DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Gilpin Hall
SURVEY COMPLETED: July 28, 2022

DATE

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 18, 2022 through July 28, 2022. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was eighty-six (86). The survey sample totaled seven (7) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0			
3201.1.2	**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 the following:		
	Cross Refer to the CMS 2567-L survey completed July 28, 2022: F689 IJ.		

Provider's Signature [signature] Title NHA Date 8/16/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085047	A. BUILDING ______ B. WING ______	C 07/28/2022

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

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from July 18, 2022 through July 28, 2022 The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was eighty-six (86). The survey sample totaled seven (7) residents. Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Alzheimer's disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Bed mobility - how resident moves to and from lying position, turns side to side and positions body while in bed; CNA - Certified Nursing Assistant; Contracture - a muscle that is drawn or shortened by shortening of the connective tissue around a muscle or rigid joint or joint limitations with fixed high resistance to passive stretch of a muscle; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DON - Director of Nursing; IJ - Immediate Jeopardy; Kardex - CNA plan of care for individual residents; Laceration - cut/tear in skin; MDS - Minimum data set - standardized assessment forms used in nursing homes;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/16/2022

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

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F 000	Continued From page 1 NHA - Nursing Home Administrator; Paralysis - loss of voluntary movement; RN - Registered Nurse; Self ambulatory dysfunction - changes in normal walking pattern.	F 000		
F 689 SS=J	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 interview and record review it was determined that for three (R1, R2, and R4) out of four residents reviewed for accidents, the facility failed to ensure supervision to prevent accidents. For R1 the plan of care was not followed resulting in an accident that led to R1's severe adverse outcome, death. This was identified as an IJ on 7/22/22 at 12:20 PM and abated on 7/26/22 at 8:00 AM. For R2 the facility failed to provide the appropriate supervision to prevent a fall with injury requiring a transfer to the ER and two staples to the head, R2 sustained harm. R4 was left unattended and fell from a shower chair resulting in a broken arm, R4 was harmed. Findings include: 1. Review of R1's clinical record revealed: 12/26/19 - R1 was admitted to the facility.	F 689	1.1 R1 did not return to the facility 1.2 Resident R2 was treated at the hospital and returned to facility. Care Plan was adjusted to provide additional measures (e.g. helmet) for increased safety. All scheduled CNA staff completed an in-service addressing the inappropriate use of furniture as a stabling device 11-23-2021. 1.3 R4 received treatment for left humeral fracture and returned to the facility. Care Plan was updated to indicate use of shower gurney and two staff persons during resident shower. E4 received counseling immediately following the incident. 2. All residents with limited bed mobility	8/1/22

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F 689 Continued From page 2

12/26/19 - A progress note on admission documented that R1's admitting diagnoses included the following: dementia, fall risk with history of falls, self ambulatory dysfunction, Alzheimers dementia, and a left hand contracture.

2/19/20 - A care plan documented that R1 was physically aggressive related to dementia, interventions included: "When the resident becomes agitated; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later."

9/14/20 - 9/23/20 - A Physical Therapy evaluation documented, R1's baseline as total care, requires support to maintain position, unable to move without loss of balance and does not bend at the waist.

3/14/22 - An annual MDS documented that R1 required extensive assist (staff provide weight bearing support) with two person physical assist with transfers and bed mobility.

3/15/22 - R1's fall risk score was 75 indicating R1 was a high risk for falls.

4/4/22 - A care plan documented that R1 was resistive to care, interventions included the approach of "if resident resists with ADL's, reassure resident, leave and return 5-10 minutes later and try again".

6/5/22 6:10 AM - A progress note documented E3 (CNA) reported to E13 (LPN) that E3 put on R1's hipsters (impact-absorbing pads worn under clothes to minimize potential damage that can occur from a fall), pants and shoes on while R1

F 689

or transfer limitations may be affected.

3. DON and RNAC have identified those residents who are unsafe to sit edge of bed without support. Care plans were updated to include direction for the CNA□s as to the level of support required when a resident is sitting upright and if a resident is safe sit on edge of bed.

Procedure created to complete sitting balance screenings (Attachment F689-1). Screenings will be performed by therapy upon admission and quarterly with care plan. The outcome of the screenings will be utilized to update the resident care plan and CNA tasks within the bed mobility ADL. Notation will be made if a resident should not sit on the edge of the bed without support. CNA□s will review the Point of Care tasks prior to giving care to the resident.

DON and Staff Development Director completed competencies for CNA□s demonstrating their knowledge and understanding of how to access each resident□s plan of care, comprehension of the resident□s transfer status, how to identify level of supervision and support needed and any safety devices required in providing care (7/26/2022). All newly hired and PRN CNA staff will be required to demonstrate this competency prior to delivering care on the floors. All scheduled CNA□s were in-serviced in providing safe care / following the care plan (Attachment F689-2).

