

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

PRINTED: 08/10/2011  
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>07/29/2011</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 000	<b>INITIAL COMMENTS</b>	F 000			
F 246 SS=D	<p>An unannounced annual survey was conducted at this facility from July 22, 2011 through July 29, 2011. 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 95. The survey Stage 2 sample totaled 44 residents.</p> <p><b>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</b></p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that 1 resident (R1) out 40 Stage 1 Census sampled residents did not have a call bell placed within reach to call for assistance. Findings include: On 7/25/11 at 11:42 AM, while testing call bells, it was observed that the access to the call bell in R1's bathroom was blocked by furniture placed directly in front of it. E25 (CNA) was asked to show how R1 would be able to use the call bell. She confirmed that it was out of reach and proceeded to reach for the call bell to drape it over the furniture and found that the call bell cord was too short. E25 stated, "That's not good," and</p>	F 246 F246	<ol style="list-style-type: none"> <li>R1's furniture has been moved and the call bell cord has been lengthened.</li> <li>All residents who can use a call bell may be affected.</li> <li>All resident rooms have been checked for clear access to call bell cords during the survey. Facility Manager or designee will check a sampling of call bell cords for length and access monthly for 90 days to ensure adequate access.</li> <li>Facility Manager will report findings of monthly checks to QA committee for 90 days.</li> </ol>	8/22/11 8/30/11 8/30/11 9/15/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

*Administrator*

8/22/11

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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NAME OF PROVIDER OR SUPPLIER  GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19806		
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F 246	Continued From page 1 stated that she would take care of it.	F 246			
F 248 SS=E	<p>On 7/29/11, an observation revealed that a red plastic cord had been added to the call bell chain and tied to R1's left adjustable safety hand rail and was now accessible for resident use.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and review of activity calendars, it was determined that the facility failed to provide regular ongoing evening activities to meet the individual needs of 4 residents (R18, R55 and two residents who preferred to remain anonymous) out of 44 Stage 2 sampled residents, who wanted to participate in evening activities. Findings include:</p> <p>Interviews with residents on 7/22/11 and 7/25/11 revealed that the facility did not have activities in the evenings.</p> <p>1. In an interview with R18 on 7/27/11 at 8:55 AM, R18 revealed that the facility had no evening activities during the week and would have some special activities in the evenings once in a while. R18 stated she attended all activities and did not like to stay in her room. She stated that residents are put to bed early and were not asked about</p>	F 248			
		F248	<ol style="list-style-type: none"> <li>R18 and R55 will be interviewed to review their individual activity preferences.</li> <li>All resident may be affected.</li> <li>All residents able to be interviewed will be interviewed by Activity Department to determine types of activities residents may enjoy in the evening. Evening activities will be offered based on the outcomes of the interviews.</li> <li>Activity Coordinator will report findings of interviews and additional activities added to QA for 90 days.</li> </ol>	<p>9/15/11</p> <p>9/15/11</p> <p>9/15/11</p> <p>9/15/11</p>	

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F 248	<p>Continued From page 2</p> <p>evening activities because only a few would attend. She stated that there would be no one here to help you after 4pm and they are getting everything ready for the night. On 7/27/11 and on 7/29/11, she stated she would attend evening activities if the facility offered them.</p> <p>2. In an interview with R55 on 7/27/11, R55 revealed that she would attend evening activities if the facility had them. R55 stated that she liked attending activities.</p> <p>3. On 7/27/11 at 9:05 AM, in an interview with a resident (who wanted to remain anonymous), the resident stated that the facility offered evenings activities once in a while but not often. The resident stated that she stayed in her room to watch TV in the evenings. She stated that facility staff did not discuss other activities the residents wanted at resident council, but only reviewed the monthly activities scheduled on the calendar with the residents.</p> <p>On 7/29/11 at 11:40 AM, the resident stated that she would attend evening activities if the facility offered them if they were interesting and fun.</p> <p>4. On 7/26/11 at 11:40 AM, in an interview with a resident (who wanted to remain anonymous), the resident stated that she would be interested in attending evening activities if the facility offered them but depended on what they were. She stated she was never asked if she wanted to have or attend activities in the evenings. She stated that facility had no activities after 2:00 PM when she showed surveyor the activity calendar in her room.</p>	F 248			

