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 29, 2025

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 Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from August 25, 2025, through August 29, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census on the first day of survey was ninety-four (94). The survey sample totaled twenty-four (24) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing 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 29, 2025: F570, F602, F607, F609, F628, F644, F684, F756, and F761.		

Provider's Signature _____ Title Administrator Date 10-3-2025

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 08/29/2025

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
E0000	Initial Comments An unannounced emergency preparedness survey was conducted at this facility from August 25, 2025, through August 29, 2025. The facility census was ninety-four (94) on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no emergency preparedness deficiencies were identified.	E0000		09/25/2025
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility on August 25, 2025, through August 29, 2025. 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 24. Abbreviations / definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; Delusional Disorder - a mental disorder characterized by having one or more false beliefs based on an incorrect interpretation of reality; Dementia - a significant decline in memory, thinking, language, and judgment; Diabetes Mellitus - medical condition where the body's ability to regulate blood sugar levels is impaired; DON - Director of Nursing; LPN - Licensed Practical Nurse; Major Depressive Disorder - a persistent mental health	F0000		09/25/2025

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F0000	Continued from page 1 condition marked by sadness, decreased interest in activities, lack of energy and poor concentration; MDS – Minimum Data Set - standardized assessment forms used in nursing homes; NHA- Nursing Home Administrator; Activities of daily living (ADLs) – tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; PASRR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Peripheral Vascular Disease - a circulation disorder caused by narrowing or blockages in arteries and veins outside of the brain and heart; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator;	F0000		
F0570 SS = E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to have a surety bond that covered the current balance in the residents' trust accounts ($28,733.79). Findings include: 8/27/25 10:15 AM – The facility provided the surveyor with a copy of the facility's surety bond from [insurance company] in the amount of $20,000 with a term of 12/08/24 to 12/08/25. 8/27/25 10:18 AM – The facility provided the surveyor a list labelled "Trust- Current Account Balance as of 8/27/25". The list named forty-five facility residents	F0570	A) No residents were affected by this deficient practice. A bond rider was obtained and provided to the survey team on August 27, 2025. The surety bond was updated to provide coverage of $30,000, ensuring protection of all resident trust funds. B) The business office reviewed all resident trust accounts and verified that the updated surety bond presented on August 27, 2025, is sufficient to cover the current amount of resident trust funds. C) The root cause has been identified to be the 2025 increase in the monthly resident personal needs allowance from $55 to $75, which resulted in higher trust fund balances. The Business Office Manager or designee will conduct quarterly reviews of resident trust accounts. During each review, the total trust fund balance will be compared against the bond coverage. If at any point the trust fund balance is anticipated to exceed the current bond coverage, the Business Office Manager will immediately notify the Administrator so the bond coverage can be adjusted accordingly.	10/13/2025

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F0570 SS = E	Continued from page 2 with personal funds accounts managed by the facility. The Client Account Summary stated that there was $28,733.79 currently in the account. 8/27/25 11:31 AM - During an interview with E3 (Executive Director) and E4 (Admissions), E3 confirmed, "The surety bond is for $20,000." The facility failed to have a surety bond in sufficient amount to assure the security of all personal funds of residents that were deposited with the facility. 8/27/25 3:10 PM – The facility presented the surveyor with a bond rider document that stated that the "Amount of bond changed from $20,000 to $30,000." 8/29/25 2:30 PM – The findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0570	Continued from page 2 D) The Business Office will provide quarterly reports of trust fund account balances and bond coverage to the QAPI Committee for a period of one year or until 100% compliance is achieved. The QAPI Committee will review results and monitor compliance to ensure that bond coverage remains sufficient.	
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R81) out of one resident reviewed for misappropriation, the facility failed to protect R81's property. This is being cited as past non-compliance with a compliance date of 6/19/25. Findings include: Facility's "Resident Abuse Policy/Procedure…Steps in Procedure: … 4. Identification – a) For the purposes of this procedure, abuse, neglect or mistreatment may be suspected in, but not limited to, the following situations: … v. Misappropriation of resident property: Intentional theft of a resident's money or property, … intentional mishandling of resident money or property by personnel authorized to handle resident money or property…". Reviewed 8/7/25. Review of R81's clinical record revealed: 9/16/20 – R81 was admitted to the facility with	F0602	"Past Noncompliance - no plan of correction required"	06/19/2025

