

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

PRINTED: 01/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19808		
(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	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from December 10, 2014 through December 18, 2014. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 91. The Stage 2 survey sample size was 29. Abbreviations used in this CMS2567 are as follows: NHA - Nursing Home Administrator DON- Director of Nursing ADON- Assistant Director of Nursing RN - Registered Nurse LPN- Licensed Practical Nurse CNA - Certified Nurse's Aide MDS - Minimum Data Set (standardized assessment form used in nursing homes) RNAC - Registered Nurse Assessment Coordinator	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to promote dining in a manner that enhanced dignity for two [R100, R34] out of 29 residents. Findings include:	F 241	1.1, 1.2: E10 will be in-serviced by Staff Development Director about not wearing gloves while serving food to residents at the table. No resident was negatively affected, so no action will be taken. 2. All residents who eat in the dining room may be affected. 3. All staff that serves food to residents will be in-serviced to deliver food to residents without gloves. Dining Observation Tool (attachment #1) will be utilized by supervisory staff during meals to ensure gloves are not worn by staff who deliver food to residents. 4. Dining Observation Tool (attachment #1) forms will reviewed by DON or designee daily until 3 consecutive days show 100% compliance with staff not wearing gloves while delivering food. After 3 consecutive days of compliance, DON or designee will review Dining Observation Tool forms weekly until 3 consecutive weeks show 100% compliance. After 3 consecutive weeks of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI Team. 3.1 E10 will be in-serviced by Staff Development Director to provide meals to all residents at a table at the same time. No resident was negatively affected, so no action will be taken. 2. All residents who eat in the dining room may be affected. 3. All staff that serves food to residents will be in-serviced to provide meals to all residents at a table at the same time. Dining Observation Tool (attachment #1) will be utilized by supervisory staff during meals to ensure that staff provide meals to all residents at a table at the same time. 4. Dining Observation Tool forms will reviewed by DON or designee daily until 3 consecutive days show 100% compliance for staff to provide meals to all residents at a table at the same time. After 3 consecutive days of compliance, DON or designee will review Dining Observation Tool forms weekly until 3 consecutive weeks show 100% compliance. After 3 consecutive weeks of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI Team.	1/31/15	

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

TITLE

(X6) DATE

Rebecca NHA *Adrianne Taylor* *1/8/15*

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 241	Continued From page 1 1. Observation of the lunch meal on 12/10/14 at 12:25 PM revealed that E10 (CNA) delivered R100's plate wearing gloves. 2. Observation of the lunch meal on 12/10/14 at 12:40 PM revealed E10 delivered R34's plate while wearing gloves. 3. Observation of the lunch meal on 12/10/14 at 12:25 PM noted R34 to be sitting in front of her lunch meal. At the same table R100 was being fed her lunch. At 12:40 PM, when R100 was almost finished her lunch E11 (LPN) sat down with R34 to feed her. Findings were discussed with E1 (NHA) and E2 (DON) at approximately 2:30 PM.	F 241			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 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;	F 272	1. MDS Section J 1400 for R70 will be corrected. 2. MDS Section J 1400 will be reviewed by RNAC or designee for all residents using Hospice services to ensure correct coding. 3. RNAC staff will be in-serviced by DON or designee about correctly coding Section J 1400 of the MDS for all residents on Hospice. RNAC or designee will report to the DON or designee when an MDS is completed for any resident receiving Hospice Services. 4. All Hospice residents MDS section J 1400 will be reviewed by DON or designee weekly to monitor coding accuracy until 3 consecutive weeks show 100% compliance with coding. After 3 consecutive weeks of compliance, DON or designee will review all Hospice residents MDS section J 1400 until 3 consecutive weeks show 100% compliance. After 3 consecutive weeks of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI Team.	1/31/15	

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F 272	<p>Continued From page 2</p> <p>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> <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 one (R70) out of 29 Stage 2 sampled residents had a comprehensive MDS assessment that was accurate. Findings include:</p> <p>R70's admission MDS assessment, dated 9/18/14, stated this resident was receiving Hospice care (end of life care). Despite this, Section J1400/Prognosis (likely course of a disease) of the MDS failed to indicate that this resident had a condition or chronic disease that</p>	F 272		

