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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilpin Hall	1101 Gilpin Avenue Wilmington, DE 19806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 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: 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).

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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:-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 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