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: December 3, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**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 October 2, 2025, through October 8, 2025. However, the revised exit date was December 3, 2025, due to the government shut down. The deficiencies contained in this report are based on interview, observation and review of facility and other documentation as indicated. The facility census on the first day of the survey was ninety-five (95). The survey sample was five residents. **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 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 October 8, 2025: F551 and F600.		

Provider's Signature [signature] NHA Title Administrator Date 1-20-2026

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 12/03/2025

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 October 2, 2025 through October 8, 2025. The deficiencies contained in this report are based on interview, observation and review of facility and other documentation as indicated. The facility census on the first day of the survey was ninety-five (95). The survey sample was five residents. Abbreviations/definitions used in this report are as follows: ADLs – activities of daily living/ tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; BIMS - Brief Interview for Mental Status/assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions); CNA – Certified Nurses Aide; Dehumanization – deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations; Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DHCQ – Division of Health Care Quality; DON – Director of Nursing; ED – Executive Director; MDS – Minimum Data Set/standardized assessment forms used in nursing homes; NHA – Nursing Home Administrator; Non-adherent – failure to follow instructions by the	F0000		12/08/2025

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 health care staff; POA – Power of attorney/ someone appointed to make decisions on your behalf; QAPI – Quality Assurance Performance Improvement/data driven proactive approach to improving the quality of life, care, and services in nursing homes; RN – Registered Nurse; SD – Staff Development.	F0000		
F0551 SS = D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a	F0551	A) Resident experienced no harm as a result of the camera being turned during the provision of care. Immediately following care the device was returned to its original and intended placement. No physical, emotional, or psychosocial concerns were identified related to this incident. B) A facility-wide sweep was conducted in all rooms known to contain authorized monitoring devices placed by resident representatives. Each applicable representative was contacted to confirm that their device remained in its proper location and to determine whether they had any concerns regarding staff interference. No concerns were reported, and all devices were verified to be located in their intended positions. C) The root cause was identified, as the employee's decision to reposition the monitoring camera. During the facility investigation, the employee stated taht the camera was turned because they believed it was inappropriate for the resident to be recorded while undressing and that the action was taken in an attempt to protect the resident's dignity. In response, the Administrator (NHA) reviewed and formalized the facility's Audio/Visual Monitoring Devices Policy (F0551-1) to explicitly state that staff are prohibited from moving, turning, unplugging, covering, or otherwise disabling any resident-or representative- approved monitoring device, except in emergency situations where resident safety is immediately threatened. The Quality Control Nurse (RN) or designee (RN / NHA): provided staff education on the revised Audio/Visual Monitoring Device Policy.	12/29/2025

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F0551 SS = D	Continued from page 2 resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R1) out of five residents reviewed for resident rights, the facility failed to ensure that rights exercised by R1's resident representative were followed by staff. Findings include: Review of R1's clinical record revealed: 6/20/23 – R1 was admitted to the facility with a diagnosis of dementia. R1's resident representative was listed as R1's power of attorney for care. 6/16/25 – The annual MDS assessment documented R1's BIMS score as a 3 (severely cognitively impaired). R1 had a motion activated camera located in R1's room, which was permitted by the facility, supplied and viewed by R1's resident representative, and known to all nursing staff. The camera, located on top of the dresser, captured the following:	F0551	Continued from page 2 Provided re-education on Resident Rights, with specific emphasis on respect for personal property and the role of monitoring devices in safeguarding residents. Entered a task reminder into the medical record of all residents with approved cameras instructing: "Do Not Touch Resident/Representative-Placed Cameras - Contact Charge Nurse if Concern." D) The Administrator or designee will conduct weekly audits for 4 weeks reviewing all rooms with authorized monitoring devices to ensure each device remains positioned as intended. If 100% compliance is achieved for four (4) weeks, the facility will transition to monthly audits for three (3) months. Upon achieving 100% compliance for three consecutive months, monitoring will conclude. All audit results will be documented and reviewed with the QAPI Committee.	

