (E) and F for accuracy in coding for locomotion.</p> <p>2.2 RNAC will review the current MDS for all residents with pressure ulcers to check for accuracy in coding. RNAC will review the current MDS for all residents Section M for accuracy in coding.</p> <p>3.1 RNACs will be in-serviced by DON or designee regarding proper coding for Section G0110 (E) and (F) of the MDS in accordance with the RAI manual. Additionally, RNAC will review prior MDS for Section G0110 (E) and (F) (locomotion) to ensure consistency. RNAC will consult RAI manual to address any discrepancies.</p> <p>3.2 RNACs will be in-serviced by DON or designee regarding proper coding for Section M of the MDS in accordance with the RAI manual. Additionally, RNAC will review prior MDS for Section M for skin conditions to ensure consistency. RNAC will consult RAI manual to address any discrepancies.</p> <p>4.1 A sampling of 5 MDS section G0110 (E) and (F) will be reviewed by DON or designee to monitor coding accuracy until 3 consecutive weeks show 100% compliance with coding. Thereafter, DON or designee will review a sampling of 5 MDS section G0110 (E) and (F) monthly until 3 consecutive months show 100% compliance. When 3 consecutive months are 100% complaint, monitoring will conclude. Results of the monitoring will reported to the QAPI team.</p> <p>4.2 A sampling of 5 MDS section Section M will be reviewed by DON or designee to monitor coding accuracy until 3 consecutive weeks show 100% compliance with coding. Thereafter, DON or designee will review a sampling of 5 MDS section Section M monthly until 3 consecutive months show 100% compliance. When 3 consecutive months are 100% complaint, monitoring will conclude. Results of the monitoring will reported to the QAPI team.</p>	5/3/2016	

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F 272	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record reviews and interviews, it was determined that the facility failed to comprehensively and/or accurately assess two (R58 and R72) out of 23 Stage 2 sampled residents. The facility failed to accurately assess R58's functional status in the area of locomotion and they failed to accurately assess R72 in the area of pressure ulcer. Findings include:</p> <p>1. A nurse's note, dated 2/3/16 and timed 4 PM, stated that R72 had a pin-point size of dark eschar present on his left heel.</p> <p>The 2/6/16 annual MDS assessment stated that R72 had no unhealed pressure ulcers.</p> <p>The facility failed to accurately assess the presence of R72's left heel pressure ulcer on the 2/6/16 annual MDS assessment.</p> <p>Findings were reviewed with E5 (RNAC) on 3/14/16 at 11:55 AM.</p> <p>2. The Documentation Survey Report, completed by CNAs, included R58's functional status for locomotion on and off the unit. The report was reviewed for the look back period of 1/10/16 through 1/16/16 for R58's Annual MDS assessment, dated 1/16/16. This report revealed the following for that timeframe:</p> <ul style="list-style-type: none"> <li>- R58 required supervision with set up help for locomotion on the unit;</li> <li>- R58 required limited assistance with one person physical assist for locomotion off the unit.</li> </ul> <p>R58's annual MDS, dated 1/16/16, was</p>	F 272		

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F 272	Continued From page 7 incorrectly coded as it stated the activity did not occur for both locomotion on and off the unit.	F 272		
F 314 SS=E	On 3/14/16 at 1 PM, in an interview, E4 (RNAC) confirmed the findings. <b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b>  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews, it was determined that for two (R21 and R72) out of 23 Stage 2 sampled residents the facility failed to ensure a resident with a pressure ulcer/sore (PU) received the treatment and services to promote healing. For R21, the facility failed to complete weekly skin assessments on two (2) occasions and failed to comprehensively assess the PU on four (4) occasions. For R72, the facility failed to comprehensively assess his left heel PU according to current clinical practice guidelines by failing to stage the PU from 11/15/15 through 3/3/16, a total of 17 times. In addition, the facility failed to notify the physician four times when R72's left heel worsened. Additionally, the facility's policy entitled "Wound Management", last revised on 2/16/16, failed to	F 314		

