

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual and complaint survey was conducted at this facility from September 17, 2015 through September 24, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 58. The survey sample totaled thirty (30).</p> <p>Abbreviations/Definitions used in this 2567 are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; ADLs - Activities of Daily Living, such as bathing and dressing; PRN - As needed; MAR - Medication Administration Record (on paper); TAR - Treatment Administration Record (on paper); eMAR - Electronic Medication Administration Record (in the computer); EMR - Electronic Medical Record; MDS - Minimum Data Set (standardized)</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Amy Lynn NHA* TITLE *Administrator* (X6) DATE *11/18/15*

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.

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

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 C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1176 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 000	Continued From page 1 assessment used in nursing homes); ROM - Range of motion, extent to which a joint can be moved safely; HS - At bedtime; Acetaminophen (Tylenol) - medication for pain or fever; Blood Pressure - measure of the force of the blood against the walls of a blood vessel; Continent - control of bladder and/or bowel function; Cancer-disease characterized by rapid growth of cells in the body; Dialysis - cleansing of the blood by artificial means when kidneys have failed; Ibuprofen (Motrin) - medication for pain, fever or reduce swelling; Incontinent - loss of control of bladder and/or bowel function; Hoyer lift - mechanical lift that transfers a person on a sling; Mobility - move about freely; Narcotic-group of drugs that produces numbness and stupor, can relieve pain; Pain Rating Scale - number scale (0 to 10) to rate pain where 0 is no pain and 10 is the worst pain possible; Pulse - the number of times the heart beats in one minute; X-ray - picture taken of bones.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1176 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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 241	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for one (R71) out of 30 sampled residents the facility failed to provide dining in a manner that enhanced dignity. Findings include: During lunch observation on 9/21/15 the following was observed: 12:00 PM - R61 arrives in the main dining room and is sat with R71. 12:02 PM - R61 received his lunch tray and starts eating. 12:12 PM - Staff take R71's lunch order. 12:13 PM - R71's lunch arrives and staff start feeding the resident. R71 watched R61 eat lunch for 11 minutes before she received her meal. Findings were reviewed with E1, NHA and E2, DON on 9/24/15 at 2:30 PM.	F 241	F 241 A. Resident #R71 was observed without a meal he was served immediately. B. No other residents were affected by this deficient practice. All tables have been numbered and assigned to servers. A random audit of resident's meal service has been completed by the Dietician (R.D.) regarding timely table service. C. Dietitian/Designee will educate the dining staff on timely table service, specifically numbered and assigned tables for each server to ensure the residents dine at the same time. Attachment 1 D. R.D./Designee will audit both residents and servers to ensure the residents are receiving their meals in a timely manner (Attachment 2). Quarterly QA committee will monitor needs and trends for continued compliance.	10/24/15
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was	F 242		

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 242	<p>Continued From page 3</p> <p>determined that the facility failed to ensure for two (R109 and R2) out of 30 sampled residents shower preferences were assessed and scheduled showers were carried out. Findings include:</p> <p>1.R109 was admitted to the facility 9/8/15. On 9/17/15 at 3:40 PM during an interview with R109, when asked the question "Do you choose how many times a week you take a bath or shower?", R109 responded "no,I don't and I've had only one in 9 days since I've been here and that was Tuesday and every other day would be nice."</p> <p>Review of R109's Monthly Charting Flow sheet (a record of when R109 was showered) documented R109 received a shower on 9/14/15, the next scheduled shower, 9/21/15 was absent of documentation indicating a shower was not offered or provided.</p> <p>9/23/15 at 11:34 AM Interview with E9 (RN staff educator), who is the person designated in the facility to obtain resident preferences for showers, E9 explained staff will automatically schedule newly admitted residents for once a week showers, until E9 changed it for specific resident preferences. E9 stated the time frame between admission and assessment for resident preferences for showers to ensure choice is "As fast as I can get there. Usually I ask them as soon as I can after they're admitted when they would like their showers. But if I have to do an education, I'm on the cart or have a new hire, I don't get to them right away."</p> <p>During an interview on 9/23/15 at 2:29 PM E9</p>	F 242	<p>F 242</p> <p>A. 1.Resident R109 shower preference has been re-assessed and she received a shower per preference and discharged on 10/6/2015. 2. R2 shower preference have been re-assessed. He is encouraged to take a shower according to his preference . Any refusals are documented and re-offered. Care plan has been amended.</p> <p>B. No other residents were affected by this deficient practice. 1. An audit has been completed by Community Life staff for residents on their shower preferences; and a schedule has been revised to reflect their preferences. 2. An audit has been completed by Community Life staff for residents on their shower preferences; and a schedule has been revised to reflect their preferences.</p> <p>C. 1.Staff Development Coordinator/Designee will educate the nursing staff on residents' shower preferences and the revision of the schedules. The education will also include documentation of receiving and refusals of showers. <i>Attachment 3</i> 2.Staff Development Coordinator/Designee will educate the nursing staff on residents' shower preferences and the revision of the schedules. The education will also include documentation of receiving and refusals of showers</p>	10/24/15
-------	---	-------	--	----------

