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: July 14, 2026

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 July 10, 2026, through July 14, 2026. The deficiencies contained in this report are based on observations, interviews, reviews of residents' clinical records, and reviews of other facility documentation as indicated. The facility census on the first day of the survey was (one hundred fifty-five) 155. The investigative sample totaled (4) four residents. Abbreviations/definitions used in this report are as follows: CNA – Certified Nursing Assistant; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; RN - Registered Nurse.		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Nursing Facilities** **Scope** **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**	A) A late entry incident report for Resident R4 was reviewed and supplemented with the available information to ensure the event was thoroughly documented, including the circumstances surrounding the event, assessments completed, interventions implemented, notifications made, and the resident's disposition. The resident received appropriate medical evaluation and treatment and upon return to the facility, received speech therapy services as indicated and was monitored 1:1 during all meals. B) The RN Quality Control Nurse conducted a review of incident reports associated with residents transferred to the hospital beginning January 1, 2026	8/14/2026

Provider's Signature [signature] Title Administrator Date 8-03-2026

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	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 July 14, 2026: F689. **Records and Reports** **Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for one (R4) out of four residents reviewed for accidents the facility failed to complete an incident report with adequate documentation of the incident. Findings include: Review of R4's clinical record revealed: 1/18/26 1:20 PM – A progress note in R4's clinical record documented, "Resident noted post meal by aide with large amount of emesis coming from her mouth and nose, with additional emesis noted on her chest. The aid immediately notified the charge nurse. Upon entering the room, the charge nurse observed that resident head had dropped forward with her chin resting on her chest, blue	to determine a correlating incident report and whether those reports contained the required documentation. The review did not identify any events without internal incident reports nor any incident reports with incomplete documentation. C) The root cause was determined to be that staff did not recognize the event as one requiring a comprehensive incident report documenting all pertinent details of the occurrence, including the resident's condition before, during, and after the event, the circumstances surrounding the event, interventions implemented, notifications made, and follow-up actions. Although the resident received timely clinical evaluation and transfer to the hospital, the incident report did not contain sufficient documentation to fully describe the event and the facility's response. The facility's Incident Report/Investigative Protocol has been revised to include specific documentation requirements and examples of the information that must be included in every incident report to ensure a complete and accurate record of the event and the facility's investigation. The RN Quality Control Nurse/designee will provide education to all licensed nurses and other applicable staff on the revised documentation requirements, emphasizing timely, objective, and complete documentation of all reportable incidents. D) The interdisciplinary clinical team will review all incident reports completed during the audit period weekly for four (4) weeks to verify that inci-	

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	color to fingertips indicating air hunger...911 notified. Oxygen was administered via non-rebreather mask. Resident was transferred back to bed via Hoyer lift, oral suctioning initiated. VS assessed... oral and nasal cavity was cleared of secretions. Paramedics arrived at scene and started their own assessment. Resident transferred to hospital via ambulance." 1/18/26 – ER hospital record documented that R4 "presented to the ED with respiratory distress after choking on food at her facility." 7/10/26 – During entrance conference interview facility incident reports and investigations dating back to September 2025 were requested for review. The facility was unable to provide any evidence related to R4's incident that occurred 1/18/26. 7/14/26 2:47 PM – During an interview, E3 (ADON) confirmed that an incident report and detailed the investigation of R4's choking incident that resulted in transfer to acute care on 1/18/26 was not completed. E3 stated, "We did talk with the nurse and other staff and implemented speech evaluation and monitoring when she returned."	dent reports contain complete and accurate documentation, including the circumstances of the event, resident assessments, interventions, notifications, investigation findings, follow-up actions, and required reporting. Once 100% compliance is achieved during the initial four-week monitoring period, the clinical team will continue to review incident reports weekly for an additional two (2) weeks to ensure sustained compliance. If 100% compliance is maintained throughout the additional two-week monitoring period, the clinical team will conduct one final weekly audit. If 100% compliance is achieved during the final audit, the monitoring period will be considered complete. Any identified concerns during the monitoring period will result in immediate correcting action, staff re-education education, and continued follow-up monitoring until sustained compliance is demonstrated. Audit results will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for review and oversight to ensure ongoing compliance.	
3201.9.8	**Reportable incidents are as followed:**		
3201.9.8.4	**Significant injuries**		
S/S – D	**This requirement is not met as evidenced by:** Based on interview and record review, it was determined that for one (R4) out of six residents reviewed, the facility failed to ensure that reportable incidents were reported to the State Agency. Findings include: Review of R4's clinical record revealed:	A) Resident R4 was treated at the hospital. Upon return to the facility, Resident R4 received speech therapy services as indicated and was closely monitored during all meals to ensure safe swallowing and reduce the risk of aspiration. B) The RN Quality Control Nurse conducted a review of all residents who	8/14/2026