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F 248	Continued From page 3 Review of the Activity calendar from July 2010 through July 2011 revealed that the facility had a total of only four (4) evening activities on 11/15/10, 2/15/11, 4/20/11 and 5/18/11. The activity schedule for July 2011 revealed that the last scheduled activities were held before 3:00 PM.  Interview with E6 (Activity Director) on 7/28/11 revealed that only 8 to 10 evening activities were offered throughout the entire year. She confirmed the facility did not offer ongoing evening activities for the residents. E6 stated that she had offered evening activities in past years, but had a low turn out.	F 248		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to provide services for five residents (R6, R44, R45, R52, and R96) out of 44 sampled by qualified persons in accordance with each resident's written plan of care. Findings include:  1. R6 was admitted to the facility in 2006 and had diagnoses that included dementia with delusions and depression. An annual Minimum Data Set (MDS) assessment, dated 5/17/11 identified R6 as having short and long term memory problems	F 282		

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F 282	<p>Continued From page 4 and cognitive skills for daily decision making as moderately impaired-decisions poor; cues/supervision required.</p> <p>The facility's Fall Risk Evaluation, dated 5/18/11 stated R6's score was "18" (score of 10 or higher is at risk). A care plan for the problem of potential for falls, dated 5/18/11 included an intervention "will continue to monitor and use fall materials."</p> <p>Review of the CNA's ADL (activities of daily living) Plans of Care ( 6/16/11 to the present) revealed they were to "Test and reapply bed or chair alarm."</p> <p>R6 was observed on 7/26/11 at 10:50 AM seated in a high back wheelchair (w/c) in her room. Although R6 was seated on a chair pressure alarm, the alarm switch was in the "off" position and the operational light was not blinking. E5 (RN supervisor) was called into the room to check the function of the alarm. E5 stated that the alarm was functional, however later E5 stated that it needed new batteries.</p> <p>On 7/27/11 at 8:10 AM, R6 was again observed seated in a high back w/c in the front hall near the nurse's station. R6 had a pressure alarm on the w/c but again the alarm was in the "off" position and not blinking. This observation was made by 2 surveyors.</p> <p>During an interview on 7/27/11 at 9:45 AM with E4 (Registered Nurse Assessment Coordinator) findings were reviewed. The facility failed to ensure that R6's chair pressure alarm was tested and functioning according to her plan of care.</p>	F 282  F282	<p>Item 1-4 (Chair Alarms)</p> <ol style="list-style-type: none"> <li>R6, R44, R52 and R96 will have chair alarms replaced with models that are not able to be turned off. 9/15/11</li> <li>All residents identified as needing a chair/bed alarm may be affected. 9/15/11</li> <li>Staff will be inserviced on proper use of chair alarms, replacing batteries and ensuring that alarms are turned on and reporting when alarms are not working. Chair alarms will be replaced with devices that turn on automatically when pressure is applied to cushion. DON or designee will check a sampling of chair alarms for proper operation monthly. 9/15/11</li> <li>Findings of monthly check will be reported to QA for 90 days. 9/15/11</li> </ol> <p>Item 5</p> <ol style="list-style-type: none"> <li>P.O. for R45 was changed on 7/27/11 as it was no longer needed. 7/27/11</li> <li>All residents may be affected. 9/15/11</li> <li>Staff will be inserviced to provide care according to Physician Orders. A sampling of orders will be checked by DON or designee monthly for 90 days to ensure the orders are followed correctly. 9/15/11</li> <li>Findings of sampling will be reported to QA for 90 days. 9/15/11</li> </ol>	