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F 314	<p>Continued From page 8</p> <p>Identify the six (6) stages of pressure ulcer classification according to current clinical practice guidelines. Findings include:</p> <p>The International NPUAP/EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Pressure Ulcer Classification System identifies the following six (6) categories/stages:</p> <ul style="list-style-type: none"> <li>- Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence; area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.</li> <li>- Stage II: presents as a shallow open ulcer with a red pink wound bed, without slough; may also present as an intact or open/ruptured serum-filled blister; presents as a shiny or dry shallow ulcer without slough or bruising (bruising indicates suspected deep tissue injury/sDTI).</li> <li>- Stage III: full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle are not exposed; slough may be present but does not obscure the depth of tissue loss.</li> <li>- Stage IV: full thickness tissue loss with exposed bone, tendon or muscle; slough or eschar may be present.</li> <li>- Unstageable: full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.</li> <li>- sDTI: purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear; area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.</li> </ul> <p>The facility policy entitled, "Skin Assessment and</p>	F 314	<p>1.1 The previous wound assessment for R21 can not be changed or modified. A current wound assessment has been completed for R21 by the wound nurse to include staging, a description of the surrounding tissue and an assessment for pain.</p> <p>1.2 The wound assessment was completed by the wound physician and wound nurse on 3/16/16 for R72's left heel. Wound physician states, "small dark area on bottom of heel- looks like Deep Tissue Injury but not in pressure area - very small - etiology not entirely clear." Therefore, the wound was not staged, because it was determined not to be a pressure ulcer.</p> <p>2.1 The most recent wound assessments for all current residents with pressure ulcers will be reviewed by DON or designee to check for the presence of staging, descriptions of surrounding tissue and assessments for pain at the wound site.</p> <p>2.2 The most recent wound assessments for all current residents with pressure ulcers will be reviewed by DON or designee to check for the presence of staging, descriptions of surrounding tissue and assessments for pain at the wound site.</p> <p>3.1 The Wound Management Procedure, (attachment #2) has been updated to reflect all 6 stages of pressure wounds and process for notification to physician. Nurses will be in-serviced by DON or designee on changes to Wound Management Procedure. Skin Assessment Competency forms (attachment #3) will be completed by Staff Development Director or designee for nurses who conduct skin assessments to ensure thorough and accurate assessment.</p> <p>3.2 The Wound Management Procedure, (attachment #2) has been updated to reflect all 6 stages of pressure wounds and process for notification to physician. Nurses will be in-serviced by DON or designee on changes to Wound Management Procedure. Skin Assessment Competency forms (attachment #3) will be completed by Staff Development Director or designee for nurses who conduct skin assessments to ensure thorough and accurate assessment.</p> <p>(Continued on next page)</p>	5/3/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GILPIN HALL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 GILPIN AVENUE WILMINGTON, DE 19806</b>		
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F 314	<p>Continued From page 9</p> <p>Wound Prevention," last revised 10/18/15, stated "...Actual Wounds:... 1. If a resident is found with a wound, it will be documented in the resident record. 2. A wound assessment will be completed weekly in the progress notes for pressure wounds or ulcers. 3. The wound assessments will describe the wound until it is healed. 4. The charge nurse will continue to check the resident's skin weekly using the Weekly Skin Assessment Tool. Notification: 1. New wounds will be reported to the resident's physician or wound physician and family or responsible party..."</p> <p>1. Review of the EMR for R21 revealed the following:</p> <p>12/29/15 timed 1:57 PM - nurse's progress note states, "...Redness noted to the sacral area...". The facility failed to complete the following:</p> <ul style="list-style-type: none"> <li>- differentiating whether the skin redness was blanchable or non-blanchable;</li> <li>- measurements of the reddened area;</li> <li>- no assessment for pain;</li> <li>- no assessment of skin temperature or any changes to surrounding tissue;</li> <li>- no staging or identification that this was a PU.</li> </ul> <p>12/29/15 timed 2:45 PM - nurse's progress note states, "A blister was noted on the resident's sacral area. MD made aware...". The facility failed to complete the following:</p> <ul style="list-style-type: none"> <li>- differentiating whether the blister was serum-filled or blood-filled;</li> <li>- measurement of blister;</li> <li>- no assessment for pain;</li> <li>- no assessment of skin temperature or any changes to surrounding tissue;</li> <li>- no staging or identification that this was a PU.</li> </ul>	F 314	<p>F314 Continued</p> <p>4.1 DON or designee will review a sampling of records for 3 residents with pressure ulcers for completion and accuracy for 3 consecutive weeks until 100% of the records are compliant. Thereafter, DON or designee will review a sampling of records for 3 residents with pressure ulcers monthly until 100% of the records are compliant. After 3 consecutive months of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI team.</p> <p>4.2 DON or designee will review a sampling of records for 3 residents with pressure ulcers for completion and accuracy for 3 consecutive weeks until 100% of the records are compliant. Thereafter, DON or designee will review a sampling of records for 3 residents with pressure ulcers monthly until 100% of the records are compliant. After 3 consecutive months of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI team.</p>	