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F 689	Continued From page 3 was laying in the bed. Then E3 assisted R1 from a laying to a sitting position; placing R1's feet on the floor, sitting him upright on the edge of the bed with only a small portion of R1's buttocks touching the mattress, "his butt cheeks were on the edge of the bed." E3 was standing in front of R1. E3 reached to his left for a washcloth, and by doing so E3 was positioned to the right of R1. R1 fell to the floor on his left side hitting his head and was bleeding. E13 assessed R1 and described the wound as "active bleeding from a laceration that measured 2.3 cm x 0.2 cm above the left eyebrow." The facility called EMS (emergency medical services) and R1 was transferred to the hospital. 6/5/22 9:04 AM - A hospital document titled "Trauma History and Physical/Consult" documented a left eye laceration after a fall, CT scan of the head (imaging that takes detailed pictures of the inside of the body) revealed a intracranial hemorrhage measuring 9 x 10 mm. (bleeding between brain and the thin tissue that covers the brain). 6/12/22 - A Certificate Of Death documented R1 died at 9:15 AM with a worsening brain bleed following a fall from side of the bed at a skilled nursing facility. 7/19/22 10:45 AM - During an interview, E3 (CNA) confirmed that R1 was a two person assist for moving in the bed and transfers but did get R1 up alone. E3 stated that R1 did not want to get up and was resistant to care kept trying to lay back down. E3 stated that he put on R1's hipsters, pants and shoes on while R1 was laying the bed. Then E3 assisted R1 alone from a laying to a sitting position; placing R1's feet on the floor,	F 689	4. DON or designee will complete a sampling of 5 caregiver competencies daily until caregivers demonstrate 100% compliance for 3 days. Next, a sampling of 5 caregiver competencies will be completely weekly until caregivers demonstrate 100% compliance for 3 weeks. Then, a sampling of 5 caregiver competencies will be completed monthly until caregivers demonstrate 100% compliance for 3 months. Once 3 consecutive months are 100% compliant, the monitoring will conclude. Results will be reported and reviewed with QAPI Committee.	

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F 689	Continued From page 4	F 689		

sitting him upright "his butt cheeks were on the edge of the bed." E3 was standing in front of R1. E3 reached to his left for a washcloth, and by doing so E3 was positioned to the right of R1. R1 was without the weight bearing support that was required. R1 fell to the floor on his left side hitting his head and was bleeding. E13 assessed R1 and described the wound as "active bleeding from a laceration that measured 2.3 cm x 0.2 cm above the left eyebrow." The facility called EMS (emergency medical services) and R1 was transferred to the hospital.

7/20/22 At approximately 2:00 PM - E11 (NHA) and E2 (DON) were notified by the survey team that during the investigation, it was determined that for one (R1) out of four residents reviewed for falls the nursing staff failed to follow the plan of care resulting in accident that lead to R1's death.

7/22/22 - An IJ was called at 12:20 PM. The State agency accepted the abatement plan on 7/22/22 at 3:30 PM which included: All CNA's will demonstrate a clear understanding of how to access each resident's care plan, a clear comprehension of the resident's transfer status, sitting balance and how to identify any safety devices required in providing care.

7/22/22 - Through interview and record review the survey team confirmed:
- Nursing staff currently working in the facility had received the education and training was conducted and their competencies had been signed by E16 (staff development coordinator).
- Oncoming staff were provided the education and training prior to being allowed on their assigned units.

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F 689	Continued From page 5 - During an interview E14 (CNA), E15 (CNA) confirmed they had been signed off on the competencies. E13 (CNA) oncoming for evening shift also confirmed she had to complete the training prior to starting her shift. 7/28/22 At approximately 11:00 AM - During an interview E17 (CNA), E11 (CNA) and E18 (CNA) confirmed that they had received the education and training and their competencies had been signed by E16. 7/28/22 - Review of facility staff competencies and staff interviews revealed that the education and training outlined in the abatement plan was completed on 7/26/22 at 8:00 AM, the IJ was removed. 2. Review of R2's clinical record revealed: 9/10/19 - R2 was admitted to the facility. 9/10/19 - An admission progress note documented that R2's admitting diagnosis included: Alzheimers, one broken rib on the right side and broken bone segments of the lower spine that support the body and permit movement. 8/6/21 - A Physical Therapy evaluation documented, R2 as being unsteady, only able to stand unsupported for 1-2 minutes and supported for 1-3 minutes. 9/8/21 - Review of R2's quarterly MDS documented, R2 required extensive assist (staff provide weight bearing support) for dressing. 9/23/21 - A care plan documented that R2 had an	F 689		

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F 689	Continued From page 6 ADL self-care deficit related to limited physical mobility and dementia. R2 i s unsteady and had limited range of motion in her legs. 11/10/21 - A facility incident report documented, R2 was being changed while holding onto a night stand, E12 reached for a clean brief and R2 fell backwards hitting her head, sustained a head injury requiring two staples to the back of the head. 11/11/21 - A progress note documented R2 returned from the hospital at 9:22 AM via wheelchair. R2 was awake, alert and denied any pain or discomfort. Discharge instructions were to remove the staples in ten days. 7/20/22 11:07 AM- During an interview with E9 (CNA) it was confirmed that R2 was a one person assist. When asked "How do you know how to care for residents, as their condition may change and do you check the Kardex (tool that is used for staff to know how each resident' ADL status)" E9 replied "I get report from the nurse, I don't usually check that every shift." 7/20/22 11:20 AM- During an interview E10 (CNA) stated that R2 was a two person assist and R2 was able to pivot during transfers. E10 stated that she does not check the Kardex every shift. 7/20/22 11:45 AM - During an interview E8 (RN) confirmed that the CNAs know they should be checking the Kardex at the beginning of each shift as the plan of care can change daily. E8 also stated that CNAs are educated during their orientation on checking every shift. 7/20/22 12:00 PM - During an interview,	F 689		