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F0551 SS = D	Continued from page 3 9/9/25 11:21 AM – Video observation of E7 (CNA) in R1's room standing in front of the dresser. E7 turned the camera to face the wall and R1's personal items. (Video 0:00:26 hour:minute:second) 9/24/25 11:47 AM – Video observation of E7 (CNA) exited the bathroom in R1's room and was putting on disposable gloves. E7 stood in front of the dresser and opened the doors. R1 was observed talking softly at the foot of her bed. E7 reached for the camera on top of the dresser and turned it away to face the wall and R1's personal items. (Video 0:00:59 hour:minute:second) 9/29/25 untimed – E7 (CNA) wrote the following statement: "... On several days I did turn the camera around because I didn't ok (sic) to be recorded." 10/6/25 12:05 AM – During an interview, E7 (CNA) confirmed that she was educated that staff are not allowed to touch the resident's personal property, specifically the camera, in the room. 10/8/25 4:00 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E12 (ED).	F0551		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by:	F0600	Across all three videos: A comprehensive root cause analysis was conducted for each incident. The analysis determined that the primary root cause in all three videos was staff's violation of the resident's right to refuse care, despite having received prior training and education on dementia care, resident rights, and abuse prevention. Employees involved had completed facility-required education related to: Dementia and dementia-related behaviors Resident rights, including the right to refuse care Abuse prevention and reporting requirements Additionally, staff involved had received	12/29/2025

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F0600 SS = D	Continued from page 4 Based on video observation, interview and review of facility documentation, it was determined that for one (R1) out of five residents reviewed for abuse, the facility failed to protect a resident's right to be free from physical and mental abuse by staff. While there was no apparent decline in mental or physical functioning of R1 at the time of the survey, it can be determined that a reasonable person in the same position would have experienced psychosocial harm, specifically dehumanization, as a result of the physical and mental abuse by staff. Review and verification of the facility's immediate actions for the staff to resident incidents on 8/2/25 and 8/20/25 were determined to have been corrected prior to the survey. An additional finding of a resident to staff incident, dated 8/31/25, was also captured on video, but was unknown to the facility until 10/3/25. Findings include: 1. Review of R1's clinical record revealed: 6/20/23 – R1 was admitted to the facility with diagnoses that included, but were not limited to, dementia, depression and anxiety disorder. 6/30/23 – R1 was care planned for ADL self-care performance deficit related to dementia. Approaches included, but were not limited to: -independent for transferring in and out of bed (10/4/24 revised); -required partial/moderate (limited assist) from staff to dress and to encourage changing clothes; -able to transfer on toilet with supervision/touching assistance. Staff needs to make sure incontinence products are in place and clean, extensive (substantial/max) assist for incontinence care (6/30/25 revised). -encourage the resident to participate to the fullest extent possible with each interaction; and -praise all efforts at self care. 1/6/25 revised – R1 was care planned for frequent refusals/resistive to care. Approaches included, but were not limited to:	F0600	Continued from page 4 resident-specific education approximately one month prior to the incidents, addressing Resident R1's diagnosis of dementia, history of frequent refusal of care, and the facility's approved interventions for managing R1's care needs. Employees are provided ongoing access to resident diagnoses, behaviors and individualized care approaches through the resident's Plan of Care in PointClickCare (PCC). Despite this education and access to guidance, staff did not implement facility-approved interventions at the time of the incidents. During investigative interviews, employees in all three scenarios verbalized concern for the resident safety; however, staff did not follow established procedures, including honoring refusal of care, disengaging when resistance occurred, utilizing de-escalation techniques, and seeking assistance as required. First Video (1) A-1) Upon learning of the incident, the involved employee was immediately suspended from the schedule pending the facility's full investigation. A head-to-toe physical assessment was completed on the resident, revealing no signs of injury or harm. A record review of all skin assessments conducted during the timeframe of the video showed no suspicious marks and no indications of mistreatment. The resident received emotional support and reassurance, though due to cognitive limitations, the resident was unable to recall the incident. No further concerns were identified. B-1) A facility-wide review was conducted in which all cognitively intact residents were interviewed, and attempts were made to interview all remaining residents, to determine whether any similar concerns had occurred. All residents interviewed reported no concerns of abuse by staff. Additionally, a review of incident logs and behavior documentation for the previous 90 days was completed to identify any patterns or related events. No additional residents were found to be affected. C-1) Facility created and implemented a Refusal of Care Policy (F0600-1) outlining expectations and procedures for safely managing resident care in situations involving dementia and dementia-related behaviors. The Quality Control Nurse (RN) provided formal education to nursing staff on the new Refusal of Care Policy and	