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	1/18/26 1:20 PM – A progress note in R4's clinical record documented, "Resident noted post meal by aide with large amount of emesis coming from her mouth and nose, with additional emesis noted on her chest. The aid immediately notified the charge nurse. Upon entering the room, the charge nurse observed that resident head had dropped forward with her chin resting on her chest, blue color to fingertips indicating air hunger...911 notified. Oxygen was administered via non-rebreather mask. Resident was transferred back to bed via Hoyer lift, oral suctioning initiated. VS assessed... oral and nasal cavity was cleared of secretions. Paramedics arrived to scene and started their own assessment. Resident transferred to hospital via ambulance." 1/18/26 – ER hospital record documented that R4 "presented to the ED with respiratory distress after choking on food at her facility." 7/9/26 – Review of the State Agencies incident reporting system lacked evidence that R4's choking incident that resulted in transfer to an acute facility on 1/18/26 was reported. 7/14/26 2:47 PM – During an interview, E3 (ADON) confirmed that R4's transfer to the hospital was not reported to the State Agency. E3 stated, "We looked at it as a medical event." 7/14/26 3:30 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	were transferred to the hospital beginning in January 2026 to determine whether any events requiring an incident report and notification had not been documented. The review found that no other required incident reports or notifications were missing. C) The root cause was determined to be that while staff appropriately recognized the resident's change in condition as requiring immediate medical evaluation and arranged for prompt transfer to an acute care hospital, the staff did not recognize that the event should have been treated as an occurrence of unknown origin or significant injury requiring completion of the facility's internal incident report, investigation, and notification to the Division of Health Care Quality (DHCQ). As a result, while the resident received timely and appropriate medical care, the facility's internal incident reporting process and required notification to DHCQ were not initiated because staff did not recognize that both the clinical response and the regulatory reporting requirements applied under the circumstances. The facility's incident report/investigative protocol has been revised to include clear guidance and examples identifying events that require internal investigation only and those that require both an internal incident report and notification to DHCQ, including events of unknown origin that result in transfer to an acute care hospital for evaluation. The RN Quality Control Nurse/designee will educate all licensed nurses and other applicable staff on the revised procedure, reporting requirements, and documentation expectations.	

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		D) The interdisciplinary clinical team will review PCC progress notes and the PCC internal incident reporting portal weekly for four (4) weeks to verify that all events meeting reporting requirements have been appropriately identified, documented, internally investigated, and when applicable, reported to the Division of Health Care Quality (DHCQ) in accordance with facility policy and regulatory requirements. Once 100% compliance is achieved during the initial four-week monitoring period, the clinical team will continue to review the same documentation weekly for an additional two (2) weeks to ensure sustained compliance. If 100% compliance is maintained throughout the additional two-week monitoring period, the clinical team will conduct one final weekly audit. If 100% compliance is achieved during the final audit, the monitoring period will be considered complete. Any identified concerns during the monitoring period will result in immediate corrective action, staff re-education, and continued follow-up monitoring until sustained compliance is demonstrated. Audit results will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for review and oversight to ensure ongoing compliance.	