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F 689	Continued From page 7	F 689		

E11(CNA) confirmed that she changes or dresses R2 while in bed as R2 cannot stand for very long. R2 " is a one or two person physical assist and I always ask another aide to help when I have R2." E11 stated that at the beginning of the shift "I always check the Kardex because I know I will have the correct information I need and, that's what I've always done."

7/21/22 11:55 AM - During an interview E12 (CNA) confirmed she had been providing care and R2 was holding onto the night stand as " it was a solid piece of furniture." E12 stated that R2 was able to follow directions at the time and had been able to stand alone in the past. E12 stated she had reached for a clean brief and witnessed R2 falling backwards and hit her head on the closet. E12 stated she couldn't stop the fall.

7/22/22 1:40 PM (approximate) - During an interview E1 (NHA) and E2 (DON) confirmed that R2 was placed in an unsafe position resulting in a fall with injuries.

Findings were reviewed with E1 (NHA) and E2 (DON) on 7/22/22 at 3:30 PM.

3. Review of R4's clinical record revealed:

10/14/21 - 12/28/21 - An occupational therapy discharge summary documented that R4's normal position was in a wheel chair with a half lap tray and leg rest and R4 had a fair sitting balance.

12/29/21 - A facility fall risk assessment documented R4 was a high risk of falling.

12/30/21 - A quarterly MDS documented that R4

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F 689	Continued From page 8 had a diagnosis of a stroke, paralysis and muscle weakness. It was further documented that R4 required extensive assist (staff provide weight bearing support) one person physical assist, also for surface to surface transfers R4 was not steady and only able to stabilize with staff assistance. 1/13/22 - A care plan documented R4 was at risk for falls and had limited physical mobility related to a stroke that paralyzed the left side. R4 had an activity of daily living self-care performance deficit (R4 required assistance with care) due to confusion related to dementia and stroke with left side weakness. 3/27/22 9:15 AM - A progress note documented that E4 (CNA) reported to the charge nurse that R4 was found on the floor next to the shower chair. E4 stated "resident slid out of the shower chair." Initial assessment documented that R4 was okay,"15 minutes later [R4] complained of left shoulder and or arm pain." Pain medication was given to R4, the physician was notified and a X-ray was ordered. 3/27/22 4:44 PM - A Radiology Report documented that R4 had a broken left arm. 3/28/22 6:56 AM - A progress note documented that R4 complained of left shoulder soreness pain medication was administered. Ice was applied to the swelling area and arm was elevated. 3/28/22 12:46 PM - A progress note documented a Therapy Fall Screen was completed on the resident due to R4 sliding out of shower chair. The X-ray revealed a possible broken left arm and a sling was ordered.	F 689		

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3/28/22 - 5:59 PM - A progress note documented that a family member was visiting and noticed a bump on the back of R4's head and the POA called facility requesting that R4 be sent to the hospital.

3/28/22 9:37 PM - A progress note documented that R4 was sent to the hospital per the family's request.

3/29/22 1:37 AM - A progress note documented that R4 returned from the hospital emergency room " Discharge diagnosis from the hospital emergency room was left humeral fracture (broken arm).

7/19/22 1:55 PM - During an interview with E5 (Housekeeper) revealed that she walked into R4's room the curtain was closed and E4 (CNA) was in the room alone. E5 told E4 that you are supposed to get help. E4 asked E5 to get the sit to stand and put it in the bathroom.

7/19/22 2:04 PM - During an interview with E4 (CNA) it was revealed that E4 left R4 in the shower chair without support or supervision, E4 turned to retrieve a bottle of deodorant and when E4 returned, E4 found R4 in the floor next to the shower chair.

7/19/22 2:35 PM - During an interview with E2 (Therapy Director) revealed that R4's assessment on 10/14/21 to 1/9/22, R4 is totally dependent and unable to sit unsupported. R4 would not be appropriate for leaving unattended in a shower chair.

7/20/22 11:35 AM - During an interview with E10

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F 689	Continued From page 10 (CNA) it was revealed that the resident was always a two person assist with showering and that she could not sit without assistance. 7/20/22 approximately 11:45 AM - During an interview with E8 (RN) it was confirmed that R4 was not steady and she would need "guidance" to sit in a shower chair. R4 was left unsupervised and unsupported in a shower chair where she fell from the shower chair that resulted in a broken arm. Findings were reviewed with E1 (NHA) and E2 (DON) on 7/28/22 at 3:30 PM.	F 689		