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F0600 SS = D	Continued from page 5 -encourage as much participation/interaction by the resident as possible during care activities; -give clear explanation of all care activities prior to and as they occur during each contact; -if resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again; -praise the resident when behavior is appropriate; and -provide resident with opportunities for choice during care provision. 6/16/25 – The annual MDS assessment documented R1's BIMS score as a 3 (severely cognitively impaired); exhibited physical, verbal and other behaviors toward others and rejection of care occurred 1 to 3 days during the assessment; behaviors significantly interfered with the resident's care; and R1's behaviors and care rejection worsened since the last assessment. R1 had a motion activated camera located in R1's room, which was permitted by the facility, supplied and viewed by R1's resident representative, and known to all nursing staff. The camera, located on top of the dresser, captured the following staff to resident incidents: First Video: On 8/2/25 at 6:00 AM, E4 (CNA) was observed making R1's bed. R1 was standing in the doorway talking softly. E4 walks over to R1 and said, "right here" while pointing to the bathroom. E4 said, "sit on the toilet, please thank you." E4 walked into the bathroom and said, "right here." R1 says, "then what… running down my leg." E4 said, "no" and walked out of bathroom and around R1 to the doorway. R1 said, "what's wrong?" E4 said, "you don't have a pull up on." R1 said, "I took it off." E4 said, "why didn't you put on a new one?" R1 responded (unable to hear clearly). E4 returned into the room from the doorway, closed the door and pointed to the bathroom. R1 then pointed to the bathroom. E4 forcefully grabbed R1 and pushed her into the bathroom while R1 was screaming. (Video 0:02:01 hour:minute:second) Second Video: On 8/20/25 at 5:35 AM, R1 was sitting on the side of the bed. E4 (CNA) was standing on the left side of R1. As R1 was observed to be taking her right arm out of her shirt, E4 immediately and forcefully	F0600	Continued from page 5 re-educated staff on the existing Resident Abuse Policy (F0600-2), including expectations for immediate reporting and required reporting timelines. D-1) To ensure compliance with the revised Abuse Policy and newly implemented Refusal of Care Policy, the Administrator or designee will conduct weekly audits until 100% compliance has been achieved for four (4) consecutive weeks. Upon achieving 100% compliance, audits will continue on a monthly basis for three (3) consecutive months. Audits will include review of: Incident Reports of alleged abuse and skin integrity Grievance records Staff training and education records Audit findings will be reported and reviewed by the QAPI Committee. If 100% compliance is maintained through the conclusion of the three-month monitoring period, ongoing auditing related to this corrective action will conclude. Second Video (2) A-2) The involved employee remained suspended from duty pending the outcome of the facility's investigation. A comprehensive physical assessment of the resident was conducted and revealed no signs of injury or physical harm. A record review of all resident's skin assessments during the timeframe captured on the video was completed, and no suspicious marks or indications of mistreatment were identified. DON provided resident emotional support and reassurance following discovery of the incident; however, due to cognitive impairment, the resident was unable to recall the event. No further physical or psychosocial concerns were noted. B-2) A facility-wide review was conducted in which all cognitively intact residents were interviewed, and attempts were made to interview all remaining residents, to determine whether any similar concerns had occurred. All residents interviewed reported no concerns of abuse by staff. Additionally, a review of incident logs and behavior documentation for the	