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F0602 SS = D	Continued from page 3 diagnoses including, but not limited to, diabetes. 9/8/23 – R81 ordered Ozempic (a weekly diabetes injectable medication) 4 mg (milligram)/ 3 ml (milliliter) sq (subcutaneously) q (every) Friday for DM2 (diabetes). 4/19/25 – R81's quarterly MDS (Minimum Data Set) recorded R81's BIMS (Brief Interview for Mental Status) as 13, which was reflective of normal cognition. 6/8/25 7 AM - E9 (LPN) signed the packing slip for delivery of R81's Ozempic 4 mg/3 ml pen (QTY) 3. E9 placed the Ozempic medication in the refrigerator in the locked medication room on the third floor. 6/13/25 8 AM – E11 (LPN) was unable to locate the medication in the refrigerator in the locked medication room. The facility failed to protect R81's property and ensure it was available for her usage. 6/13/25 approximately 6:45 PM – E10 (LPN) gave R81 her Ozempic shot, when the replacement dosage came from the pharmacy. 8/28/25 11:50 AM – During an interview, E12 (LPN) stated, "The Ozempic medication is stored in the refrig (refrigerator) in the locked med (medication) room. Only nurse have the keys to the med room. It is kept in a lock box in the refrig…Since the incident with the missing Ozempic, the facility started a "Controlled Medication Accountability sheet", which is kept in the narc (narcotic) book and is counted with the narcs by the nurses at change of shift." 8/28/25 1:45 PM – During an interview, R81 stated, "I didn't give anyone permission to take any of my medications." 8/29/25 11:03 AM – During a telephone interview, C1 (pharmacy billing specialist) confirmed that the facility ordered and paid for an additional dose of Ozempic on 6/13/25 with a cash price of $1122.04. 8/29/25 12:30 PM – The finding was reviewed with E1 (NHA), who reiterated all the steps the facility performed after discovering the medication was missing. 8/29/25 3:45 PM – E1 (NHA) provided signed documentation of interventions the facility initiated after discovering that R81's Ozempic was missing. The actions included:	F0602		

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F0602 SS = D	Continued from page 4 - obtaining a new dose of Ozempic, which the facility paid for, on the evening of 6/13/25 so R81's care was not impacted. - notifying the police and filing a police report. - reviewing the video surveillance of the medication delivery on 6/8/25 and the staff processing of the medications to confirm proper handling of the medication. - identifying and interviewing all nursing staff with access to the 3rd floor locked medication room between 6/8/25 through 6/13/25. - notifying the Pharmacy of the medication disappearance. - assisting the Pharmacy in creating an accountability sheet to track Ozempic medication upon delivery to the facility. The accountability sheet requires nurses to check and sign off on the presence of the medication on each shift. - educating the nurses regarding the new process of the accountability sheet for Ozempic medication. - discussing the missing medication at the QAPI meeting on 6/17/25. During this meeting, it was noted that there were no video available from within the medication room. - initiated a plan for the QAPI committee to review the accountability sheets for Ozempic for a one year period. - installed new cameras in each medication room effective on 6/19/25. 8/29/25 10 AM -The surveyor was able to confirm these actions were initiated and ongoing with a PNC compliance date of 6/19/25. 8/29/25 2:30 PM – The findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0602		
F0607 SS = C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F0607	A) The facility provides multiple abuse trainings, at orientation and throughout the year which include the definitions and types of abuse, how to recognize signs and symptoms of abuse, the duty to report and how to report abuse. The QAPI team also routinely investigates and tracks all allegations of abuse and develops interventions as appropriate. No residents were	10/13/2025

