DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall Nursing Home **DATE SURVEY COMPLETED:** 8/30/22

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 follow-up survey, for the complaint survey ending July 28, 2022, was conducted at this facility from August 26, 2022 through August 30, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census the first day of the survey was 85. The survey sample totaled three 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.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed August 30, 2022: F689.		

Provider's Signature _____ Title NHA Date 9/7/2022

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 _____	R-C 08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	1101 GILPIN AVENUE WILMINGTON, DE 19806

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{F 000}	INITIAL COMMENTS An unannounced Follow-Up Survey, for the Complaint Survey ending July 28, 2022, was conducted at this facility from August 26, 2022 through August 30, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and other documentation as indicated. The facility census the first day of the survey was 85. The survey sample totaled three residents. Abbreviations and definitions used in this report are as follows: 1:1 - one resident to one staff person; ADLs (activities of daily living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; CNA - Certified Nursing Assistant; DON - Director of Nursing; ER - Emergency Room; Impulsive - individual acts without thought; Incontinent - loss of control of bladder and bowel; LPN - Licensed Practical Nurse; MD - Medical Doctor; Neuro checks - a series of simple questions and physical tests to determine if the nervous system is impaired; NHA - Nursing Home Administrator; NP - Nurse Practitioner; POA - Power of Attorney; Progressive Supranuclear Palsy - medical condition that causes balance, movement, speaking, and vision problems; Restorative Nursing Program - nursing interventions that are initiated when a resident is	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/16/2022

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

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{F 000}	Continued From page 1 discharged from formalized physical, occupational, or speech rehabilitation therapy; RN - Registered Nurse; Root cause analysis - process of discovering the root cause(s) of problems in order to identify appropriate solutions; SPG - Safety Program Group.	{F 000}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of R1's clinical record and facility documentation as indicated, it was determined that for one (R1) out of three sampled residents for accidents, the facility failed to ensure that R1 received adequate supervision to prevent accidents, specifically two falls, on 8/20/22 day shift while actively in a Safety Program (SP) where one Safety CNA was assigned to three residents. Findings include: 8/1/19 (last revised) - The facility's Personnel Manual on page 2 stated, "... 4. Cell Phones/Electronic Devices... use of personal cell telephones... while on duty, or in any resident area, is strictly prohibited...". 7/11/22 (last revised) - The facility's policy and procedure entitled, Safety Program Procedure,	{F 689}	1) R1 was evaluated at the hospital and returned to the facility on 8/20/2022 with no new orders. Root cause analysis for both falls sustained by R1 on 8/20/2022 was identified as neglect on the part of E7. Upon review of the incidents (8/22/2022), E7 was removed from the schedule pending investigation and ultimately terminated based on findings during facility investigation. Director of Nursing or designee provided nursing staff in-service on facility policy of cell phone/personal device usage (See ATTACHMENT F689-4) on 8/22 and 8/23/2022.	9/15/22

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{F 689}	Continued From page 2 stated: "... Purpose: To provide a safe environment and increased supervision for residents with a high risk for falls... Steps in Procedure:... 3. If there is more than one resident assigned to the safety aide, the safety aide is solely responsible for watching all the residents... Reporting and Documentation:... 2. Resident care plan will be updated to reflect 1:1 care." Review of R1's clinical record revealed: 6/13/22 - R1 was admitted to the facility with diagnoses that included Progressive Supranuclear Palsy (a medical condition that causes problems with balance, vision, speech, movement and swallowing) and Dementia. 6/13/22 at 4:33 PM - R1's Morse Fall Scale assessment upon admission indicated that he was at high risk for falling. 6/15/22 - R1 was care planned for being at risk for falls with interventions that included, but were not limited to: -hipsters on at all times; -anticipate and meet the resident's needs; -call light within reach and encouragement to use it. "R1 needs prompt response to all requests for assistance." -non-skid socks or shoes when mobilizing in wheelchair; -fall mat at bedside while in bed; -bed and chair alarm, check placement and function every shift. 6/15/22 - The comprehensive care plan documented R1's actual falls, which included three falls (one with no injury and two with injuries) from admission through 6/30/22.	{F 689}	2) Director of Nursing reviewed all current residents and their risk for falls and wandering. Those identified as high risk were assigned to the facility Safety Program to provide increased safety and supervision. Safety Program was reimplemented as of 8/29/2022. 3) The Safety Program procedure (see ATTACHMENT F689-3R Safety Program Procedure) was reviewed and updated. - Two or more nursing staff to be assigned to the Program to ensure proper supervision within a designated area. - Staff are to monitor needs of the residents in the Program throughout the day, positioning themselves and redirecting residents as needed. - Director of Nursing or designee has in-serviced all nursing staff on the procedure of the Safety Program prior to assignment within the Program. 4) Director of Nursing or designee will complete 3 audits daily of staff cell phone usage while on duty until 100% compliance is achieved for three consecutive days. three audits of staff cell phone usage will be conducted weekly until three consecutive weeks are 100% compliant. Followed by 3 audits a month until 100% compliance is achieved for three consecutive months. All results will be presented and reviewed by QAPI Committee. (see ATTACHMENT F689-5 Phone Audit)	