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F 314	<p>Continued From page 10</p> <p>12/30/15 timed 9:37 PM - a Skin/Wound Note stated R21 was seen by the WCN for a beefy red circular superficial ruptured blister. The note included measurements and stated there was no pain or discomfort or any drainage from the wound and stated the treatment was changed. The facility failed to assess for any changes to the surrounding tissue, failed to note this was a PU and failed to stage it.</p> <p>1/1/16 timed 7:26 PM - a Skin/Wound Note stated the ruptured blister wound now had "dark colored tissue," the size had increased and the surrounding skin was reddened. The facility again failed to stage this PU.</p> <p>1/10/16 and 1/24/16 - there was no evidence in the EMR that Weekly Skin Assessments were completed for R21.</p> <p>Findings were confirmed by E2 (DON) during an interview on 3/14/16 at approximately 11:00 AM.</p> <p>2. Review of R72's weekly Skin/Wound Notes (SWNs) from 11/15/15 through 1/1/16 revealed the following:</p> <ul style="list-style-type: none"> <li>- On 11/15/15, R72's heels were red and non-blanchable. Treatment ordered to apply skin prep to R72's bilateral heels every shift until redness resolves and elevate heels while in bed;</li> <li>- On 11/18/15, bilateral heels were red, non-blanchable and very soft. The left heel was worse than the right heel and R72 complained of discomfort to the left heel only. The clinical record lacked evidence that the physician was notified of the change to R72's left heel;</li> <li>- On 11/25/15, left heel was non-blanchable, soft and continued to be worse than the right heel.</li> </ul>	F 314		

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F 314	<p>Continued From page 11</p> <p>The clinical record lacked evidence that the physician was notified of the change to R72's left heel;</p> <ul style="list-style-type: none"> <li>- From 12/2/15 through 12/24/15, left heel was non-blanchable and soft;</li> <li>- On 1/1/16, left heel was less red and blanchable;</li> <li>- On 1/8/16, left heel had a pin-point size of dark eschar, continued to be red and very soft. The clinical record lacked evidence that the physician was notified with R72's change in skin condition and the wound assessment lacked staging of R72's left heel pressure ulcer;</li> <li>- On 1/15/16, left heel had a pin-point size of dark eschar, continued to be red and soft. The wound doctor was informed of the eschar and said to continue with the skin prep treatment and follow up if needed;</li> <li>- From 1/20/16 through 2/3/16, pin-point size of dark eschar remained unchanged and heel continued to be soft;</li> <li>- On 2/11/16, dark eschar increased in size and measured 0.3 cm x 0.3 cm (length x width) and mild erythema noted around the dark eschar; The clinical record lacked evidence that the physician was notified when R72's left heel PU increased in size;</li> <li>- From 2/19/16 through 3/3/16, dark eschar remained unchanged and measured 0.3 cm x 0.3 cm; and</li> <li>- On 3/11/16, dark eschar measured 0.3 cm x 0.2 cm and left heel was soft with mild redness; two new pin-point sized necrotic areas were identified on the left heel. All wounds were noted as unstageable. While the original PU decreased in size, two new areas were identified and R72 was added to the list of residents to be seen by the wound physician.</li> </ul>	F 314	

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F 314	<p>Continued From page 12</p> <p>Review of the facility's policy entitled "Wound Management", last revised on 2/16/16, revealed only PU stages 1, 2, 3 and 4. The facility's policy failed to identify the six (6) stages of pressure ulcer classification according to current clinical practice guidelines, which included Unstageable and sDTI.</p> <p>The facility failed to comprehensively assess R72's left heel PU to include staging according to current clinical practice guidelines from 11/15/15 through 3/3/16, a total of 17 times.</p> <p>In an interview on 3/14/16 at approximately 4 PM, E8 (LPN) confirmed the findings.</p> <p>Findings were reviewed with E2 on 3/14/16 12:55 PM.</p>	F 314		
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic</p>	F 329		