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F 272	Continued From page 3 may result in a life expectancy of less than 6 months. The facility failed to complete an accurate comprehensive assessment for R70. This finding was discussed with E4 (RNAC) on 12/18/14 at approximately 11:00 AM and with E1 (NHA) and E2 (DON) at approximately 2:30 PM.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a	F 278	1. MDS Section B 1200 for R29 will be corrected. 2. All residents who are visually impaired may be affected. RNAC or designee will review MDS Section B 1200 for all residents who have been admitted within the last three months to ensure correct coding. 3. RNAC staff will be in-serviced by DON or designee about correctly coding Section B 1200 of the MDS and ensuring that residents use their visual appliances prior to beginning the resident interview during the assessment. Additionally, RNAC will review the most recent prior MDS Section B 1200 to ensure consistency. 4. A sampling of 5 MDS Section B 1200 will be reviewed by DON or designee weekly to monitor coding accuracy until 3 consecutive weeks show 100% compliance with coding. After 3 consecutive weeks of compliance, DON or designee will review a sampling of 5 MDS Section B 1200 monthly until 3 consecutive months show 100% compliance. After 3 consecutive months of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI Team.	1/31/15

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F 278	<p>Continued From page 4 material and false statement.</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 the accuracy of the MDS assessment for one (R29) out of 29 Stage 2 sampled residents. Findings include:</p> <p>The Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, Version 3.0, stated that prior to conducting the assessment for Vision, the nurse was to ask the resident whether eye glasses are used and if they have them at the nursing home. Additionally, the manual instructs the nurse to ensure that the resident who usually uses visual appliances, such as eye glasses or a magnifying glass, have them in place for the assessment.</p> <p>7/18/14- A nursing admission assessment was completed and in the vision segment identified R29 as blind in the left eye and wearing glasses.</p> <p>7/28/14 - An admission MDS assessment stated R29's vision was moderately impaired (not able to see newspaper headlines but can identify objects) and corrective lenses (eye glasses) were present.</p> <p>10/26/14- A quarterly MDS assessment identified R29 as vision impaired (sees large print, but not regular print in newspapers/books) with no corrective lenses.</p> <p>During an interview on 12/18/14 at 10:06 AM, R29 confirmed visual impairment and possession</p>	F 278			

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F 278	Continued From page 5 of eye glasses at the facility. An interview on 12/18/14 at 10:20 AM with E13 (LPN) confirmed that R29 does have eye glasses at the nursing home. During an interview on 12/18/14 at 11:25 AM, E4 [RNAC] confirmed that during R29's 10/26/14 MDS assessment, an attempt was not made to obtain R29's glasses. E4 further explained "I wouldn't stop the interview and get them unless they (the resident) ask me to do so." The facility failed to conduct an accurate assessment in the area of "Vision" as evidenced by the failure to ensure R29's eye glasses were in place during the assessment. Findings were reviewed on 12/18/14 with E1[NHA] and E2 [DON] at approximately 2:30 PM.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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F 279	<p>Continued From page 6</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R75, R44, R32 and R103) out of 29 Stage 2 sampled residents reviewed, the facility failed to develop a care plan based on an identified need. Findings include:</p> <p>1. R75's annual MDS assessment, dated 1/8/14, identified the resident had impaired vision (sees large print, but not regular print in newspapers/books) and did not have corrective lenses. The MDS Care Area Assessment triggered for review and the facility indicated that they would proceed with care planning.</p> <p>The most recent quarterly MDS assessment, dated 10/12/14, also stated R75 had impaired vision with no corrective lenses.</p> <p>There was no care plan initiated for vision impairment.</p> <p>During an interview on 12/18/14 at approximately 11 AM with E4 (RNAC) it was revealed that a care plan for impaired vision was never initiated.</p> <p>2. R44 was admitted to the facility on 9/11/14 from the hospital with diagnoses that included anxiety disorder. R44 was prescribed Seroquel (antipsychotic/used to treat mental and emotional conditions) 200 milligram 1 tablet by mouth at</p>	F 279	<p>1. Care plans for R75, R44, R32 and R103 will be corrected.</p> <p>2. MDS and care plans for residents admitted within the last 3 months will be reviewed by RNAC or designee to ensure care plans for visual impairment, activities and medication have been correctly initiated.</p> <p>3. RNAC and Activity Director will be in-serviced by DON or designee on providing a care plan for each resident with an identified need in the MDS. Additionally, RNAC or designee will document in a progress note the reason why a triggered care area assessment may not be care planned.</p> <p>4. A sampling of 5 MDS Section B 1200, F 0500 and N 0410 will be reviewed by DON or designee weekly to monitor triggered care area assessments that require a care plan until 3 consecutive weeks show 100% compliance. After 3 consecutive weeks of compliance, DON or designee will review a sampling of 5 MDS Section B 1200, F 0500 and N 0410 monthly until 3 consecutive months show 100% compliance. After 3 consecutive months of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI Team.</p>	1/31/15

