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	08/29/2025

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

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 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 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).

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 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 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:- 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).

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 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 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).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 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 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).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 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, . 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, moderate10/18/22 – Delusional disorders10/24/22 – 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. 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. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 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 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).

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F 0756 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 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).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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).