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F 329	<p>Continued From page 13</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to have one (R41) out of 23 stage 2 sampled residents' drug regimens free from unnecessary medications. The facility failed to monitor R41's lipid profile periodically as indicated for Zocor, a medication for hyperlipidemia. Findings include:</p> <p>According to the product information for Zocor lipid determinations should be performed after 4 weeks of therapy and periodically thereafter.</p> <p>Review of the March 2016 MAR revealed that R41 had been on Zocor daily for hyperlipidemia since 12/24/15.</p> <p>Chart review of laboratory (lab) results lacked lipid profiles including review of labs from a hospitalization in December 2015. R41 was readmitted to the facility from the hospital on 12/24/15.</p> <p>Findings were reviewed with E3 (ADON) during an interview on 3/14/16 at approximately 2:15 PM. On 3/14/16 at approximately 4:30 PM, E3 provided documentation and stated the only lipid profile she could find was from R41's physician's office and it was dated 3/6/14. E3 further stated</p>	F 329	<ol style="list-style-type: none"> <li>1. Lipid profile was ordered by physician and completed for R41 on 3/18/16.</li> <li>2. Pharmacy Consultant will review records for all residents receiving statin type medications and check that corresponding labs to monitor are complete.</li> <li>3. ADON or designee will utilize Medication Review Form (attachment #4) to review medications that require therapeutic monitoring as part of each quarterly care plan meeting. ADON or designee will notify physician of labs that may be required.</li> <li>4. DON or designee will review a sampling of 5 residents for completion of required labs weekly until 3 consecutive weeks are 100% compliant. Thereafter, DON or designee will review a sampling of 5 residents for completion of required labs monthly until 3 months are 100% compliant. Once 3 months are 100% compliant, monitoring will be completed. DON or designee will report findings to QAPI team.</li> </ol>	5/3/16

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F 329	Continued From page 14 that R41 had been on Zocor since admission to the facility on 3/26/15. Received telephone confirmation on 3/15/16 at 5:18 PM from E3 that there were no additional labs in R41's clinical record and she was checking with the resident's physician's office.  The facility failed to have R41's drug regimen free from unnecessary medications and they failed to ensure lipid determinations were conducted periodically.	F 329			
F 333 SS=E	<b>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</b>  The facility must ensure that residents are free of any significant medication errors.  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 residents were free of any significant medication errors for two (R6 and R41) out of 23 Stage 2 sampled residents. For R6, the facility failed to ensure that extended release Potassium Chloride was not crushed. For R41, the facility failed to ensure that Nitrobid paste and Insulin via sliding scale coverage were administered appropriately as per the parameters of the physician order. Findings include:  1. The facility's [name of] Pharmacy Systems Inc. Policies & Procedures For Pharmaceutical Care", last revised 8/20/14, stated, "...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.	F 333	1.1 Physician ordered Potassium for R6 to be changed to liquid form. 1.2 A) Charge Nurses continue to monitor Blood Pressure as ordered for R41. 1.2 B) Physician ordered A1C lab to be completed for R41. 2.1 DON or designee will review all residents receiving pureed diets and compare against the "Medications- Do Not Crush" list. 2.2 A) DON or Designee will review all residents receiving nitrobid paste medications and check the documentation for the previous month to see if it was administered correctly. 2.2 B) DON or designee will review the records of residents receiving sliding scale insulin coverage and check to see if they received the correct dosage in the previous month. 3.1 Staff Development Director will in-service Nursing staff on proper medication administration procedures. Nursing staff will be required to complete a Medication Administration Test annually. Staff Development Director or designee will conduct med pass observations annually with charge nurses to monitor for accuracy of medication administration.	5/3/16	