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F 279	<p>Continued From page 7 bedtime.</p> <p>Record review revealed there was no care plan developed addressing R44's anxiety disorder and the use of anti-psychotic medication, Seroquel. Interview with E4 at approximately 11:00 AM on 12/18/14, confirmed there was no care plan related to R44's anxiety and use of Seroquel.</p> <p>This finding was discussed with E1 (NHA) and E2 (DON) on 12/18/14 at approximately 2:30 PM.</p> <p>3. The admission MDS assessment, dated 9/25/14, stated R32's preferences for activities while at the facility were as follows: Very Important - getting outside when weather was good; Somewhat Important - listening to music; visiting with animals; current events; and religious services. Although the MDS Care Area Assessment did not trigger "Activities" as a potential problem area, it was checked off to proceed with care planning.</p> <p>On 12/16/14 at 1:55 PM, an activities care plan was requested from E5 (Activities Director).</p> <p>During an interview on 12/17/14 at 9:22 AM, E5 confirmed that R32, "did not have a care plan for activities."</p> <p>4. R103's admission MDS assessment, dated 10/19/14, identified the resident as having a vision impairment with no corrective lenses (eye glasses). The MDS Care Area Assessment triggered for review and the facility indicated that they would proceed with care planning.</p> <p>During an interview on 12/17/14 at 2:52 PM, E4</p>	F 279			

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F 279	Continued From page 8 stated, "R103 was coded Impaired because of inability to read small print." E4 confirmed that R103 was not wearing eye glasses at time of the assessment and stated, "I care planned that there was impaired visual function." During an interview on 12/18/14 at 11:23 AM, E4 confirmed that R103 did not have a care plan initiated at the time of assessment. E4 stated, "R103 doesn't have a care plan. I put one in [place] yesterday."	F 279			
F 323 SS=D	Findings were reviewed on 12/18/14 with E1 and E2 at approximately 2:30 PM. 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 water temperature readings taken in resident rooms during the survey, it was determined that the facility failed to maintain hot water at a temperature (below 110 degrees Fahrenheit [F]) that would not burn or would not create an accident hazard for three (R1, R2, and R82) out of 29 residents sampled. Findings include: On 12/12/14 at 9:45 AM, the following hot water	F 323	1. Water temperatures in room 333, 334 and 322 will be adjusted so that the temperature does not exceed 110 degrees. 2. All residents who can utilize faucets may be affected. 3. Facility Manager will record temperatures of 5 resident rooms daily at various locations within the facility to ensure that water temperatures are below 110 degrees. Additionally, water mixing valve will be inspected for proper operation. 4. Administrator or designee will review daily water temps for 3 days until 100% compliant. Once 3 days of water temps are 100% compliant, Administrator or designee will review water temps weekly until 3 weeks are 100% compliant. After 3 weeks of water temps are compliant the review will be concluded, however, Facility Manager will continue taking daily water temps. Results will be reported to QAPI team.	1/31/15	