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F 282	<p>Continued From page 5</p> <p>2. R44 had a care plan, dated 6/14/11 for the problem potential for injury related to falls. Interventions included "utilize bed alarm and chair alarm as needed."</p> <p>On 7/26/11 at approximately 11:00 AM, R44 was observed seated in the hall in a geri chair with a pressure alarm. The alarm control was turned to the "off" position and the light was not blinking. In an interview with E9 (CNA) immediately after the observation, E9 confirmed that the alarm was not turned on. The facility failed to provide services by qualified persons in accordance with R44's written plan of care.</p> <p>3. R52 had a care plan, dated 2/18/11 for the problem potential for injury related to falls. Interventions included "utilize chair alarm when (out of bed) if needed."</p> <p>On 7/26/11 at approximately 11:00 AM, R52 was observed seated in the hallway in a Broda chair with a pressure alarm. The alarm control was turned to the "off" position and the light was not blinking. R52 was observed being taken to her room for care where she was lifted via a stand up lift. When lifted out of the chair the alarm failed to sound. E5 (RN supervisor), present at this time, asked the CNA to lower the resident back in the chair after which she turned the alarm switch to the "on" position. R52 was again raised from the chair and the alarm sounded. E8 (CNA) confirmed that the alarm had been turned off when the resident was seated in the hall. The facility failed to provide services by qualified persons in accordance with R52's written plan of care.</p>	F 282		

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F 282	<p>Continued From page 6</p> <p>4. R96's CNA ADL Plans of Care (time frame 4/21/11 through present) stated "test and reapply bed or chair alarm."</p> <p>R96 was observed in the hall seated on a pressure alarm in a geri chair on 7/26/11 at approximately 11:00 AM. The alarm switch was turned to the "off" position and the light was not blinking. In an interview with E9 (CNA) immediately after the observation, E9 confirmed that the alarm was not turned on. The facility failed to provide services by qualified persons in accordance with R96's written plan of care.</p> <p>5. R45 has a history of pressure ulcers on her back and buttock area. A physician's order, dated 4/13/11 stated that R45 was not to be up in the chair for more than 60 minutes at a time. Review of R45's ADL (activities of daily living) care plan (used by CNA's-certified nurses aides) stated the same. Staff documented on the July 2011 treatment administration record that R45 was out of bed in the chair daily at 9 AM, 1 PM and 6:30 PM.</p> <p>R45 was observed out of bed reclined in her gerichair from approximately 8:30 AM until 1:10 PM on 7/27/11. During an interview with E11 (LPN assigned to resident) on 7/27/11, she stated that R45 stays up all morning and goes to bed after lunch. E11 confirmed findings that the physician's order and care plan is not being followed for R45. She further stated that the physician's order should have been changed after R45's buttock area wound healed.</p> <p>E12 (CNA assigned to resident) stated during an interview on 7/27/11 that the 11-7 shift gets R45</p>	F 282		

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F 282	Continued From page 7 up every day, but she did not know what time.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by accessible ointments in the 2nd floor clean utility room, bathroom hot water temperatures above 110 degrees Fahrenheit, and the unsafe handling of oxygen tanks by contract vendors. Findings include:  1. During the environmental tour of the 2nd floor hallway on 7/27/11 at 10:35 AM with E13 (Maintenance Manager), E15 (Corporate EMS Manager) and E14 (Housekeeping Manager), the door to the clean utility room was observed ajar and unlocked. The room had an unlocked cart full of ointments used for wound care. E15 confirmed the door was left ajar and proceeded to lock it.	F323  F 323	1. (Door latch) Referenced utility room will have a mechanical door closer installed. 2. All residents of the 2 <sup>nd</sup> floor may have been affected. 3. A mechanical door closer will be installed on the doors of the utility rooms on 2 <sup>nd</sup> and 3 <sup>rd</sup> floor. Facility Manager will check operation of the door closer monthly. 4. Facility Manager will report findings of monthly check to QA for 90 days.  1. (Oxygen tanks)All residents may be affected. 2. All residents may be affected 3. Front Desk staff will be in-serviced to prevent vendors from entering facility to supply oxygen tanks or remove oxygen tanks without appropriate carts to secure oxygen tanks. 4. Facility Manager will report to QA any instances reported by Front Desk of vendors attempting to deliver or remove oxygen tanks without appropriate carts for 90 days.	9/15/11  9/15/11 9/15/11  9/15/11 9/15/11 9/15/11  9/15/11	

