

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

PRINTED: 10/06/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085032</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER VILLAGE HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1175 MCKEE ROAD DOVER, DE 19904</b>	

(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
F 000	INITIAL COMMENTS  An unannounced annual survey was conducted at this facility from September 17, 2014 through September 23, 2014. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 54. The stage two survey sample was twenty three (23).  Abbreviations used in this 2567 are as follows:  NHA- Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); RNAC - Registered Nurse Assessment Coordinator.	F 000		
F 272 SS=0	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ande Messersmith TITLE: NHA (X6) DATE: 10/27/14

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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(X4) ID PREFIX TAG <b>1</b>	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
F 272	Continued From page 1 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to initially conduct an accurate assessment that reflected the resident's Activities of Daily Living (ADL) status for one (R37) out of 23 Stage 2 sampled residents. Findings include:  Review of R37's admission MDS dated 06/27/14 documented that R37 was scored as a 3 (required extensive assistance) for transferring from one level to another. The 30-day Medicare	F 272	F 272 A. Resident #R37 was not negatively affected by deficient practice. The MDS was modified and resubmitted to CMS. B. A sample of 10 MDSs were audited to ensure accurate assessment of ADLs. Attachment # 1 C. The RNAC will review the ADL coding on all MDSs completed by the RNAC backup prior to submission. RNAC has provided education to the RNAC backup regarding appropriate ADL coding. Attachment # 2 D. MDS audits will be completed by the RNAC/designee weekly to ensure appropriate ADL coding until 100% compliance is achieved. The NHA/designee to ensure compliance. Variances will be corrected and results will be reported to the QA committee for review. See Attachment #1	10/14/14  10/24/14  11/30/14

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NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 MCKEE ROAD DOVER, DE 19904	
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F 272	Continued From page 2 MDS on 07/18/14 indicated R37 was scored as a 4 (totally dependent) for transferring from one level to another.  Review of the CNA charting revealed that R37 was totally dependent when transferring during the period from admission, 06/20/14, until 07/08/14. This time frame covered the time that the admission MDS was completed.  An interview with E13, Therapy Department Director, on 9/23/14 at approximately 11:00 AM, revealed that the therapy notes for R37 for the time period between 06/23/14 and 07/09/14 indicated that the resident needed maximum assistance (totally dependent) with transferring during physical therapy.  Findings were shared with E2, DON, on 09/23/14 at 2:30 PM.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	F 279 A. Resident #R43's care plan has been created and updated to reflect anxiety needs. B. Social Services Director will complete an audit on current residents to identify residents with anxiety/behaviors. Care plans will be developed to reflect those needs. Attachment #3 C. RNAC will educate Social Services Director on completing care plans for residents with anxiety/behaviors. Social Service Director will identify residents with behaviors related to anxiety during her assessments/clinical meeting and create or update care plans accordingly. Attachment #4	10/14/14 10/24/14 10/24/14



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  086032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/23/2014
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1178 MCKEE ROAD DOVER, DE 19904	
(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
F 279	Continued From page 4  The facility failed to develop a care plan related to R43's anxiety. This failure was confirmed on 9/19/14 at approximately 11:15 AM by E2, DON who agreed there should have been an anxiety care plan in place that identified specific behaviors related to R43's anxiety.  2. R51 had a care plan dated 7/25/14 and updated 9/6/14 for resident at risk for falls related to unsteady gait, visual impairment and broken hip.  The goal stated that the resident will remain free from pressure related injuries for 90 days. The goal did not relate to the risk of falls and the risk of injuries from falls.  An interview on 9/23/14 at 11:00 AM with E9, RNAC confirmed the goal was not appropriate and stated that she would change it.  Findings were reviewed with E1, NHA and E2 on 9/23/14 at 2:30 PM.  3. R51 had an admission MDS dated 7/22/14 that documented in the area of Activity Preferences that while at the facility books, newspapers and magazines were very important. The MDS also documented that listening to music and religious services were somewhat important.  Review of the Activity History assessment dated 7/22/14 documented that the resident's most common use of time was watching baseball on TV and the preferred program style was 1:1 and independent leisure. When asked what the resident enjoyed in the community that she may want to do while a resident in the facility the	F 279	change to Answers on Demand as the clinical documentation system which ensures accuracy when printing care plans.  D. RNAC will conduct weekly care plan audits for residents scheduled for care plan meetings to ensure proper alignment of goals and interventions on printed care plans until 100% compliance is achieved. Variances will be corrected and results presented to the QAPI committee. Attachment #5  F 279 A. Resident #R51s care plan was revised to incorporate the interests identified on the Activity Assessment. B. The Community Life Director/designee will complete an audit on current residents to ensure compliance with the care plan reflecting interests identified on the Activity Assessment. Attachment # 7	9/30/14  11/30/14  10/14/14  10/24/14