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{F 689}	Continued From page 3 6/30/22 - In response to a third fall with injury, R1's at risk for falls care plan was revised to include an additional intervention: one to one (1:1) supervision at all times. 7/18/22 at 4:58 PM - A psychosocial note by E12 (Psych NP) documented that R1 "... now has 1:1 care secondary to falls. Pt (Patient) has poor impulse control and poor safety awareness...". 8/12/22 - The following care plan intervention was added: "RNP (Restorative Nursing Program):... Be ON ALERT because he is very impulsive." 8/18/22 at 1:00 PM - A neurology consultation with E13 (NP) documented, "... He (R1) had a few falls, 2 with him ending up in the ED (Emergency Department) after hitting his head. He now has 1:1 supervision with no further falls... He has had multiple falls and difficulty with ADLs. We discussed fall safety...". Fall #1 8/20/22 at 7:15 AM - R1 fell outside of the nurse's station. The facility's incident report, completed by E8 (LPN), documented "While getting report, this writer heard a loud sound and when I returned I saw resident sitting on the floor in front of the nurse's station while the wheelchair was flipped back... Resident assessed no visible injury noted. Assisted from the floor to the wheelchair. Emotional support provided. MD POA and DON (notified)... No witnesses found...". The facility's Incident Report and investigation did not capture that R1 was in a Safety Program where one SP CNA was assigned to three residents (R1, R4 and R5).	{F 689}	Director of Nursing or designee will complete 3 audits daily of placement and functionality of any ordered assistance devices to prevent accidents until 100% compliance is achieved for three consecutive days. Three audits will be conducted weekly of placement and functionality of assistance devices until full compliance is met for three consecutive weeks. Followed by three audits of assistance devices monthly until 100% compliance is achieved for three consecutive months. All results will be presented and reviewed by QAPI Committee. (see ATTACHMENT F689-6 Device Audit) A High Risk Committee (Including, but not limited to: Director of Nursing, Assistant Director of Nursing, Therapy, RNAC, Administrator, Activities Director, Dietary Manager/Dietician) has been developed to provide an on-going weekly review of performance of the Safety Program. High Risk Committee will review and report to QAPI all Resident falls, behaviors and other incidents to determine effectiveness of the Program and appropriateness of its participants. Changes to the participants, or Individual Care Plan will be made by the identified discipline as needed.	

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{F 689}	Continued From page 4 In response to this fall, E7 (SP CNA) documented as part of the facility's post fall process that R1 was sitting next to her and he kept unlocking his wheelchair. E7 told him to stop and then he was on the floor. E7 documented that R1 wanted attention. 8/22/22 - According to the facility's investigation, the surveillance video captured E7 (SP CNA) "Seated in front of the resident (R1) at the desk outside the 3rd floor nurses station. E7 was looking down on her cell phone at 7:50:36 (hour/minute/second). Resident stood up from his wheelchair while E7 was texting on her phone. Resident took a couple of steps forward while CNA was still looking at her phone. Resident is holding onto the back of the CNA's chair that she was seated in. The CNA looks back at the resident as he starts to fall towards his right side back toward his wheelchair. He falls on the wheelchair, causing the chair to fall over." Fall #2 8/20/22 at 1:30 PM - R1 fell a second time while in the Safety Program with E7, the assigned SP CNA. An incident note by E8 (LPN) at 2:08 PM documented, "This writer was walking down the hall on Gilpin side to room (#) and saw CNA (E7) wheeling resident and said 'He fell again.' Resident assessed noted with laceration across his forehead, three bumps on the head and one near his right eye. Neuro checks initiated and was WNL (within normal limits). Resident denies pain when asked. Emotional support provided. MD POA and DON notified. Order to send resident to ER (Emergency Room) for further evaluation. 911 notified arrived (1:40 PM) and departed with resident at (1:46 PM) for (name) hospital. V/S (vital signs) 116/76 (blood pressure), 69 (pulse),	{F 689}		