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F 323	<p>Continued From page 8</p> <p>2. On 7/25/11 at 1:55 PM, observation of two hospice personnel (E16 and E26) in the elevator revealed E16 was carrying an oxygen tank on his shoulder, and E26 had an unsecured oxygen tank on the floor next to him. In an interview with E16 on 7/25/11 he revealed that the oxygen tank was empty and he did not work for the facility. E16 stated that he only picked up empty oxygen tanks and brought replacements. The unsecured oxygen tank was a safety concern.</p> <p>During the survey exit meeting on 7/29/11, E1 (Administrator) stated that E16 and E26 were not facility staff and that E1 had talked to the vendor about this safety concern.</p> <p>3. On 7/27/11 at 9:35 AM during the environmental tour with E15 (Corporate EMS Manager), E13 (Maintenance Manager) and E14 (Housekeeping Manager), resident rooms 347, 355, and the 2nd floor Vanburen common shower room hot water sink temperatures were 113.9, 113.9 and 115.7 degrees Fahrenheit respectively, posing an accident hazard.</p> <p>Interview with E13 with E15 on 7/27/11 revealed that they monitored water temperatures daily first thing in the mornings when the residents were taking showers.</p> <p>The facility procedure entitled, "Water Temperature Testing", documented that "hot water at fixtures accessible to patients/residents shall not exceed 110 degrees Fahrenheit at any time."</p> <p>Interview with E15 (Corporate EMS Manager) on 7/29/11 at 8:00 AM revealed that they lowered the</p>	F 323 F323	<ol style="list-style-type: none"> <li>(Water temp) Facility Manager adjusted water temp mixing valve during the survey.</li> <li>All residents may be affected.</li> <li>Facility Manager has adjusted mixing valve water temp to below 110 degrees. Facility Manager or designee will check resident water temps in Van Buren wing daily and log results.</li> <li>Facility Manager will report findings of log to QA for 90 days.</li> </ol>	7/29/11 9/15/11 9/15/11 9/15/11

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F 323	Continued From page 9 setting of the hot water tank mixing valve temperature.	F 323		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  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.  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 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R18) out of 44 Stage 2 sampled residents, the facility failed to ensure medications were adequately monitored. Findings include:	F 329  F329	1. Behavior sheets have been modified to monitor R18 for delusional behavior. 2. All residents taking antipsychotic medication may be affected. 3. Residents taking antipsychotic medication will be reviewed to ensure proper monitoring on the psychoactive flow records. These records will be provided to the ordering physician for review monthly. 4. DON or designee will review a sampling of residents taking antipsychotic medication for 90 days to ensure proper completion of flow records. Results of this sampling will be reported to QA for 90 days.	8/17/11  8/17/11 9/15/11  9/15/11

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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>07/29/2011</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 329	Continued From page 10  R18's medication review revealed the resident was receiving the antipsychotic medication Seroquel since October, 2009 for a diagnosis of dementia with delusions.  Review of the Psychoactive Drug Monthly Flow Record (completed by licensed nursing staff), Mood & Behavior Sheet (completed by CNAs), and nurse's notes from 1/1/11 through 7/28/11 lacked evidence that the target behavior of delusions was being monitored.  Findings were reviewed with and confirmed by E2 (Director of Nursing) on 7/28/11.	F 329			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334  F334	1. Pneumococcal Immunization was given to R83 on Jul 27, 2011. 2. All residents may be affected. 3. All residents will be reviewed upon admission for pneumococcal immunization. If not given, and resident or representative agree to vaccine, facility will get order from physician to administer. Staff development RN will maintain records of immunizations given. 4. Staff Development RN will submit monthly reports to QA on all pneumococcal immunizations given	7/27/11 8/17/11 9/15/11 9/15/11	

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F 334	<p>Continued From page 11</p> <p>the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that –</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative</p>	F 334			