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F 279	Continued From page 5 response was cards/games/word games, reading/writing and TV viewing/movies.  The current care plan for September 2014 documented the resident's main focus for activities was to get home as quickly as possible. She enjoys jigsaw puzzles but cannot see them currently due to vision concerns. The goal was to allow the resident to focus on goals for going home. Approaches included the resident was independent with activities she provides in her room. The interests identified in the assessment process were not included in the care plan.  An interview on 9/22/14 at about 3:30 PM with E11, Resident Life Coordinator and on 9/23/14 at 9:20 AM with E12, Activity Director confirmed that the care plan did not reflect the activity assessment for R51.	F 279	C. The Community Life Director developed an Individualized Care Planning Guide Sheet. Attachment #8A The Community Life Director will educate the activities staff on the Individualized Care Planning Guide Sheet Attachment # 8B	10/24/14	
F 514 SS=D	Findings were reviewed with E1, NHA and E2 on 9/23/14 at 2:30 PM. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	D. The Community Life Director/designee will conduct audits on new admissions weekly until 100% compliance is achieved with care plans reflecting the interests identified on the Activity Assessment. Variances will be corrected and results presented to the QAPI committee. See Attachment# 7	11/30/14	

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F 514	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that for one (R39) out of 23 sampled residents the facility failed to maintain a clinical record that was complete and accurate. Findings include:  Review of R39's Treatment Administration Record (TAR) from 4/30/14 to 9/16/14 revealed the facility failed to document the assessment of the arterial venous (AV) shunt site (site in the arm that provided access to blood for dialysis treatment).  4/23/14 - Care plan documented to check left arm AV shunt for bruit (swishing sound heard with stethoscope at AV shunt access site) and thrill (vibration felt at AV shunt access site) every shift and document.  9/17/14 - Physician's order documented to check bruit and thrill every shift.  On 9/19/14 at approximately 9:30 AM an interview with E7, LPN who confirmed that R39 has had an AV shunt site for many years and that the order dropped off after the resident was hospitalized on 4/17/14. E7 stated that a staff member must have realized that the order was not on the TAR and reinitiated the order on 9/17/14.  Findings confirmed with E2, DON on 9/19/14 at approximately 11:45 AM. 483.75(o)(1) QAA	F 514	F 514 A. Resident #R39 was not negatively affected by deficient practice. The POS was immediately modified to show the assessment of the thrill and bruit. B. The Staff Development Director completed an audit on current dialysis residents to ensure compliance with the thrill and bruit every shift. Attachment #9 C. The Staff Development Director will educate licensed staff on the assessment of the AV Fistula every shift and ensuring it is included in the physician orders. The Charge Nurse will perform a second check of monthly recaps to ensure accuracy. Attachment #10	10/14/14  10/17/14  10/24/14
F 520		F 520		



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F 520	Continued From page 8  During an interview on 9/23/14 at 1:30 PM with E1, NHA, and E2 DON, it was confirmed that the sign-in sheets for the remaining quarterly meetings were not able to be provided.  The facility QA committee must meet quarterly. The facility was able to produce evidence of only two quarterly meetings since the prior survey date of, 10/25/13; failing to provide evidence of any quarterly meetings prior to 6/10/14.  Findings were reviewed with E1 and E2 on 9/23/14 at 2:30 PM.	F 520	D. NHA or designee will complete a quarterly audit for one year to monitor completion of sign in sheets for all quarterly QAPI meetings for 100% compliance. Attachment #12	12/23/14



**DELAWARE HEALTH  
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Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

NAME OF FACILITY: Westminster Village

DATE SURVEY COMPLETED: September 23, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced annual survey was conducted at this facility from September 17, 2014 through September 23, 2014. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 54. The stage two survey sample was thirty (30).</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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</b></p>	

Provider's Signature Anda Messersmith Title NHA Date 10/27/14



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	<p><b>adopted and incorporated by reference.</b></p> <p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey report completed on 9/23/14, F272, F279, F514 and F520.</p>	<p>Cross refer to the CMS 2567L survey completed 9/23/14. <i>12/23/14</i></p> <p>F272, F279, F514, F520.</p>

Provider's Signature *Standa Messersmith* Title *NHA* Date *10/27/14*