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F0607 SS = C	Continued from page 5 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility's abuse policies and procedures and interview, it was determined that the facility failed to develop and implement an abuse policy that included all the requirements. The facility's policy lacked evidence of: established coordination with the QAPI program, required training regarding the signs of abuse and the different types of abuse, and failed to include language regarding the prohibition and prevention of retaliation for reporting. Findings include: 8/25/25 11:30 AM - The facility provided a copy of their "Resident Abuse Policy/Procedure" for the survey review. The facility's policy lacked evidence of: established coordination with the QAPI program, required training regarding the signs of abuse and different types of	F0607	Continued from page 5 negatively affected by this deficiency. B) All residents have the potential to be affected by this deficient practice. C) The root cause of this deficiency was identified as the facility's failure to incorporate recent CMS policy updates into the existing policy language. To address this, Resident Abuse Policy has since been revised by the Nursing Home Administrator (NHA) and Director of Nursing (DON) (Attachment F0607-1) to ensure alignment with current CMS requirements and facility practices. In addition, a separate Anti-Retaliation Policy (Attachment F0607-2) has been developed by the Administrator and Director of Nursing to formally address the prohibition and prevention of retaliation against any individual who reports allegations of abuse or quality of care concerns. Both the revised and newly developed policies have been implemented and distributed to all facility leadership and department heads. RN Quality Control Nurse, or RN designee has provided in-service education on these policy updates, including training on the prohibition of retaliation, appropriate reporting procedures, and protections for those who report abuse or concerns. The policies have also been incorporated into new hire orientation and annual mandatory training for all staff. To reinforce awareness, anti-retaliation signage (Attachment F0607-3) has been posted in visible areas throughout the facility. D) The Administrator or designee will conduct monthly audits for three (3) consecutive months to ensure compliance with the revised Abuse Policy and newly implemented Anti-Retaliation policy. Audits will include review of abuse allegation logs, grievance records, and staff training records. Results will be reported and reviewed at QAPI meetings. Following three months of 100% compliance, audits will transition to quarterly monitoring for two additional quarters. If compliance is maintained, ongoing monitoring will be concluded.	

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F0607 SS = C	Continued from page 6 abuse, and failed to include language regarding the prohibition and prevention of retaliation for reporting. 9/29/25 10:34 AM - During an interview, E1 (NHA) stated that the facility does a lot of training regarding abuse throughout the year. She stated that she was not aware that the facility's abuse policy lacked several CMS (Centers for Medicare and Medicaid Services) requirements, including policy regarding training to recognize the signs of abuse and to identify different types of abuse, policy regarding the prevention of retaliation and the inclusion of QAPI in their abuse policy. 8/29/25 2:30 PM - The findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0607		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0609	A) Resident R49 with dementia and unable to share cause of injury. Resident continued to mobilize with minimal impact from fracture while awaiting final outcome of Xray. Fracture has healed. Resident R90 was not injured in the event and had no recollection of the incident during follow-up interview by nursing staff moments later. Although the incidents were not reported within the 2-hour timeframe, the reports were completed. The facility was unable to demonstrate compliance with the 2-hour reporting requirement in these cases. B) A review of all incident reports for the month of September was conducted and found that they were reported timely. C) Reporting guidance within Abuse policy lacked timelines for reporting of incidents which led to this deficient practice. Abuse Policy has been updated by Director of Nursing and Nursing Home Administrator (Attachment F0609-1) to include a table indicating reporting timelines. All licensed nurses will be in-serviced about the reporting requirements by RN Quality Control Nurse or RN designee. D) Director of Nursing (DON) or designee will perform audits of all reportable incidents for timely submission weekly for three (3) consecutive weeks until 100% compliance is achieved. After that, DON or designee will audit all reportable incidents monthly until 100% compliance is achieved for three (3) consecutive months. After three consecutive months at 100% compliance is achieved, the monitoring will be concluded. All audit results will be reported to QAPI	10/13/2025

