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: August 17, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced annual and complaint survey was conducted at this facility on August 10, 2026, through August 17, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was (ninety-four) 94. The survey sample size was (forty-six) 46.		
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 was not met as evidenced by:** Cross Refer to the CMS-2567 - L survey completed August 17, 2026: F684 and F756.		

Provider's Signature Jennifer Bowen NHA Title Administrator Date 8-21-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILPIN HALL	**1101 GILPIN AVENUE , WILMINGTON, Delaware, 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
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from August 10, 2026 through August 17, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		08/21/2026
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility on August 10, 2026 through August 17, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 94. The survey sample size was 46. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Anticoagulation - medication that works to prevent the coagulation (clotting) of blood; Atrial fibrillation - irregular and often rapid heart rate that commonly causes poor blood flow to the body OR irregular heart rhythm; CNA - Certified Nurse Aide; ED - Executive Director; Dementia - a significant decline in memory, thinking, language, and judgment; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; Olanzapine - an antipsychotic medication used to treat schizophrenia and bipolar disorder;	F0000		08/21/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0000	Continued from page 1 Parkinson's - a progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; Paroxetine - an antidepressant medication used to treat major depressive disorder; POA (Power of Attorney) - someone appointed to make decisions on your behalf; RN - Registered Nurse; Schizophrenia - a severe, chronic brain disorder that affects how a person thinks, feels and acts.	F0000		08/21/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R41) out of eight residents reviewed for accidents, the facility failed to ensure necessary care and services were provided in accordance with professional standards of practice and residents' needs. Findings include: Review of R41's record revealed: 8/3/21 - R41 was admitted to the facility with diagnoses including diabetes, atrial fibrillation, Parkison's and major depression. In addition, R41 was ordered anticoagulation therapy. 6/27/26 6:15 PM –A facility Incident Report documented that R41 sustained an unwitnessed fall in her room. On assessment, R41 was at her baseline cognitively and was noted to have right "forehead and periorbital hematoma (bruising)." R41 was currently receiving anticoagulation therapy. R41's POA declined having R41 sent to the hospital.	F0684	R41 had a subsequent vital sign and neurological assessment completed on 6/28/26 at 12:15am and again on 6/28/26 at 2:15am with no further signs or changes of concern identified status post fall. R41 was subsequently seen and evaluated by her physician on 7/1/26 for follow-up related to the fall. It was determined that there were no further injuries related to the fall. A review of all resident falls occurring during the past month was completed by the ADON to ensure post-fall assessments were completed thoroughly and in accordance with the facility's procedures. No additional gaps in post-fall assessments were identified. The root cause was identified as a process deficiency in the facility's existing Fall Policy and Procedure. Although post-fall requirements were addressed within the facility's overall Fall Policy and Procedure, the process did not sufficiently isolate and detail the specific requirements for completion and follow-up of post-fall assessments. To strengthen the process and promote consistent implementation, the facility created a separate Post-Fall Assessment Procedure (attached F-684-1) by extracting and further clarifying the post-fall requirements from the existing Fall Policy and Procedure. The revised procedure specifies the required timing of post-fall assessments and requires completion of all applicable assessments, including clarification of the limited circumstances in which an assessment cannot be completed, such as when the resident is out of the building or refuses the assessment. The	09/04/2026