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F 333	<p>Continued From page 15</p> <p>Personnel authorized to administer medications do so only after they have familiarized themselves with the medication... Long-acting or enteric coated dosage forms should generally not be crushed; an alternative should be sought..."</p> <p>Review of the facility's medication list of "Oral Dosage Forms that should not be crushed 2015" included slow release potassium.</p> <p>R6's POS, dated 2/17/16, included the medication Potassium Chloride Extended Release (ER) 20 meq 2 tablets daily for hypokalemia which was originally ordered on 3/10/14.</p> <p>On 3/7/16 at 8:50 AM, E7 was observed during medication pass observation. E7 placed all of R6's pills into the plastic sleeve to crush them when she was stopped by surveyor due to Potassium Chloride ER, a non crushable medication, being in the plastic sleeve. When asked what the ER meant, E7 stated, "Extended Release" and added it was hard to crush the Potassium ER tablets, but, R6 cannot swallow it so she has been crushing it. E7 then looked up Potassium Chloride ER on her cell phone and E7 stated It was not to be crushed since crushing can cause the medication to be released all at once. E7 further stated that each time she has administered R6's Potassium Chloride ER, she has crushed the medication.</p> <p>Review of R6's MARs revealed E7 (LPN) administered Potassium Chloride Extended Release 20 meq 2 tablets by mouth one time a daily at 9 AM as followed: January 2016 MAR - 20 times; February 2016 MAR - 19 times; March 2016 MAR - 3 times.</p>	F 333	<p>3.2 (A &amp;B) Staff Development Director will in-service Nursing staff on proper medication administration procedures. Nursing staff will be required to complete a Medication Administration Test annually. Staff Development Director or designee will conduct med pass observations annually with charge nurses to monitor for accuracy of medication administration.</p> <p>4.1 DON or designee will conduct a sampling of 5 Medication Pass observation competencies weekly until 3 consecutive weeks are 100% compliant. Thereafter, DON or designee will conduct a sampling of 5 Medication Pass Observation Competencies monthly until 3 consecutive months are 100% compliant. Once 3 consecutive months are 100% compliant, monitoring will conclude. DON or designee will report findings of the competencies to QAPI team.</p> <p>4.2 (A&amp;B) DON or designee will conduct a sampling of 5 Medication Pass observation competencies weekly until 3 consecutive weeks are 100% compliant. Thereafter, DON or designee will conduct a sampling of 5 Medication Pass Observation Competencies monthly until 3 consecutive months are 100% compliant. Once 3 consecutive months are 100% compliant, monitoring will conclude. DON or designee will report findings of the competencies to QAPI team.</p>		

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F 333	<p>Continued From page 16</p> <p>On 3/8/16, R6's blood work was drawn and the potassium result was within normal limits.</p> <p>The facility failed to ensure that residents were free of significant medication errors when R6's extended release Potassium was incorrectly and repeatedly crushed when administered. On 3/7/16 at 8:50 AM, E7 confirmed the findings.</p> <p>2A. R41 had a physician's order, dated 3/26/15, for Nitrobid ointment 2% to be applied topically (usually to chest or back) every 8 hours as needed for BP &gt; 160/90 and leave for 8 hours and recheck (BP).</p> <p>Review of MARs from January 1, 2016 through March 8, 2016 revealed the following:</p> <p>2/22 6:00 AM- BP 181/83- did not get paste, should have;</p> <p>2/28 6:00 AM- BP 169/100- no paste given; should have;</p> <p>3/8 6:00 PM- 152/71- paste given when out of parameters.</p> <p>B. Review of R41's physician orders, dated 12/24/15, included blood sugar (BS) checks 4 times a day at 7:30 AM, 11:30 AM, 4:30 PM, and 7:30 PM.</p> <p>R41 also had a physician's order for Insulin coverage, dated 2/16/16, to cover R41's BS 3 times a day at 7:30 AM, 11:30 AM and 4:30 PM according to the following scale:</p> <p>0-99: no coverage;</p>	F 333		

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F 333	<p>Continued From page 17 100-150: 2 units (u) Insulin; 151-200: 4 u ; 201-250: 6 u; 251-300: 10 u; 301-350: 14 u; 351-400: 18 u; &lt; 70 or &gt; 400 call MD.</p> <p>Review of January 1, 2016 through March 8, 2016 MAR's revealed the following:</p> <p>2/19 11:30 AM- BS 292, gave 19 u Insulin, should have received 10 u;</p> <p>2/20 7:30 AM- BS 111, no coverage given, should have received 2 u;</p> <p>2/20/16 11:30 AM- BS 142, no coverage given, should have received 2 u;</p> <p>2/26/16 4:30 PM- BS 266, no coverage given, should have received 10 u.</p> <p>Findings were reviewed and confirmed by E3 (ADON) during an interview on 3/14/16 at approximately 2:15 PM.</p> <p>The facility failed to ensure that R41 was free of significant medication errors. Nitrobid ointment has the potential to quickly lower BP and cause it to become too low and Insulin errors can cause the BS to become too high or too low.</p>	F 333		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local</p>	F 371		