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F0600 SS = D	Continued from page 6 grabbed R1's left arm and pulled her up off the bed, standing her up, and pushed R1 from behind as R1 said, "Hey, Hey… Help" and continuously yelled as R1 was pushed into the bathroom. E4 was not observed speaking to R1 during this physical interaction. (Video 0:00:25 hour:minute:second) 9/29/25 4:48 PM – In response to a meeting with R1's resident representative regarding R1's care where these videos were shown, the facility immediately reported the videos dated 8/2/25 and 8/20/25 to the State Agency within the two-hour requirement. Immediate action was taken when these video incidents were brought to the facility's attention and prior to the current survey that started on 10/2/25 at approximately 1:30 PM. 9/29/25 – The staff member involved was identified and a written statement was obtained by E2 (DON) from E4 (CNA) prior to being suspended pending investigation: -E4 wrote, "I went to [R1's] room to give her care, took her to the bathroom and she was screaming but her clothes were really wet and I had to change her and was not happy to leave her in that state." The facility completed the following prior to the current survey, which was verified by the surveyor onsite: -9/29/25: Interview and written statement were obtained from E4 (CNA). E4 was immediately suspended pending a facility investigation. -9/30/25: E2 (DON) interviewed R1 who was unable to recall the incidents. E2 provided emotional support to R1. -9/30/25: All cognitive residents were interviewed for abuse concerns with staff. -9/30/25: E8 (RN/SD) in-serviced nursing staff on the "Abuse Policy, Reporting Abuse, No Retaliation" and "Refusal of Care" policy. -10/1/25: E2 (DON) reviewed R1's records for skin issues or bruising during the time period. No suspicious marks were identified.	F0600	Continued from page 6 previous 90 days was completed to identify any patterns or related events. No additional residents were found to be affected. C-2) Facility developed and implemented a formal Refusal of Care Policy (F0600-1) to guide staff in appropriate and safe approaches to residents with dementia or dementia-related behaviors. The Quality Control Nurse (RN) provided education to all staff on the newly created policy as well as re-education on the facility's Resident Abuse Policy (F0600-2). This training included clarification of required reporting timelines, appropriate behavioral interventions, and staff responsibilities when a resident refuses care. D-2) To ensure compliance with the revised Abuse Policy and newly implemented Refusal of Care Policy, the Administrator or designee will conduct weekly audits until 100% compliance has been achieved for four (4) consecutive weeks. Upon achieving 100% compliance, audits will continue on a monthly basis for three (3) consecutive months. Audits will include review of: Incident Reports of alleged abuse and skin integrity Grievance records Staff training and education records Audit findings will be reported and reviewed by the QAPI Committee. If 100% compliance is maintained through the conclusion of the three-month monitoring period, ongoing auditing related to this corrective action will conclude. Third Video (3) A-3) Upon learning of the incident, the involved employee was immediately removed from the unit and suspended pending completion of the facility's investigation. A head-to-toe physical assessment was completed on the resident, and no injuries, bruising, or suspicious marks were identified. A review of the resident's skin assessments during the relevant timeframe also revealed no signs of injury or trauma. Emotional support and reassurance were provided. Due to	