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F0684 SS = D	Continued from page 2 8/10/26 1:30 PM - During survey screening, R41 was observed to have healing bruise of the right periorbital (around the eye) area and right cheek. 8/17/26 1:30 PM - A review of R41's EHR (Electronic Health Record) revealed a form titled "Gilpin Hall Obvious or Suspected Head Injury Post Fall Assessment" which included directions to document vital signs and neurological assessments "Q [every] 30 minutes x [times] 4, then Q 1 hour x 2, then Q 2 hours x 2." Initial vital signs and neurological assessment were completed at 6:15 PM, followed by vital signs and neurological assessments 6:45 PM, 7:15 PM, 7:45 PM, 8:15 PM and 9:15 PM. For the vital signs and neurological assessment due at 10:15 PM, staff documented "ASLEEP." 8/17/26 5:05 PM – Findings were reviewed with E1 (NHA), E2 and E3 (ED) during the exit conference	F0684	Continued from page 2 procedure further specifies that the physician must be notified when a resident refuses a post-fall assessment. The procedure also clarifies that, when a resident leaves the facility before completion of the required neurological assessment schedule, neurological assessments will resume upon the resident's return to the facility until the required assessment schedule has been completed. Current licensed nursing staff will be educated by the DON or RN designee regarding the revised Post-Fall Assessment Procedure and the clarified requirements. The Post-Fall Assessment Procedure will also be incorporated into the orientation process for all newly hired licensed nursing personnel. All post fall assessments will be reviewed daily by ADON or RN designee for accurate completion. After 3 consecutive days of 100% compliance, all post fall assessments will be reviewed weekly for accurate completion. After 3 consecutive weeks of 100% compliance, a sampling of 5 post-fall assessments will be reviewed within one month. If the sampling of assessments continues with 100% compliance for 2 consecutive months, monitoring will conclude. All outcomes of monitoring activity will be reviewed with QAPI Committee.	09/04/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician	F0756	R24's pharmacy medication review was re-submitted to the outside ordering provider, and a response has been received. No changes were made to the resident's medication order per the ordering provider. An audit was conducted by DON for the past 30 days of pharmacy recommendations, no other residents were identified to have outstanding pharmacy recommendations without physician response. The root cause was identified as a gap in facility policy and procedure that did not direct nursing staff to escalate non-responsive outside providers to the attending physician, nor did the policy provide a timeline with which they should work within before notification is provided to the attending physician. The Medication Regimen Review procedure was revised (Attached F-756-1) to include the escalation of notice to the primary physician if an outside provider fails to respond to pharmacy recommendation within 2 weeks of notification. The primary physician will then address the pharmacy recommendation or contact the prescribing	09/04/2026

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F0756 SS = D	Continued from page 3 and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R24) out of five residents reviewed for unnecessary medications, the facility failed to act on pharmacy medication review recommendations for R24. Findings include: Review of R24's clinical record revealed: 10/30/25 – A pharmacy medication review documented a recommendation for P1 (facility physician) that R24's medication paroxetine 30 mg every bedtime be considered for possible dose reduction in attempts to eliminate or find the minimally effective dose. The pharmacy medication review report lacked evidence of P1's acknowledgment and signature that the recommendation was reviewed. 4/29/26 - A pharmacy medication review documented a recommendation for P1 that R24's medication olanzapine 5 mg every bedtime be for possible dose reduction in attempts to eliminate or find the minimally effective dose. The pharmacy medication review report lacked evidence of P1's acknowledgment and signature that the recommendation was reviewed. 8/13/26 5:20 PM – During an interview, E4 (ADON) stated that R24's pharmacy recommendations were forwarded to P2 (R24's outside facility psyche MD) to respond. E4 further stated that she is encountering a problem with getting responses from	F0756	Continued from page 3 physician. Nursing management will be in-serviced by the DON or RN designee regarding the procedural change. All pharmacy recommendations will be reviewed monthly by DON or RN designee until 3 consecutive months have 100% compliance. After 3 consecutive months of 100% compliance, monitoring will move to two months of review for physician response to recommendations. Once two consecutive months have maintained 100% compliance, one additional month of review of all pharmacy recommendations will be conducted. If this review is 100% compliant monitoring will be considered complete and compliance achieved. Outcomes of monitoring reports will be reviewed with QAPI committee.	09/04/2026

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F0756 SS = D	Continued from page 4 P2. E4 stated she will call P2's office again "now" to follow up on R24's October 2025 and April 2026 pharmacy recommendations. 8/13/26 5:30 PM – In an interview, E2 (DON) stated that the facility's policy in responding to the pharmacy MMR is within 30 days. E2 also stated that R24's recommendations were being followed by P2, who knew R24 very well even from before admission. E2 also stated that P1 is not comfortable making the adjustments for R24's medications and refers psych medications to P2. When asked about the facility's delay in responding to the recommendations, E2 stated, "... I was not aware of these MRRs not responded by [P2]". E2 also stated, "I would have followed up on him [P2] had I known about these". 8/14/26 10:26 – E4 presented to this surveyor copies of R24's 10/30/25 and 4/29/26 pharmacy medication regimen reviews with responses signed by P2 dated 8/14/26. 8/14/26 10:30 AM – In an interview, P1 stated, "I don't review psych medication recommendations. I don't prescribe psych meds. Usually, the psych NP or the psych doctor who diagnoses, prescribes, and makes dose adjustments signs and takes care of it. Nobody brought to my attention any pharmacy recommendations that were not acted on." 8/14/26 5:05 PM – Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ED) during the Exit Conference.	F0756		09/04/2026