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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 07/14/2026

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
F0000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from July 10, 2026, through July 14, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records, and review of other facility documents as indicated. The facility census on the first day of the survey was ninety-three (93). The survey sample totaled six (6). Abbreviations/definitions used in this report are as follows: CNA – Certified Nursing Assistant; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; RN - Registered Nurse.	F0000		07/27/2026
F0689 SS = G	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 record review and interview it was determined that for one (R4) out of four residents reviewed for accidents the facility failed to provide assistive devices to prevent an accident. R4 was transported in a facility vehicle without all safety straps secured. The facility driver came to a sudden stop and R4 fell forward and acquired two broken legs causing physical harm. The facility was found	F0689	"Past Noncompliance - no plan of correction required"	07/27/2026

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F0689 SS = G	Continued from page 1 to be in past noncompliance with correction completed as of 1/8/26. Findings include: Review of R4's clinical record revealed: 12/3/25 - An annual MDS assessment documented that R4 was cognitively intact and required substantial maximum assistance with upper body dressing and weighed 265 pounds. 12/7/25 - R4's care plan for self-care deficit included the intervention for staff to provide extensive assistance with upper body dressing. 1/5/26 12:42 PM - The facility submitted an incident report to the State Agency that alleged R4 experienced a fall while traveling in the facility van. 1/5/26 2:46 PM - R4 was admitted to the hospital with a diagnosis of bilateral foot pain. X-rays of both legs showed broken bones. 1/5/25 - A statement written by E6 (CNA) documented, "[E5 (driver) had to slam on the brakes. When I looked [R4] was on her knees with the seat belt still attached." 1/6/26 - A statement written by E4 (former NHA) documented "[E5 (driver)] and I inspected the transport van to investigate the proper operation of the safety belts. We reviewed and inspected the wheelchair harness and seatbelts and wheelchair locking mechanisms an discussed their proper operation. We found the safety belts and devices not damaged and discussed searching for longer safety belts for bariatric (plus) sized residents." 1/7/26 - The facility policy was revised to include, "If using [facility] transportation, the driver must confirm that the wheelchair is properly locked in place and all seat belts are properly fastened before departure. If any defects or faults with equipment are found, the driver must report this information to the administrator or designee immediately and if not able to be fixed the appointment must be rescheduled." 1/7/26 - An employee warning record documented that E5 (driver) was suspended by the facility for "carelessness." 1/9/26 - An employee warning record documented that E6 (CNA) was suspended by the facility for "carelessness." 7/13/26 2:30 PM - Review of the facility training	F0689		07/27/2026

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F0689 SS = G	Continued from page 2 and sign-in sheets revealed that on 1/7/26 - 1/8/26 the facility conducted education with staff who assist with resident transports on safe transfer of residents with the use of equipment [straps]. 7/13/26 2:40 PM - During an interview E1(NHA) stated, "We inspected all our bariatric patients and determined one other patient at risk and cancelled their use of the facility van until arrival of our seat belt extender for safety of larger residents". 7/13/26 3:08 PM - During an interview, E5 (driver) confirmed that the shoulder belt was not fastened for R4 during the transport in the facility van on 1/5/26. E5 stated "the strap didn't fit across [R4]. We thought since the seatbelt and wheelchair were fastened it would still be safe." 7/13/26 3:09 PM - E1 (NHA) provided copies of the audits that the facility completed 1/12/26 - 2/27/26 to verify residents were securely strapped in during transports on the facility vehicle. Review of the audits indicated 100% compliance. 7/13/26 3:15 PM - During an interview, E6 (CNA) confirmed that she and [E5 (driver)] did not apply R4's shoulder belt during the transport on 1/5/26. E6 stated, "It didn't fit and we were afraid it would hurt her chest being so tight. We thought with the seatbelt and the wheelchair secured that would hold her". 7/13/25 3:30 PM - Review of facility investigation and corrective measures completed by E4 (former NHA) and E2 (DON) documented that immediately following the incident, the facility halted further use of the vehicle, inspected the vehicle for disrepair, and identified the need to order extenders for the shoulder straps to fit bariatric residents. Simultaneously, the facility reviewed all residents for safe use of the facility vehicle, educated all staff on safe security of residents during transport, and revised the transportation policy. The facility concluded interventions in response to R4's accident as of 1/8/26. 7/14/26 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F0689		07/27/2026