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F0600 SS = D	Continued from page 7 -10/1/25: E2 (DON) met with E4 (CNA) and showed the videos. E4 remained on suspension until E4's employment was terminated on 10/6/25. -10/1/25: QAPI team was updated by E2 (DON). Based on the actions above, the facility corrected the non-compliance on 10/1/25. 10/6/25 at 2:31 PM – During an interview with DHCQ staff, E4 (CNA) confirmed she worked 11 PM to 7 AM at the facility. In review of the 8/2/25 at 6:00 AM incident, E4 stated that she was trying to get R1 into the bathroom. E4 stated that she did not know that R1 had a dementia diagnosis. E4 stated that R1 doesn't like to use the bathroom and refuses care a lot. With toileting, R1 was really wet and R1 was shivering. I felt bad for her and was trying to take off her clothes. I didn't plan to hurt her." On 8/20/25 at 5:34 AM, E4 (CNA) stated that R1 was wet and the bed was wet. R1 wasn't standing. E4 stated, "I was only helping her for the condition that she was in. I used that approach to try to help her, but I was not trained in that way. Yes, R1 "was the most challenging resident I had." When asked what are you trained to do when a resident refuses (or was non-adherent) to care? E4 stated, "... let the nurse know. I didn't tell the nurse, that was a mistake. I should have let the nurse know." When asked did you learn not to force a resident if the resident refuses, E4 stated, "Yes, I will never do it again. I always ask for help. I am not sure what happened that day. She always yells like that and she doesn't like to be changed. Everybody knows and yes the nurses know that she doesn't like to be changed." When asked if she had dementia and abuse training, E4 stated, "Yes." When reviewing resident rights, E4 replied in an upset tone of voice and said "I'm sorry." 2. 10/3/25 10:06 AM – During an interview, E2 (DON) was asked by the DHCQ special investigator and surveyor to view an additional video to identify the nursing staff member involved. E2 immediately stated that she was not aware of this additional video, dated 8/31/25, and identified the staff member involved as E6 (RN). Third Video: On 8/31/25 at 9:48 AM, E6 (RN) was standing on R1's left side with R1 standing next to her bed. R1 said... (unable to hear clearly). E6 said, "Please take your medicine [name of R1]." R1 said, "All at one time?" E6 said, "Yep, like you do every day, every morning." R1 started to move. E6 said, "You want	F0600	Continued from page 7 cognitive impairment, the resident was unable to recall the event. No further physical or emotional concerns were noted. B-3) A facility-wide review was conducted in which all cognitively intact residents were interviewed, and attempts were made to interview all remaining residents, to determine whether any similar concerns had occurred. All residents interviewed reported no concerns of abuse by staff. Additionally, a review of incident logs and behavior documentation for the previous 90 days was completed to identify any patterns or related events. No additional residents were found to be affected. C-3) The Quality Control Nurse (RN) continues to provide ongoing education to all staff on the facility's Refusal of Care Policy (F0600-1) and Resident Abuse Policy (F0600-2). The facility has developed and posted visual reminder posters (F0600-3) throughout resident-care areas with the message: "Stop, Step Back. Call for Help" to reinforce appropriate de-escalation and resident-rights practices when staff encounter challenging behaviors. D-3) Director of Nursing (DON) or designee will complete five (5) random observation audits (F0600-4) of direct-care interactions weekly for two (2) weeks to ensure that resident rights, safety, and proper behavioral-response procedures are followed. If 100% compliance is achieved for two weeks, the DON or designee will then complete two (2) random observation audits per week for an additional two (2) weeks. After maintaining compliance for this period, two (2) final observation audits will be completed during the following one-week period. If compliance remains at 100% audits will conclude. All audit findings will be reviewed during QAPI Committee.	