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F0609 SS = D	Continued from page 7 Based on interview, record review and review of the facility's policy and procedures, it was determined that for two (R49 and R90) out of six residents reviewed for abuse, the facility failed to report the allegations of abuse and injury of unknown origin within the two-hour requirement. Findings include: 1. Review of R49's clinical record revealed: 7/18/25 3:27 PM – An x-ray report was received by the facility which stated that R49 had an acute hand fracture. 7/21/25 12:53 PM – Review of the State Agency's Incident Summary Report documented that the facility reported R49's injury of unknown origin, a hand fracture, approximately three days later. 8/28/25 2:40 PM – During an interview, surveyor reviewed finding with E2 (DON). E2 stated she wasn't aware of this and would look at it. 2. Review of R90's clinical record revealed: 6/4/25 10:00 AM – The facility's incident report documented an allegation of resident-to-resident abuse between R90 and R62. 6/4/25 1:59 PM – Review of the State Agency's Incident Summary Report documented that that the facility reported the incident approximately four hours after the altercation.	F0609	Continued from page 7 Committee.	
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F0628	A) Resident R96's transfer and discharge were initiated and planned by the family. The family confirmed that all discharge needs were in place within the community and that the resident would return home with family support. The resident did not experience a negative impact by the omission of Ombudsman notification. The facility has been unable to correct this deficient practice of timely notification; however, the Ombudsman Office was notified retroactively on August 28, 2025, regarding R96's discharge. B) A review of all Ombudsman transfer logs for 2025 was completed. This review identified one additional resident who had not been reported to the Ombudsman as	10/13/2025

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F0628 SS = D	Continued from page 8 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F0628	Continued from page 8 discharging to the community. This resident was the spouse of R96. Consistent with R96, the discharge was initiated and planned by the family, with appropriate community supports arranged. This resident was not negatively affected by this deficient practice. The Ombudsman was notified of this resident's discharge retroactively on August 28, 2025, concurrently with R96. C) The root cause was identified as an oversight related to discharges home, which are not a common practice at this long-term care facility. To address this: The Discharge Checklist (Attachment F0628-1) was revised to specifically include Ombudsman notification for all resident discharges. Nursing Home Administrator provided education to all staff responsible for recording transfer and discharge notifications. The education emphasized the importance of timely Ombudsman notification and accurate tracking procedures. D) The Administrator or designee will perform monthly audits of all Ombudsman notifications to ensure that each transfer and discharge is properly documented and communicated to the Ombudsman. Audit results will be reviewed with the QAPI Committee each month. The monitoring schedule will proceed as follows: Monthly audits will continue until three (3) consecutive months of 100% compliance are achieved. Thereafter, audits will continue monthly until an additional two (2) consecutive months of 100% compliance are achieved. Finally, one additional month of Ombudsman notifications will be audited. If 100% compliance is achieved for that period, monitoring will be concluded.	

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F0628 SS = D	Continued from page 9 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F0628		

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 08/29/2025

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F0628 SS = D	Continued from page 10 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the	F0628		

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F0628 SS = D	Continued from page 11 time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R96) out of one resident sampled for closed record review, the facility failed to notify the Ombudsman of R96's discharge to the community. Findings include: Review of R9's records revealed: 7/3/25 2:30 PM – A nurse progress note documented that R96's daughter arrived in the facility to pick up her mom [R96] as R96 was discharging home to live with her daughter. 8/28/25 1:15 PM – Review of the facility's April 2025 Transfer Log lacked evidence that the Ombudsman was notified of R96's discharge to the community on 7/3/25. 8/28/25 4:09 AM – In an email correspondence, E1 (NHA) documented, "Ombudsman was notified today (8/28/25) of [R96]'s discharge home". 8/29/25 8:39 AM - In a follow up interview, E1 confirmed that the Ombudsman was not notified of R96's discharge home when the July 2025 list was submitted to	F0628		