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F 334	Continued From page 12 refuses the second immunization.  This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies, and staff interview, it was determined that the facility failed to offer the pneumococcal vaccination to one (R83) out of five sampled residents in a timely manner. Findings include:  The facility's policy entitled "Immunization of Residents: Pneumococcal and Influenza" stated "all residents will receive immunization that aid in preventing infectious diseases unless medically contraindicated, declined by resident/POA or otherwise ordered by the resident's attending physician or the facility's medical director".  R83 was initially admitted to the facility on 6/2/11. Review of the pneumococcal immunization informed consent, dated 6/2/11 revealed that R83 gave the facility consent to administer the vaccine.  Record review lacked evidence that the pneumococcal vaccination was administered. Interview with E17 (Clerical staff) on 7/25/11 and E4 (RNAC) on 7/26/11 confirmed that R83 had not received the vaccination. Finding was reviewed with the E2 (DON) on 7/27/11 at 2:30 PM.  Review of R83's medication administration record on 7/28/11 revealed that the pneumococcal vaccine was administered on 7/27/11 at 8:00 PM.	F 334			



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F 371	Continued From page 14 newly hired employees be screened for the above food borne illnesses before they start handling food. The screening of Food employees health at time of hire, would alert the facility if the new employee had certain food borne illness that would prevent them from working with food.  E18, E19, E20, E21, and E22 were hired on 3/8/11, 3/2/11, 1/5/11, 3/2/11 and 7/14/08 respectively. Interview with E21 on 7/26/11 and E18 on 7/27/11 revealed they were aware of Salmonella as the facility covered it with them when they were hired.	F 371			
F 441 SS=E	Although the facility's food employee health form asked "have you ever been diagnosed with a food borne illness?" it failed to list any of the five food borne illnesses (Salmonella, Shigella, Ecoli, Hepatitis A and Norovirus) and only two (Salmonella and Ecoli) were addressed in the new hire employee orientation packet or their in-service materials. All five should had been addressed at the time of hire.  On 7/26/11, E7 (Food Services Director) and E23 (Assistant Food Services Director) confirmed this finding. E7 and E23 revealed on 7/28/11 they only covered two food borne illnesses at the time of employee hire and these were Salmonella and Ecoli.  On 7/29/11, E7 provided a copy of the newly revised health form that included all five food borne illnesses. She stated their packages would be modified to include all five food borne illnesses and all the food staff would be in-serviced. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 15  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. (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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441  F441	1. All residents may be affected. 2. All residents may be affected. 3. Laundry exhaust fan will be repaired. Facility Manager or designee will check proper operation of laundry exhaust fan monthly. 4. Facility Manager will report findings of monthly check to QA for 90 days.	9/15/11 9/15/11 9/15/11  9/15/11	

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to handle, store, and process linens so as to prevent the spread of infection in regards to nonworking vents and storage of soiled linen. Findings include:  Observations of the laundry room on 7/27/11 at 11:30 AM with E14 (Housekeeping Manager) and E15 (EMS Corporate Manager) revealed that the exhaust vent connected to the ceiling inside the soiled washer room was not working. The vent was not exhausting soiled air out of the room.	F 441			
F 463 SS=E	Interview with E13 (Maintenance Manager) on 7/27/11 revealed that the exhaust vents are checked monthly but he did not have any documentation on these checks. E13 revealed they would check the motor on the roof.  Interview with E15 on 7/28/11 revealed that they did not have the exhaust vents of the laundry on their scheduled maintenance system check and would add the laundry vents to have them checked on a routine basis. 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by:	F 463			

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F 463	<p>Continued From page 17</p> <p>Based on observations and staff interviews, it was determined that the facility failed to have a functional call bell system in place for ten (R9, R10, R12, R21, R30, R31, R40, R71, R92, and R95) out of 40 sampled Stage 1 Census residents. Additionally, the common shower rooms on the 2nd and 3rd floors failed to have the audio component of the call bell system functioning. Findings include:</p> <p><b>I Resident Rooms:</b></p> <p>1. On 7/22/11 at 11:16 AM, R9's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station.</p> <p>2. On 7/22/11 at 11:18 AM, R21's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station.</p> <p>Interview with E4 (RNAC) on 7/22/11 revealed that the facility was working on replacing the emergency call system used by residents.</p> <p>3. On 7/22/11 at 11:30 AM, R30's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station. The phone panel at the nurse's station did not display the room number and displayed an error message. E1 (Administrator) was observed checking the error</p>	F 463		