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F 323	Continued From page 9 temperature was recorded from the bathroom sink in degrees Fahrenheit (F): 1. Room 334 [R82] = 118.3 F On 12/17/14, the following hot water temperatures were recorded from the bathroom sinks: 2. Room 333 [R1] = 114.5 F 3. Room 334 = 115.0 F 4. Room 322 [R2] = 113.2 F E9 (Maintenance Director) was made aware of the hot water temperatures on 12/18/14. E9 indicated that the water temperature could be adjusted down with no difficulty. Findings were reviewed with E1 (NHA) on 12/18/14 at approximately 2:30PM.	F 323			
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R79) out of 29 sampled residents the facility failed on multiple occasions to monitor a resident on a fluid restriction to ensure adequate hydration. Findings include: The facility's Intake and Output policy included the procedures and reporting;	F 327			

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F 327	<p>Continued From page 10</p> <p>-The residents meal and fluid intake totals will be recorded by the CNA in the (name of former electronic medical record [EMR] program).</p> <p>-If a nurse provides fluids, the total fluid amount consumed will be added to EMR.</p> <p>-If a resident is on fluid restriction, the totals will be calculated in EMR and available to the charge nurse to monitor.</p> <p>-Report resident's decreased or increases in resident's intake to responsible party, physician, and dietitian.</p> <p>R79's care plan included the following;</p> <p>6/13/14 diagnosis of congestive heart failure (decreased function of heart resulting in fluid retention) with interventions including monitor intake and output.</p> <p>6/26/14 potential fluid volume overload related to congestive heart failure with interventions including monitor and document intake and output as per facility policy and added 7/30/14 fluid restriction of 1200 cc (cubic centimeters) daily.</p> <p>6/28/14 potential dehydration due to occasional confusion and forgetfulness related to dementia, diuretic (medication to reduce fluid in body) use and fluid restriction with interventions including monitor and document intake and output as per facility policy and added 7/30/14 fluid restriction of 1200 cc daily.</p> <p>Physician's orders included;</p> <p>- 7/2/14 Lasix 80 milligrams (mg) daily for edema (fluid retention).</p> <p>- 7/30/14 Zaroxolyn 2.5 mg daily for edema glive</p>	F 327	<ol style="list-style-type: none"> 1. R79 was not negatively impacted and so no action was taken. 2. A review of all residents on fluid restrictions will be conducted by DON or designee to ensure accurate monitoring. 3. Intake and Output Procedure (attachment #2) has been revised to reflect current software program. Nursing staff will be in-serviced by Staff Development Director or designee regarding Intake and Output Policy revision and how to properly monitor residents on fluid restrictions. Nursing Supervisor will review the Fluid Intake every shift for these residents and report to the DON. 4. DON or designee will review fluid intake records for all residents on fluid restrictions daily for accurate monitoring. After 3 consecutive days of 100% compliance, DON or designee will review fluid intake records for all residents on fluid restrictions weekly. After 3 weeks of 100% compliance the review will continue monthly. After 3 months of 100% compliance, the review will be concluded. Results will be reported to QAPI team. 	1/31/15

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19806		
(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 327	<p>Continued From page 11</p> <p>30 minutes prior to Lasix.</p> <p>- 7/30/14 Fluid restrction 600 milliliters (ml/equal to cc) daily times of administration 2 PM, 480 ml daily times of administration, 10 PM, 120 ml daily times of administration 6 AM to maintain 1200cc/day fluid restriction</p> <p>In the EMR under TASK the aides were instructed to document fluid intake at breakfast, lunch, dinner and as needed. A report could be run to total these intakes daily.</p> <p>Review of the EMR in the medication administration record (MAR) the nurses documented fluids the residents received each shift. The MAR did not total these intakes daily.</p> <p>A review of R79's fluid entries from 10/1/14 through 12/16/14 documented in the MAR and totaled by the surveyor revealed intakes of; 980cc - 5 times, 1020cc - 5 times and 1040cc - 10 times. There was no evidence that the facility was aware that R79 did not consume the 1200cc allowed daily on these dates.</p> <p>An interview on 12/17/14 at 12 PM with E13 (LPN) revealed that all fluids consumed with meals and hydration rounds are documented on the MAR. She further stated that the aides only document the hydration and not the meals in the EMR. E13 stated the nurses do not specifically total it up they just always give the resident what is ordered and R79 always takes what she is given.</p> <p>An interview on 12/17/14 at 12:14 PM with E3 (ADON) revealed there should be a report of the daily fluids and the nurses should be looking at it.</p>	F 327			