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F0628 SS = D	Continued from page 12 the Ombudsman on 8/15/25. 8/29/25 1:33 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 8/29/25 2:30 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0628		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (R7 and R6) out of three residents reviewed for PASRR, the facility failed to coordinate with the PASRR program under Medicaid and refer the residents for assessments. Findings include: 1. R7's clinical records revealed: 11/25/20 – A PASRR Level 1 Screen was completed by the facility and documented that a neurocognitive disorder/dementia as primary and progressed. R7's medications included Lexapro and Zyprexa for anxiety. 11/27/20 – R7 was care planned for the use of antipsychotic medication, Risperdal related to frontotemporal dementia, delusions and related history of psychosis. 10/24/22 2:40 PM – A psych progress notes documented,	F0644	A) New PASRR screenings were submitted for R6 and R7. Both residents met the exemption criteria due to their dementia diagnosis and were not affected by this deficiency. B) A review of all residents who experienced a significant change, or received a medication change in the past month, was conducted to determine if any met the criteria for a new Resident Review. No additional residents were identified as requiring an updated PASRR. C) The root cause of this deficiency was identified as recent CMS changes outlining qualifying triggers for updated PASRR submissions. To correct and prevent recurrence: The Director of Nursing (DON), Assistant Director of Nursing (ADON), Admissions Director and Administrator completed PASRR training for updated referral trigger requirements on September 16, 2025. (Attachment F0644-2) The policy for Preadmission Screening and Resident Review (PASRR) has been updated to reflect a new PASRR must be completed if there is a significant change in the resident's condition "including new psychiatric diagnoses or addition or discontinuation of antipsychotic medication." (Attachment F0644-1) A weekly review of all residents with significant changes will be completed during clinical rounds to determine if PASRR criteria are triggered. The DON or designee will submit updated information through the PASRR portal (Maximus) and update resident care plans accordingly. D) The DON or designee will conduct weekly audits of residents with significant changes requiring a new PASRR:	10/13/2025

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F0644 SS = D	Continued from page 13 "... Psych meds Risperdal 0.5 mg BID (twice a day) Lexapro 5 mg q (every) am (morning) ... new diagnostic code F22 delusional disorder with psychosis. F03.93 unspecified dementia with psychosis ..." Review of R7's diagnoses list revealed the following new diagnoses: 10/17/22 – Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. 10/17/22 – Major Depressive Disorder (MDD), recurrent, moderate 10/18/22 – Delusional disorders 10/24/22 – Unspecified dementia, unspecified severity, with psychotic. 1/3/24 - Pseudobulbar affect. 4/25/25 – R7's care plan for the use of antipsychotic medication, Risperdal related to frontotemporal dementia, delusions and related history of psychosis. 7/2/25 - R7's quarterly MDS assessment documented anxiety disorder, depression, psychotic disorder and pseudobulbar affect among her active psychiatric/mood disorder diagnoses. 8/27/25 1:52 PM – In an email correspondence, S1 (State PASRR Authority) confirmed that the facility should submit a new assessment for a status change to include MDD as a new major diagnosis and to update R7's current mental status and diagnoses. 8/27/25 3:00 PM – Findings were discussed with E2 (DON). 2. R6's clinical records revealed: 1/29/24 – R6 was admitted to the facility with diagnoses including dementia, peripheral vascular disease, and diabetes mellitus. 4/22/24 – R6's Level I PASSR screening reflected diagnoses including dementia, anxiety, and major depressive disorder. The listed medications prescribed for R6 were trazodone to treat depression and lorazepam to treat anxiety. R6 had no known behaviors that affected interactions with others.	F0644	Continued from page 13 Weekly for three (3) consecutive weeks until 100% compliance in achieved. Bi-weekly for two (2) consecutive weeks until 100% compliance is maintained. A final audit covering one (1) week will be conducted. If 100% compliance is achieved, monitoring will be concluded. Results of all audits will be reviewed with the QAPI Committee to ensure continued compliance and oversight.	