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F 371	<p>Continued From page 18 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and Interviews, it was determined that the facility failed to distribute and serve food under sanitary conditions. Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation on 3/7/16 at 11:35 AM, the second floor microwave contained food debris on the interior. Dirty food service equipment could harbor food borne pathogens and attract pests.</li> <li>2. During an observation on 3/7/16 at 11:50 AM, the third floor microwave contained food debris on the interior. Dirty food service equipment could harbor food borne pathogens and attract pests.</li> <li>3. During a lunch observation on 3/7/16 at 12:00 PM, a dirty food service ladle was observed in the hand washing sink of the third floor dining room. Hand washing sinks must not be used for any other purpose other than washing hands in the food service area due to potential for cross contamination.</li> </ol> <p>All findings were reviewed and confirmed by E12 (FSD) after the kitchen tour on 3/7/16 at approximately 2:00 PM.</p>	F 371	<ol style="list-style-type: none"> <li>1.1 No residents appear to have been affected. Dietary Manager cleaned microwave on 2nd floor.</li> <li>1.2 No residents appear to have been affected. Dietary Manager cleaned microwave on the 3rd floor.</li> <li>1.3 No residents appear to have been affected. Dietary Manager removed the ladle from the hand-washing sink.</li> <li>2.1 All residents have the potential to be affected.</li> <li>2.2 All residents have the potential to be affected.</li> <li>2.3 All residents have the potential to be affected.</li> <li>3.1 Dietary Manager or designee will in-service all dietary staff regarding routine cleaning of microwave ovens. Dietary Manager or designee will utilize the "Pantry Inspection Checklist" (attachment #5) until correction is complete, then incorporate into existing inspection forms.</li> <li>3.2 Dietary Manager or designee will in-service all dietary staff regarding routine cleaning of microwave ovens. Dietary Manager or designee will utilize the "Pantry Inspection Checklist" (attachment #5) until correction is complete, then incorporate into existing inspection forms.</li> <li>3.3 Dietary Manager or designee will in-service all dietary staff to keep hand-washing sinks free of ladles or other equipment. Dietary Manager or designee will utilize the "Pantry Inspection Checklist" (attachment #5) until correction is complete, then incorporate into existing inspection forms.</li> <li>4.1 Dietary Manager or designee will inspect pantries daily to make sure microwave on 2nd floor is clean until 3 consecutive days are 100% compliant. Thereafter, Dietary Manager or designee will inspect pantries weekly until 3 consecutive weeks are 100% compliant. Once 3 consecutive weeks are 100% compliant, monitoring will be concluded. Results will be submitted to QAPI team.</li> <li>4.2 Dietary Manager or designee will inspect pantries daily to make sure microwave on 3rd floor is clean until 3 consecutive days are 100% compliant. Thereafter, Dietary Manager or designee will inspect pantries weekly until 3 consecutive weeks are 100% compliant. Once 3 consecutive weeks are 100% compliant, monitoring will be concluded. Results will be submitted to QAPI team. (Continued on next page)</li> </ol>	5/3/16



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

PRINTED: 04/29/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GILPIN HALL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 GILPIN AVENUE WILMINGTON, DE 19806</b>		
(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 428	Continued From page 20 profile, dated 3/6/14, from the resident's family physician's office.  Although a pharmacy review was done monthly from April 2015 to present, the facility failed to identify that R41 was not getting lipid determinations performed periodically as indicated while taking Zocor.	F 428			
F 431 SS=E	<b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	1. The charge nurse signed the 8 hour verification form to indicate that the narcotic count was complete and no residents were negatively affected, therefore, no further action was taken. 2. ADON conducted a count for all narcotics on 4/5/16. The counts were determined to be correct. Charge Nurses continue to document narcotic use on individual narcotic sheets and narcotic counts occur at each shift change. 3. Staff Development Director will in-service Nursing staff on proper narcotic count procedure. Nursing Supervisor will review 8 Hour Verification form to ensure that it is completed correctly and document findings on the Supervisor Checklist (attachment #6) on each shift. 4. DON or designee will review Supervisor Checklist regarding 8 Hour Verification Form daily for 3 days until there are 3 consecutive days 100% compliance. Thereafter, DON or designee will review Supervisor Checklist 3 days per week until there are 3 weeks of 100% compliance. After 3 weeks are found to be 100% compliant, the monitoring will conclude. Findings will be reported to QAPI team.	5/3/16	