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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 327	Continued From page 12 On 12/17/14 at 1:45 PM E2 (DON) provided the Intake and Output policy but stated it needed to be updated to reflect the new EMR program they were using. The name of the former program should be removed and the new name inserted. She stated that all fluid intake should be in the new clinical record EMR documentation not the MAR. An interview on 12/17/14 at 2:19 PM with E14 (CNA) revealed that the documentation done in the EMR by the aides is for hydration only which is done at 10 and 2 on the day shift. The nurses document the fluids with the meals. A interview on 12/17/14 at 2:25 PM with E15 (CNA) revealed that the CNA documentation in the EMR by the aides is for hydration only at 10 and 2. She stated that the nurses do the meal fluids and they do it in their computer. An interview on 12/18/14 around 12:30 PM with E2 revealed that all fluids should be documented in the EMR, totaled and reviewed daily. However, in the change over of computer EMR programs the nurses have been putting the fluids on the MAR and they are not being totaled and reviewed.	F 327			
F 371 SS=F	These findings were reviewed with E1 (NHA) and E2 on 12/18/14 at 2:30 PM. 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371			

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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 371	<p>Continued From page 13</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on dining observations and review of the rinse temperatures of the dishwashing machine in the kitchen, it was determined that the facility failed to ensure that food is distributed and served under sanitary conditions and that dishware was properly sanitized. Findings include:</p> <p>1. During a lunch time observation on 12/10/14 the following was observed:</p> <p>a. At approximately 12:25 PM, E7 (CNA) was seen rubbing/scratching her whole right arm while waiting at the food service window for the server to hand her a resident's plate of food to serve. E7 did not wash hands, took the plate and went on to serve.</p> <p>b. At 12:40 PM, E12 (dietary aide) with gloved hands, went to serve food on one of the residents' table and while talking to the resident, her right hand was holding onto the back of an empty dining chair next to the resident and then continued to serve food with the same gloved hands.</p> <p>c. E12, while at the food service window station and waiting to pick up another plate of food to serve, she slightly brushed her hair on her left temple with her gloved hands.</p>	F 371	<p>1.1, 1.2 E6, E7, E8 and E12 will be in-serviced regarding serving and handling food under sanitary conditions. No resident was adversely affected and so action was taken for individual residents.</p> <p>2. All residents who eat in the dining room may be affected.</p> <p>3. All staff that serves food to residents will be in-serviced regarding serving and handling food under sanitary conditions. Dining Observation Tool (attachment #1) will be utilized by supervisory staff during meals to ensure serving and handling food under sanitary conditions.</p> <p>4. Dining Observation Tool forms will reviewed by DON or designee daily until 3 consecutive days show 100% compliance with serving and handling food under sanitary conditions. After 3 consecutive days of compliance, DON or designee will review Dining Observation Tool forms weekly until 3 consecutive weeks show 100% compliance. After 3 consecutive weeks of 100% compliance, the monitoring will conclude. Results of the monitoring will be reported to the QAPI Team.</p> <p>1.3 Dish Machine was repaired during the survey.</p> <p>2. Though all resident who are able to eat may be affected, no residents were negatively affected.</p> <p>3. Dietary Manager will replace testing thermometer and conduct daily dish machine temperature audits to ensure temperature reaches a minimum of 180 degrees. Dish Machine will be inspected for proper operation. Paper temperature probes, (T-sticks) will no longer be used for temperature recording.</p> <p>4. Administrator or designee will check the temperature of dish machine daily for 3 days to ensure minimum temperature of 180 degrees is reached. After 3 consecutive days of checks are 100% compliant, Administrator or designee will check the temperature of dish machine weekly to ensure minimum temperature of 180 degrees is reached. After 3 consecutive weeks of checks are 100% compliant, the review will be concluded. Results will be reported to QAPI Team.</p>	1/31/15	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER GILPIN HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 GILPIN AVENUE WILMINGTON, DE 19808	
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F 371	Continued From page 14 d. E8 (CNA) was observed in the food service area opening the supply closet door and the refrigerator with her gloved hands. She was also observed holding 2 slices of bread and placing them in the toaster oven. While waiting for the toast, she rested her gloved hands on the table where the toaster oven was and then picked up the toasted bread with the same, now contaminated, gloved hands. 2. During a second dining observation on 12/17/14 at approximately 12:30 PM, E8 (CNA) was observed serving food with her gloved hands. With her gloved hands, she touched the front of her dress and the back of a chair after leaving the plate of food on the resident's table. She then went to the food service window where she opened a bread bag and with now contaminated gloved hands (instead of using tongs) took out two (2) slices of bread, and placed them on a plate. These findings were discussed with E1 (NHA) and E2 (DON) on 12/18/14 at approximately 2:30 PM. 3. On 12/15/14 at 12:30PM, the maximum recorded internal temperature of the Hobart-brand dishwasher was 152.8 degrees Fahrenheit (F). The minimum accepted temperature is 160 degrees F. The dishwasher service contract company was notified by E16 (Food Services Director) and E17 (Assistant Food Services Director) and arrived to make adjustments to the machine on this date. On 12/17/14 at 11:05AM, the maximum recorded internal temperature of the dishwashing machine	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 371	Continued From page 15 was 157 degrees F. The service contract company was again notified by E16 and returned to make additional adjustments to the machine on this date. E16 obtained three positive, 160 degree F, results, out of five attempts utilizing the T-stick, disposable, temperature monitoring strips. Findings were reviewed with E1, E16 and E17 on 12/18/14.	F 371			