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F 463	<p>Continued From page 18 message on the phone outside the nursing station.</p> <p>4. On 7/22/11 at 11:15 AM, R71's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station. The phone panel at the nurse's station did not display the room number.</p> <p>5. On 7/22/11 at 10:55 AM, R95's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station.</p> <p>Interview with E10 (CNA), while the light was on, revealed that she also did not hear any audio informing her of a call bell in need of answering. Interview with E4 (RNAC) confirmed that the nurse's station phone panel failed to display the room which had a call bell turned on.</p> <p>6. On 7/22/11 at 11:00 AM, R12's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station. The phone panel at the nurse's station did not display the room number.</p> <p>7. On 7/22/11 at 11:00 AM, R10's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station. The phone panel at the nurse's station did not display the room number.</p> <p>8. On 7/25/11 at 9:51 AM, R31's call bells were</p>	F 463			

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F 463	Continued From page 19 tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station.  Interview with E15 (EMS Corporate Manager), while the light was on, revealed that he confirmed that the audio was not working.  9. On 7/25/11 at 10:29 AM, R40's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station.  Interview with E24 (CNA), while the light was on, revealed that she confirmed that the audio was not working.  10. On 7/25/11 at 10:34 AM, R92's call bells were tested in the bedroom area and bathroom. Although the overhead light above the entrance door lit up there was no audio heard in the hall or at the nurse's station.  II Common Shower Rooms  Observations made during the environmental tour on 7/27/11 at 10:05 AM with E15 (Corporate EMS Manager), E13 (Maintenance Manager) and E14(Housekeeping Manager) revealed the 2nd floor Vanburen wing call bell system lacked audio in the hall outside the shower room area. E15 confirmed this finding on 7/27/11.  Additionally on 7/22/11 at 9:35 AM, the 3rd floor Vanburen wing common shower room (room 346)	F 463  F463	1. Referenced call bell audio signals for R9, R21, R30, R71, R95, R12, R10, R31, R40, R92 as well as 2 <sup>nd</sup> and 3 <sup>rd</sup> floor Van Buren Spa areas were recaptured within 3 hours of heat related power surge and are now audible at the nursing station. 2. All residents in need of emergency call system may be affected. 3. Call system audio signal was recaptured, checked and fully operational within 3 hours of the heat related power surge. Call bell audio signal will be tested monthly by Facility Manager or designee. 4. Facility Manager will report findings of check to QA for 90 days.	7/27/11  9/15/11  9/15/11  9/15/11	

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F 463	<p>Continued From page 20</p> <p>lacked audio that could be heard in the hall outside the shower room area.</p> <p>On 7/22/11, E15 was overheard stating that he wanted to turn off the TV on the hallway to determine if he could hear the call bell sound in the hall outside the shower room. E15 stated he could not hear the sound of the call bell because the TV audio was high. E15 confirmed this finding and stated that they were working on replacing the call bell system.</p> <p>Interview with E15 on 7/29/11 revealed the facility had a power surge on 7/22/11 in the morning and that he was alerted of this at approximately 8:00AM when the survey team entered the facility. He stated that when they have a power surge, the facility has to reset all the panels of the call bell system.</p>	F 463		
F 520 SS=F	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require</p>	F 520	<ol style="list-style-type: none"> <li>1. All residents may be affected.</li> <li>2. All residents may be affected.</li> <li>3. Administrator will require that a physician, Director of Nursing and three other facility staff members are present for QA meetings. Sign in sheets will be maintained to ensure that necessary members are present.</li> <li>4. Administrator will report to QA requirements and attendance at</li> </ol>	<p>9/15/11</p> <p>9/15/11</p> <p>9/15/11</p> <p>9/15/11</p>

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F 520	<p>Continued From page 21</p> <p>disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview, it was determined that the facility failed to meet the requirements for the number of Quality Assessment (QA) committee members to be present for quarterly meetings which included the Director of Nursing (DON), a physician and at least three other facility staff members. Findings include:</p> <p>Review of the facility QA quarterly meeting sign in sheets revealed the following: 11/10/10 - a physician was not in attendance. 3/3/11 - only two other facility staff present. 5/4/11 - a physician was not present. 7/20/11 - the DON and a physician were not present.</p> <p>During an interview with E1 (Administrator) on 7/29/11, the findings were acknowledged.</p>	F 520			