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NAME OF PROVIDER OR SUPPLIER  <b>GILPIN HALL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1101 GILPIN AVENUE WILMINGTON, DE 19806</b>		
(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 431	<p>Continued From page 21</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the facility's established system of records to account for the receipt and disposition of all controlled drugs was consistently conducted by two (2) licensed nurses at each change of shift for four (4) out of four (4) medication charts. There were multiple occasions when there were missing signatures. Findings include:</p> <p>The facility's "Eight-Hour Verification" form, used to conduct the receipt and disposition of controlled drugs stated, "must be signed at the end of every shift by both nurses... Supervisory staff will be checking this form on regular basis...".</p> <p>On 3/9/16 at approximately 9:30 AM, review of the second floor Gilpin Unit's "Eight-Hour Verification" form revealed that staff (name unknown) had signed out prematurely as the off-going nurse on the 3-11 PM shift. Additionally, E6 (LPN) on the third floor, Van Buren unit, also signed out prematurely as the off-going nurse on the 3-11 shift.</p> <p>Review of the January, February and March 2016 "Eight-Hour Verification" forms for the 2nd floor and third floor units (total of 4 medication carts) revealed a total of 228 missing signatures for the</p>	F 431		

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F 431	Continued From page 22 on-coming and/or off going nurse.  The facility failed to ensure that the facility's established system of records of receipt and disposition of all controlled drugs was maintained and periodically reconciled in accordance with the facility's standard of receipt and disposition.	F 431		
F 441 SS=D	This was reviewed with E2 (DON) on 3/9/16 at approximately 1:00 PM. <b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	<p>Continued From page 23</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a safe, sanitary environment to help prevent the development and transmission of disease and infection for 2 (R6 and R97) out of 4 residents observed during the medication pass observations on 3/7/16. Findings include:</p> <p>1. On 3/7/16 at 8:50 AM, E6 (LPN) was observed wearing gloves while assembling medications for R97. While assembling the medications, E6 touched multiple surfaces including the medication cart and medication packages, thus contaminating the gloves. E6 then administered eye drops to R97 wearing the same contaminated gloves.</p> <p>Finding was reviewed with E6 during an interview on 3/7/16 at 9:05 AM and confirmed.</p> <p>2. On 3/7/16 at 9:02 AM, during a medication pass observation, E7 (LPN) incorrectly put her bare fingers into the medication cup containing all of the oral medications poured for R6 and removed 2 extended release Potassium Chloride</p>	F 441	<p>1.1 DON provided an in-service on proper medication administration procedures relating to infection control practices to E6. R97 was not negatively affected.</p> <p>1.2 DON provided an in-service on proper medication administration procedures relating to infection control practices to E7. R6 was not negatively affected.</p> <p>2.1 All residents under the care of E6 have the potential to develop infections and it was determined by Staff Development Director that no infections resulted from the deficient practice of E6. Staff Development Director will in-service Nursing staff on proper medication administration procedures relating to infection control practices.</p> <p>2.2 All residents under the care of E7 have the potential to develop infections and it was determined by Staff Development Director that no infections resulted from the deficient practice of E7. Staff Development Director will in-service Nursing staff on proper medication administration procedures relating to infection control practices.</p> <p>3.1 Staff Development Director will in-service Nursing staff on proper medication administration procedures relating to infection control practices. Nursing staff will be required to complete a Medication Administration Test annually.</p> <p>3.2 Staff Development Director will in-service Nursing staff on proper medication administration procedures relating to infection control practices. Nursing staff will be required to complete a Medication Administration Test annually.</p>	5/3/16	



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

**NAME OF FACILITY:** Gilpin Hall

**DATE SURVEY COMPLETED:** March 14, 2016

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual recertification survey was conducted at this facility from March 7, 2016 through March 14, 2016. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 91. The Stage 2 survey sample size was 23.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the CMS 2567-L survey completed March 14, 2016 F253, F272, F314, F329, F333, F371, F428, F431, and F441</p>	<p>Cross refer to CMS 2567-L survey ending March 14, 2016: F253, F272, F314, F329, F333, F371, F428, F431, and F441</p>	<p>4/15/16</p>

Provider's Signature *[Signature]* Title Administration Date 3/30/16