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{F 689}	Continued From page 5 98.2 (temperature), 18 (respirations)." In response to this fall, E7 (SP CNA) documented that R1 was sitting in front of her watching a movie in the small lounge area. E7 documented that she was "Trying to sit R4 down because he was trying to stand and before I knew (sic) all I heard was (R1) hitting the floor." E7 documented that R1 said "he wanted more attention." 8/20/22 at 9:00 PM - R1 returned to the facility after being evaluated at the hospital status post fall with no further injuries. 8/23/22 at 8:59 AM - The Therapy Fall Screen by Physical Therapy (PT) for the two falls documented, "8/20/22 at 7:15 (AM) Resident sitting on floor in front of NSG (nursing) station with WC (wheelchair) flipped back. Possible standing w/o (without) assist. 8/20/22 at (1:30 PM) CNA reported resident had another fall. No info on report as to how or where. Resident requires assist to stand due to impaired balance and safety awareness...". 8/24/22 - Per the facility's investigation, during an interview with E7 (SP CNA), she "was 1:1 for R1 and was in... Gilpin hallway cubby (lounge) where R1 was watching TV with two more residents, when E7 turned her back to help R4, a resident in the Safety Program with something. E7 could not recollect with (sic) what she was helping R4 (sic),... saw R1 standing up, but was unable to break the fall for she could not reach him on (sic) time, after fall per E7 R1 was trying to get back in (sic) wheelchair. E7 called for help, but nobody was around and she got him in (sic) wheelchair and wheeled him to the nurse."	{F 689}		

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{F 689}	Continued From page 6 8/25/22 - The facility's five day follow-up to R1's second fall with transfer to the ER reported the following to the State Agency: "Root cause analysis is a privileged document. Result of Investigation:...Resident had a diagnosis of dementia and lack (sic) safety awareness, very impulsive, easy to redirect, resident was on 1:1 at the time of the fall, and the AID (sic) assigned was right there but unable to break the fall... Were changes made to the Care Plan? No...". The facility did not disclose to the State Agency the root cause of the fall nor that R1 was in a Safety Program where the assigned CNA was supervising R1 and two other residents. 8/26/22 (untimed) - The facility's form entitled Employee Warning record documented that E7 was terminated for a violation on 8/20/22 at 1:00 PM due to substandard work and carelessness, specifically "(E7) was assigned to sit 1:1 with residents who were at risk for falls. (E7) was texting on her cell phone and not watching the residents when a resident stood up, walked behind her and fell. (E7) is terminated for neglect." 8/26/22 at 10:00 AM - Two surveyors observed the facility's surveillance video of R1's first fall. In addition to observing E7 (SP CNA) on her personal cell phone and not performing her duty to supervise, the immediate response by nursing staff after R1's fall was failure to perform a thorough nursing assessment before picking R1 up off the floor and placing him back in his wheelchair. 8/26/22 at 12:35 PM - During an interview, E3 (CNA) stated that she toilets R1, but he is in a 1:1 with another CNA. E3 stated that the Safety CNA	{F 689}		

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{F 689}	Continued From page 7 assigned to R1's 1:1 also looks after other residents as well (R4 and R5). 8/26/22 at 12:45 PM - During an interview, E11 confirmed that she was the assigned SP CNA for the Safety group today. E11 stated that she was assigned to watch three residents, including R1, R4 and R5. 8/26/22 at 1:37 PM - During an interview, E8 (LPN) stated that she was in the nurse's station when the first fall occurred, and she heard a loud "Boom" sound. E8 did not recall hearing the chair alarm. She stated that she was so angry and asked, "How could a resident fall on 1:1?" For fall #2, E8 stated that as she was walking down the hallway, she saw E7 (SP CNA) pushing R1 in his wheelchair towards her. E8 stated that she asked E7 what happened and E7 said he fell again. E8 stated that R1's forehead was bleeding. 8/29/22 at 2:34 PM - During an interview, E9 (LPN) stated that she was in the nurse's station when R1's first fall occurred and she heard a loud noise, a "Bang or Boom." E9 stated that R1 was in an awkward position on the floor and asked if he had pain and R1 said no. E9 stated that R1 was a little agitated and that she helped stand him up when they got the wheelchair situated. 8/30/22 at 8:27 AM - During an interview, E10 (PT) stated that the Safety Program was generated by nursing. E10 stated that therapy will discuss the resident's needs or therapy's concerns. E10 stated that R1 was completely impulsive as he will pop up out of the wheelchair if he needs to use the bathroom and staff need to anticipate his needs.	{F 689}		

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{F 689}	Continued From page 8 8/30/22 at 1:45 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E6 (ED) and E5 (ADON).	{F 689}		