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F0644 SS = D	Continued from page 14 5/28/24 2:49 PM – Nursing staff documentation in R6's clinical record stated, "Resident has been having increased issues AEB [as evidenced by]…aggressiveness as well as physical altercations with staff…" 5/28/24 4:21 PM - R6 was diagnosed with delusional disorder and unspecified psychosis. An antipsychotic medication, Seroquel, was ordered for R6. 7/28/25 6:17 PM – Psychiatric documentation in R6's clinical record stated, "…Pt [patient] is difficult to manage…Pt [patient] has no impulse control…redirection not always effected [sic]…meds [medication] required…" 8/16/25 - A quarterly MDS assessment for R6 documented diagnoses including anxiety, depression, and psychotic disorder. 8/29/25 10:58 AM – During an interview, E2 (DON) stated, "If 4/22/24 was the last PASSR screening in the chart for this resident, there was no PASSR screening after that date." 8/29/25 2:30 PM – The findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0644		
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 record review and interview, it was determined that for one (R1) out of three residents reviewed for hospitalization, the facility failed to have evidence that the physician's order for a daily weight was completed. Findings include: Review of R1's clinical record revealed: 12/12/22 – R1 was admitted to the facility with a diagnosis of heart failure. 10/24/24 – A physician's order stated, "Weight 1 time a	F0684	A) Resident R1 is alert and oriented, with a history of frequent refusals of care. The resident is care planned for non-compliance and frequent refusals. The resident did not experience a negative effect from this deficient practice. B) A review of all residents with daily weight orders was conducted to ensure documentation of weights or refusals. No other residents were identified as missing documentation. C) A combination of resident non-compliance and nursing oversight in documenting refusals was found to be the root cause of this deficient practice. The RN Quality Control Nurse created a Refusal of Care Policy (Attachment F0684-1) for staff to follow with regards to instances of resident refusal of care. The RN Quality Control Nurse or RN designee will: Provide all licensed nurses education on the Refusal of Care Policy and Procedure. Educate all licensed nurses about the importance of accurately documenting daily weight results or clearly noting refusals.	10/13/2025

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F0684 SS = D	Continued from page 15 day at 8AM. Notify MD [Medical Doctor] for Weight Gain of 2-3LBS or more over a 2-day period or gain of 5LBS a week. Dx: [Diagnosis] Heart Failure…". Review of R1's June 1-24, 2025, eMAR (electronic Medication Administration Record) revealed that the facility failed to obtain a daily weight or have a documented reason for not obtaining a weight on seven (7) out of 24 opportunities. 8/29/25 9:25 AM – During an interview, E6 (RN) stated that it was the nurse's responsibility to weigh R1. Surveyor and E6 reviewed R1's weights and discussed that R1 refused at times. E6 acknowledged the finding. R1's clinical records lacked evidence that he refused to have his weights obtained. 8/29/25 2:30 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0684	Continued from page 15 Provide staff direction on notification procedures regarding refusals, including notification to physician through the most appropriate means of communication (secure message, email, phone and/or in-person). D) The Assistant Director of Nursing (ADON) or designee will audit documentation for all residents with daily weight orders to ensure either the weight is recorded or the refusal is documented.. All audit results will be reviewed with the QAPI team. The monitoring schedule will be as follows: Weekly audits until three (3) consecutive weeks of 100% compliance are achieved. Following that, monthly monitoring for one (1) month until 100% compliance is reached. After successful completion of this process, monitoring will be concluded.	
F0756 SS = C	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 and the facility's medical director and director of nursing and	F0756	A) The facility's Medication Regimen Review Policy already included a timeframe for routine monthly reviews. In addition, the facility's Medication Administration system is integrated with the contracted pharmacy provider, which automatically alerts nursing staff if an immediate issue with a medication order arises. In such cases, the physician is notified prior to proceeding with the order. In this instance, the facility's policy did not specify a designated timeframe for the physicians response to immediate concerns, and revisions to address this requirement cannot be applied retroactively. No residents were adversely affected by this deficient practice. B) Recent CMS updates require that the Medication Regimen Review (MRR) policy include a defined timeline for provider notification. This update had not been incorporated into the facility's existing policy and was identified as the root cause of this deficiency. A review of all recent medication orders was completed. All alerts generated by the pharmacy system were properly communicated to the prescriber for follow-up, and no residents were negatively affected by this deficient practice. C) The Medication Regimen Review policy (Attachment	10/13/2025