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 12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0600 SS = D	Continued from page 8 to sit down. I will hold this." E6 reached for the cup of water in R1's left hand, but R1 doesn't let it go. E6 held the cup with R1 still holding it as R1 sat down on the side of the bed. E6 said, "There you go. Put that in your mouth, your pills." R1 said (something unclear) and was holding the pills in her right hand in a fist. E6 bent slightly forward then stood up straight and said, "Please take them." R1 said, "No. I am not going to take them until…(unable to hear clearly)". R1 had her right hand in a fist close to her chest. E6 reached for R1's right hand and was attempting to retrieve the medications. R1 asked, "What are you doing now?" E6 was bent down trying to get the medications out of R1's right hand. R1 said, "You're breaking my fingers. You did too." R1 slapped/hit E6 on the right arm with R1's right hand. R1 was still holding the cup of water in the left hand. After getting hit, E6 turns to R1, bent over, and pointed her finger at R1's face and said, "Do not hit me." E6 proceeded to pick up the medications off the floor. R1 said, "You will break another finger." E6 exited R1's room and closed the door. R1 said, "That's you alright. Get out of here." R1 drinks water out of the cup in her left hand. (Video 0:02:05 hour:minute:second) Immediately after seeing the 8/31/25 9:48 AM video, E2 (DON) removed E6 (RN) from the nursing floor to be interviewed by the DHCQ investigator and surveyor onsite. E6 met with E2 (DON) after and was requested to write a statement. Then E6 was suspended pending the completion of the facility's investigation. 10/3/25 10:51 AM – During an interview with DHCQ staff, E6 (RN) stated that she was very familiar with R1, a dementia resident. E6 stated that sometimes R1 becomes very anxious, confused, would scream out and become combative if R1 feels threatened. When asked about administering medications to R1, E6 stated that R1 likes to put the pills in her hand and count them (1,2,3,4,5,6). E6 stated that there was a time where she had to take the pills back, but she never forced her hand open. E6 stated she would wait 5-10 minutes to give R1 time to take the pills before taking them back. E6 stated that if reapproach doesn't work, you just have to keep trying. E6 stated that R1 can be verbally abusive and hit E6 once or twice during care. E6 stated she did not remember telling a supervisor about it. E6 stated that she would never hit R1 back or threaten R1. E6 stated that R1 had a reputation of being difficult. E6 stated that a resident cannot be forced to do anything. E6 confirmed that she received training for abuse and dementia care.	F0600		

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F0600 SS = D	Continued from page 9 10/3/25 untimed – E6's (RN) written statement provided to the facility was: "There was an occasion when [R1] had her medication in her hand, she would not take the medications, so I wanted to remove them from her hand. She had her fingers closed & [and] when I opened her fingers she started screaming. I did not force open her hand. I was simply trying to remove the pills from her hand because she did not want to take them. I did not put any force on her fingers. I just opened her fingers. She started screaming when I took the pills. I did not put any physical pressure on her hand. I just wanted to make sure that she did not have the pills in her possession for safety." 10/6/25 – The facility interviewed all residents again to determine if they were abused or mistreated by staff. No residents were identified. In addition, the facility reviewed R1's clinical record with the additional date from the video to determine if there was any bruising or suspicious marks, with none noted. 10/6/25 untimed – Facility management met with E6 (RN) to review the video in person. E6 submitted a second written statement to the facility: "On 8/31/25, I attempted to administer [R1's] medication several times. If she had refused the medications, I would have documented as so. As I have previously stated, when I was in the patients' room [R1's room], I was trying to free-up the medication from her hand. I was not trying to do it forcefully. I only wanted to remove the medications from her possession to protect any "mis-haps" as the patient has (sic) does have a diagnosis of severe dementia. When [R1] struck me, I should not (sic) not have tried to reprimand her in any way. I should have calmly walked out after she hit me and got the nursing supervisor." Review of R1's clinical record revealed no evidence of a nurse's note documenting the 8/31/25 medication refusal. 10/7/25 – R1's care plan was updated to include "key phrases to assist with encouraging the resident to allow care… and for staff to alert nurse if resident refuses care." 10/7/25 – QAPI committee was updated by E2 (DON). E6's	F0600		

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F0600 SS = D	Continued from page 10 (RN) employment was terminated and her license was reported to the State of Delaware's Board of Nursing. The facility failed to ensure R1 was free from physical and mental abuse. 10/8/25 4:00 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E12 (ED).	F0600		