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: Glipin Hall

DATE SURVEY COMPLETED: December 18, 2014

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>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from December 10, 2014 through December 18, 2014. 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 91. The survey sample totaled was 29.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <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>		

Provider's Signature [Signature] Title Administrator Date 1/8/15



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: Glipin Hall

DATE SURVEY COMPLETED: December 18, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Cross refer to CMS 2567-L, survey date completed December 18, 2014, F241, F272, F278, F279, F323, F327, and F371.	Cross refer to Plan of Correction Dated January 8, 2015 for CMS 2567-L, survey date completed December 18th, 2014, F241, F272, F278, F279, F323, F327, and F371.	1/31/15

Provider's Signature *Paul S. NMA* Title Administrator Date 1/8/15



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DSAAPD

LONG TERM CARE

December 2, 2015

Mr. Robert H. Smith
Licensing and Certification Administrator
DHSS/LTCRP
3 Mill Road, Suite 308
Wilmington, DE 19806

Dear Mr. Smith:

Enclosed is the Plan of Correction for the Annual Survey for Governor Bacon Health Center conducted in October 2015. Thank you for giving us an extension until December 2, 2015 to respond. As per the instructions in your letter, the GBHC plan of correction includes the following:

- Identified the corrective actions for those residents affected by the deficient practice;
- Listed the steps taken by GBHC to identify other residents having the potential to be affected by the same deficient practice;
- Described the measures that will be put in place to ensure that the deficient practice does not recur;
- Identified how GBHC plans to monitor our corrective action plan for each deficiency to achieve success.

Governor Bacon Health Center (GBHC) is submitting the Plan of Correction as written credible allegation of compliance for correcting the deficiencies found during the survey. I thank the members of the survey team for their efforts identifying areas where GBHC was non-compliant with the regulations for nursing facilities. Their findings will help GBHC staff maintain high standards of care and provide opportunities for improvement in the services we offer to our residents.

If you have any questions or need additional information, please feel free to call me at (302) 836-2335.

Sincerely,

A handwritten signature in black ink, appearing to read "Lois M. Quinlan".

Lois M. Quinlan, PhD, LNHA
Director

Attachments: Completed Statement of Deficiencies/Plan of Correction - Form CMS-2567L
Completed State Survey Report

cc: John Oppenheimer, LTC Section Chief