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 C 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	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 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from February 12, 2015 through March 3, 2015. The deficiency contained in this report is based on observations, interviews, review of the resident's clinical record and review of facility policies and procedures and other documentation as indicated. The facility census was 90 (ninety) residents on the initial day of the survey and the survey sample totaled 4 (four) residents. Abbreviations are as follows: ED - Executive Director; NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set (standardized assessment form used in nursing homes).	F 000		
F 279 SS=D	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	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 3/25/15

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING ______ B. WING ______	C 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	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 279	Continued From page 1 psychosocial well-being as required under §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). This REQUIREMENT is not met as evidenced by: Cross refer F323. Based on review of the care plan and facility documents it was determined that the facility failed to develop and revise a comprehensive care plan needed to provide adequate supervision and physical assistance to prevent a fall with injury for one resident (R1) out of four sampled. Findings include: Clinical record review revealed R1 had diagnosis that included dementia (memory loss) and hemiplegia (half of the body is paralyzed). According to the MDS dated 11/2/2013 and completed for a significant change, the annual MDS dated 10/25/2014 and the quarterly MDS dated 1/23/2015 R1 experienced short-term and long- term memory problems and impaired cognitive (thinking) skills for daily decision-making. Further review of the above referenced MDS assessments also revealed that R1 exhibited limited range of motion of both upper and lower extremities. The significant change MDS dated 11/2/2013 and the annual MDS dated 10/25/2014 also revealed that R1 was totally dependent on the physical assistance of two staff members for bed mobility. Review of the facility incident report dated 11/25/2014 revealed that R1 sustained a fall with	F 279	1. R1 care plan was changed on 2-12-15 to reflect a 2 person assist with bed mobility. 2. All residents who are assessed as a 2 person assist for bed mobility will have their care plans reviewed and revised to ensure that the care plan corresponds to MDS assessment section G 0110, A(bed mobility). 3. DON or designee will provide RNACs with specific training to ensure that care plans correspond to MDS assessment information in section G 0110, A(bed mobility) according to the RAI manual. Further, RNAC will include specific notes within MDS assessments if care plan includes multiple levels for bed mobility. 4. For the first week of monitoring, DON or designee will check all care plans for MDS assessments completed during that week to ensure that care plans for bed mobility correspond to the latest MDS section G 0110, A, (bed mobility). Next, a sampling of 2 care plans for bed mobility will be monitored by DON or designee weekly to ensure that care plans correspond to section G 0110, A, (bed mobility) until 3 consecutive reviews are 100% accurate. Next, a sampling of 5 care plans for bed mobility will be monitored by DON or designee monthly to ensure that care plans correspond to section G 0110 A, (bed mobility) until 3 consecutive reviews are 100% accurate. Once 3 consecutive reviews are found to be correct, the monitoring will be concluded. Results will be reported to QAPI.	4/20/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING ______ B. WING ______	C 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	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 279	Continued From page 2 injury on 11/25/2014 that required an evaluation at an acute care facility. R1 was diagnosed with a subdural hematoma (collection of blood in the brain) as a result of trauma. The injury occurred while R1 was turned in bed by E5 (CNA) who was working individually to remove a mechanical lift sling located under the resident. As E5 continued to pull upon the mechanical lift sling R1 rolled out of the bed onto the floor. Although the MDS assessments dated 11/2/2013 and 10/25/2014 consistently demonstrated that the physical assistance of two staff members was required for R1's bed mobility, this information was not incorporated into the care plan. Further review of the current care plan revealed that the intervention "Two staff/CNA to change, reposition and transfer resident (every) shift" was developed and added to the problem "...high risk for falls due to (d/t) confusion, and impaired mobility...on 2/12/2015. " This finding was reviewed with E2 (NHA) by telephone on 3/3/2015 at approximately 2:56 PM.	F 279		