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F0756 SS = C	Continued from page 16 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 review of facility documentation and interview, it was determined that the facility failed to ensure that the monthly drug regimen review policy included 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. 12/5/20 - A facility document entitled, "Medication Regimen Review", revised 8/31/21, 2/23/23, 7/15/24, and 8/6/25, documented, "Medications are reviewed in multiple ways including, but not limited to the MRR conducted by the consultant pharmacist...." 8/27/25 11:27 AM - A review of the facility's Medication Regimen Review lacked evidence of the time frames for the different steps in the process and steps the pharmacist must take when an irregularity is identified. 8/27/25 12:30 PM - During an interview, E2 (DON) stated, "The policy does not have the time frames for the different steps in the medication review policy." 8/29/25 2:30 PM – The findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0756	Continued from page 16 F0756-1) has been updated by Director of Nursing to include the following clarification: "In the event that an irregularity requires immediate action, the consultant pharmacist will alert the DON, ADON, Administrator or Nursing Supervisor either verbally or via email of the urgent need for a response to a specific recommendation on the day it was discovered. The facility must contact the prescriber immediately (by phone, secured conversation, fax and/or email) who should respond to the pharmacy recommendation within 48 hours." This update identifies the means of communication when reaching the prescriber and ensures timely communication and escalation of urgent medication-related issues. D) The Director of Nursing (DON) or designee will review all consultant pharmacist reports to verify that prescribers responded within the required timeframe. This monitoring will continue for three (3) months until there are three consecutive months of 100% compliance. Afterwards, monitoring will continue until two (2) consecutive months provide 100% compliance. At which point, monitoring will reduce to a review of one (1) month of consultant pharmacist reports. When 100% compliance is achieved in this final month, facility will be considered back in compliance. Results of these reviews will be presented to and discussed with the QAPI Committee to ensure sustained compliance and oversight.	
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F0761	A) At the time of survey, the second floor did not contain narcotics requiring storage in the lockbox. The facility acknowledges the deficient practice in that lockboxes in both medication rooms were not secured inside the refrigerators at the time of the survey. On August 28, 2025, at 2:00pm, the maintenance department resecured both lockboxes to the refrigerators. All refrigerated narcotic medications were accounted for,	10/13/2025

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F0761 SS = D	Continued from page 17 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined for two out of two medication rooms reviewed for storage of controlled substances, the facility failed to ensure that the locked boxes were permanently affixed to medication room refrigerators. 8/27/25 10:12 AM - During a tour of the second-floor medication room, the storage box for the controlled substances was observed on top of the refrigerator. The third-floor controlled substances box was observed in refrigerator, but it was not permanently affixed. 8/28/25 9:30 AM - The second-floor medication room, the storage box for the controlled substances continued to be on top of the refrigerator. The third-floor controlled substances box continued to be in the refrigerator, but it not permanently affixed. 8/28/25 10:00 AM - During an interview E14 (RN) stated, "The controlled substances that have to be refrigerated are kept in the refrigerators and counted every shift." 8/29/25 2:30 PM – The findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E5 (ADON).	F0761	Continued from page 17 and no residents were adversely affected by this deficient practice. B) An inventory of all narcotic medications confirmed that all medications were present and accounted for. No residents were identified as having been impacted. C) Recent repairs/replacement of the refrigerators in the medication rooms was identified to be the root cause of the deficient practice. To correct this: Facility's Medication Storage Procedure (Attachment F0761-1) was revised by Director of Nursing to include: "if a medication refrigerator needs to be replaced by maintenance, a nurse must be present during the transfer and ensure that the narcotic lockbox is affixed properly to the new refrigerator." Both nursing and maintenance staff will be in-serviced on this updated policy to ensure proper procedure is followed whenever a medication refrigerator is exchanged. D) The Director of Nursing (DON) or designee will conduct an audit of all medication refrigerators to verify lockboxes remain properly affixed within the refrigerators. Results of audits will be reviewed with QAPI Committee. The monitoring schedule will be as follows: DON or designee will audit lockbox placement until 100% compliance is achieved for four (4) consecutive weeks. After which, the audit will be performed bi-weekly for one (1) month or until 100% compliance is reached. Finally, the audit will be performed once a month. At this point, when 100% compliance is achieved, the facility will be considered back in compliance.	