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
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Wilmington, Delaware 19806  
(302) 577-6661

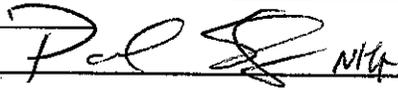
STATE SURVEY REPORT

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NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: July 29, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>An unannounced annual survey was conducted at this facility from July 22, 2011 through July 29, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 95. The survey Stage 2 sample totaled 43 residents.</p>	
3201	<p><b>Regulations for Skilled and Intermediate Nursing Facilities</b></p>	
3201.1.0	<p><b>Scope</b></p>	
3201.1.2	<p>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.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report date completed 7/29/11, F246, F248, F282, F323, F329, F334, F371, F441, F463, and F520.</p>	<p>3201.1.2 Cross refer to CMS 2567-L survey date completed 7/29/2011, F246, F248, F282, F323, F329, F334, F371, F441, F463, F520.</p>
3201.7.0	<p><b>Plant, Equipment and Physical</b></p>	

Provider's Signature  Title Administrator Date 8/22/11



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Residents Protection

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STATE SURVEY REPORT

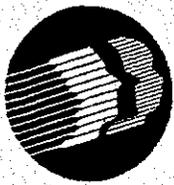
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NAME OF FACILITY: Gilpin Hall

DATE SURVEY COMPLETED: July 29, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
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3201.7.5	<p><b>Environment</b></p> <p><b>Kitchen and Food Storage Areas.</b></p> <p><b>Facilities shall comply with the Delaware Food Code.</b></p> <p><b>2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.</b></p> <p><b>(A) The permit holder shall require food employees and conditional employees to report to the person in charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or conditional employee shall report the information in a manner that allows the person in charge to reduce the risk of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the food employee or conditional employee:</b></p> <p><b>reportable symptoms (1) Has any of the following symptoms:</b></p> <p><b>(a) Vomiting,</b></p> <p><b>(b) Diarrhea,</b></p> <p><b>(c) Jaundice,</b></p> <p><b>(d) Sore throat with fever, or</b></p> <p><b>(e) A lesion containing pus such as a boil or infected wound that is open or draining and is:</b></p> <p><b>(i) On the hands or wrists, unless an impermeable cover such as a finger cot or stall protects the lesion and a single-use glove is worn over the impermeable cover,</b></p> <p><b>(ii) On exposed portions of the arms, unless the lesion is protected by an impermeable cover, or</b></p>	<p>3201.7.5 Cross refer to CMS 2567-L survey date completed 7/29/2011, F371.</p>
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	<p>(iii) On other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage; reportable diagnosis</p> <p>(2) Has an illness diagnosed by a health practitioner due to:</p> <p>(a) Norovirus, (b) Hepatitis A virus, (c) Shigella spp., (d) Enterohemorrhagic or Shiga toxin-producing Escherichia Coli or (e) Salmonella Typhi; reportable past illness</p> <p>(3) Had a previous illness, diagnosed by a health practitioner, within the past 3 months due to Salmonella Typhi, without having received antibiotic therapy, as determined by a health practitioner; reportable history of exposure</p> <p>(4) Has been exposed to, or is the suspected source of, a confirmed disease outbreak, because the food employee or conditional employee consumed or prepared food implicated in the outbreak, or consumed food at an event prepared by a person who is infected or ill with:</p> <p>(a) Norovirus within the past 48 hours of the last exposure, (b) Enterohemorrhagic or Shiga toxin-producing Escherichia Coli or Shigella spp. within the past 3 days of the last exposure, (c) Salmonella Typhi within the past 14 days of the last exposure, or (d) Hepatitis A virus within the past 30 days of the last exposure; or Reportable history of exposure</p> <p>(5) Has been exposed by attending or working in a setting where there is a</p>	



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	<p><b>confirmed disease outbreak, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a confirmed disease outbreak...</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report date completed 7/29/11, F371.</p>	