F 323 SS=G	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:	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING ______ B. WING ______	C 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	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 323	Continued From page 3 Cross refer F279 Based on clinical record review, review of facility documents and staff interviews it was determined that the facility failed to provide adequate supervision and physical assistance to prevent a fall with injury sustained by one resident (R1) out of 4 (four) sampled. Findings include: Clinical record review revealed R1 had diagnosis that included dementia (memory loss) and hemiplegia (half of the body is paralyzed). According to the MDS dated 11/2/2013 and completed for a significant change, the annual MDS dated 10/25/2014 and the quarterly MDS dated 1/23/2015 R1 experienced short-term and long- term memory problems and impaired cognitive (thinking) skills for daily decision-making. Further review of the above referenced MDS assessments also revealed that R1 exhibited limited range of motion of both upper and lower extremities. The significant change MDS dated 11/2/2013 and the annual MDS dated 10/25/2014 also revealed that R1 was totally dependent on the physical assistance of two staff members for bed mobility. Further review of the clinical record also revealed a nurse's note dated 11/25/2014 and timed 6:23 PM that stated "...E5 (CNA)...notified E6 (LPN) ...R1 on floor...R1 noted with a hematoma and a cut bleeding moderately on the left parietal (area of the head that forms the sides and top of the skull)...left facility at 5:02 PM (to acute care facility). Another nurse's note dated 11/26/2014 and timed 12:37 AM stated R1 returned on 11/25/2014 at 11:45 PM to the long-term care facility from an acute care facility with a discharge diagnosis of a subdural hematoma (collection of blood in the brain) as a result of trauma.	F 323	1. R1 care plan was changed on 2-12-15 to reflect a 2 person assist with bed mobility. 2. All residents who are assessed as requiring a 2 person assist for bed mobility will have their care plans reviewed and revised to ensure that the care plan corresponds to MDS assessment section G 0110, A(bed mobility). 3. Care plan tasks regarding bed mobility will include the required number of care givers in accordance with MDS Section G 0110, A. Supervisor checklist (attachment #2) now includes increased supervision of bed mobility for residents who require 2 person bed mobility assistance. CNA's and Nurses will be in-serviced regarding bed mobility care to be delivered according to the care plan. RN Shift Supervisors will be in-serviced regarding the changes to the Supervisor Checklist. 4. Supervisor checklist is provided to DON after completion. For the first week of monitoring, Staff Development Coordinator or designee will conduct staff competencies (Attachment #1) for residents whose MDS assessments were completed during that week to ensure that staff follow the care plan for bed mobility in accordance with the latest MDS section G 0110, A, (bed mobility). Next, Staff Development Coordinator or designee will conduct a competency for a sampling of 2 residents weekly to ensure that staff follow care plan for bed mobility in accordance with section G 0110, A, (bed mobility) until 3 consecutive reviews are 100% accurate. Next, a sampling of 5 competencies for bed mobility will be monitored by Staff Development Coordinator or designee monthly to ensure that staff follow care plans in accordance with section G 0110, A, (bed mobility) until 3 consecutive reviews are 100% accurate. Once 3 consecutive reviews are found to be correct, the monitoring will be concluded. Results will be reported to QAPI.	4/20/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING ______ B. WING ______	C 03/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	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 323	Continued From page 4 Review of the completed facility incident report dated 11/25/2014 with attached investigation revealed that : - E5 witnessed R1's fall - E5 was providing care to R1 without the assist of a second person - R1 fell to the floor while being turned in bed - R1 hit her head on the floor when she fell During an interview with E5, conducted on 2/23/2015 at 2:15 PM, these findings were reviewed and confirmed. The facility failed to ensure that R1 was provided the required physical assistance when she sustained a fall with injury on 11/2/2014 during the repositioning in bed with the assistance of one staff member. These findings were reviewed with E1 (ED), E2 (NHA), E3 (DON) and E4 (ADON) on 2/24/2015 at 4:15 PM and again with E2 by telephone on 3/3/2015 at 2:55 PM.	F 323		

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 3, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced complaint survey was conducted at this facility from February 12, 2015 through March 3, 2015. 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 was 90 (ninety) residents on the initial day of the survey and the survey sample totaled 4 (four) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.**		

Provider's Signature [signature] Title Administrator Date 3/25/15

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: Gilpin Hall

DATE SURVEY COMPLETED: March 3, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement is not met as evidenced by: Cross refer to CMS 2567-L, survey date completed February 24, 2015: F0279, F0323.	Cross refer to CMS 2567-L, survey date completed March 3, 2015: F0279, F0323	

Provider's Signature [signature] Title Administrator Date 3/25/15