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 242	<p>Continued From page 4</p> <p>reported that she completed the preferences assessment with R109 at that time, and that R109 had a shower the evening before, 9/22/15 and that subsequent showers would be evenings three times a week.</p> <p>R109 was admitted to the facility on 9/8/15, however an assessment for her preferences of showers was not completed until 9/23/15, fifteen days later. The facility failed to allow R109 the right to receive healthcare consistent with her choices specifically her shower preferences and scheduling.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) on 9/24/15 at 2:30 PM.</p> <p>2. On 9/17/15 at 10:40 AM when asked the question "Do you choose how many times a week you take a bath or shower?", R2 responded that showers are twice a week and the resident indicated the desire to have three showers a week. The resident had not informed the facility of the desire to increase shower frequency. On 9/21/15 at 12:10 PM R2 stated "I have not had a shower in three weeks."</p> <p>Review of nursing notes between 7/1/15 - 9/22/15 and the bathing entry on the July, August and September 2015 electronic monthly CNA flowsheets showed:</p> <ul style="list-style-type: none"> - Shower scheduled on day shift on Tuesdays and Saturdays (accommodated the Monday, Wednesday and Friday dialysis treatment out of the facility). - Of the 24 scheduled showers, R2 refused six (6) times (was washed up when shower refused 1 time per nursing note dated 7/14/15 at 12:23 PM). - One (1) shower was recorded as being done 	F 242	<p>D. 1.R.N. Supervisor will audit the documentation of showers daily until 100% compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance.</p> <p><i>Attachment 4</i></p> <p>2.R.N. Supervisor will audit the documentation of showers daily until 100% compliance is achieved Variances will be monitored and trended monthly in QAPI meetings for continued compliance.</p>		

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 242	<p>Continued From page 5 (8/18).</p> <p>- Seventeen (17) times there was no indication that the shower was offered or provided on either the CNA flowsheet or in the nursing notes.</p> <p>9/23/15 interview at 11:30 AM with E6 (RN supervisor) recommended reviewing nursing notes for refusals when approached about the missing CNA shower documentation.</p> <p>9/23/15 interview at 11:44 AM with E9 (RN staff educator), who determined shower preferences on admission, confirmed missing shower documentation and stated that R1 often refused showers. E9 indicated there was no formal process for the re-evaluation of shower preferences. The resident must inform staff when desiring to change the frequency or days of showering. Surveyor informed E9 of R2's desire for three showers a week.</p> <p>Between 7/1/15 and 9/22/15 R2 had one shower and was washed up once. The facility failed to ensure R2 the right to receive his showers as scheduled.</p> <p>The findings were reviewed with E1 and E2 on 9/24/15 at 2:30 PM.</p>	F 242			
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p>	F 246			

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 246	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for two (R1 and R5) out of 30 sampled residents the facility failed to provide reasonable accommodations for individual needs. R1 could not reach the call bell and R5 did not have a functioning light at his bedside. Findings include:</p> <p>1. The following observations were made of R1: 9/17/15 11:15 AM - the resident was observed in bed with his call bell on the floor behind the head of the bed. The resident, who is capable of using the call bell, was unable to reach it. 9/24/15 11:45 AM - the resident was observed in bed with the call bell clipped to the base unit on the wall, out of reach of the resident.</p> <p>2. The following observations were made of R5: 9/17/15 12:40 PM - the over bed light was not functioning from the pull cord that was reachable from the bed. 9/24/15 9:03 AM - The over bed light was still not functioning. R5 did not have a light that could be turned on from his bed. An interview on 9/24/15 around 1:00 PM with E11 (Director of Environmental Services) revealed that no work order had been submitted for the non functioning light and he was having it fixed at</p>	F 246	<p>F 246</p> <p>A. 1. Resident #R1 did not have a negative outcome as a result of this deficient practice. R1's call bell was appropriately placed within his reach. 2. The light for R5 was repaired.</p> <p>B. 1. No other residents were affected by this deficient practice. An audit has been completed by R.N. Supervisor and call bells observed to be within reach. 2. A lighting audit was completed by maintenance of all health care center rooms, confirming that all lights are functioning.</p> <p>C. 1. Staff Development Coordinator/Designee will re-educate the nursing staff on placement of residents' call bells. <i>Attachment 5a</i> 2. The maintenance staff will be educated by the maintenance director/designee on performing rounds to check on light malfunctions. <i>Attachment 6a</i></p> <p>D. 1. R.N. Supervisor will audit call bell placement during rounds on every shift until 100% compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance. <i>Attachment 5b</i> 2. A weekly random lighting audit will be conducted by the maintenance director/designee until 100% compliance is achieved. <i>Attachment 6b</i> Variances will be monitored and trended monthly in QAPI meetings for continued compliance.</p>	10/24/15
-------	--	-------	--	----------

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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 246	Continued From page 7 that time.	F 246			
F 272 SS=D	<p>These findings were reviewed with E1 (NHA) and E2 (DON) on 9/24/15 at 2:30 PM.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>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; 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.</p>	F 272	<p>F 272</p> <p>A. #R85 has been discharged on 6/25/15. The facility was unable to correct the inaccurate MDS.</p> <p>B. No other residents were affected by this deficient practice. An audit has been completed by RNAC for residents admitted since 9-24-15 to determine all correct admission assessments completed.</p> <p>C. RNAC has been educated by Director of Health Informatics on appropriate MDS upon re-admission. <i>Attachment 7</i></p> <p>D. RNAC will audit all admissions weekly to ensure appropriate MDS created until 100% compliance achieved. RNAC will then audit all admissions every two weeks until 100% compliance achieved. RNAC will audit all admission monthly until 100% compliance achieved. <i>Attachment 8</i> – Variances will be monitored and trended monthly in QAPI meetings for continued compliance.</p>	10/24/15	

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

PRINTED: 10/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1176 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 272	Continued From page 8 This REQUIREMENT Is not met as evidenced by: Based on record review and interview it was determined that for one (R85) out of 30 sampled residents the facility failed to ensure the accuracy of the comprehensive assessment. Findings include: Review of R85's MDS's in the EMR documented an admission MDS dated 3/24/15. Review of EMR also revealed that after a hospital stay from 6/1 - 6/3/15 E12 (RNAC) initiated a new admission MDS assessment dated 6/10/15. This inaccurately reflected that the resident was new to the facility, not returning from a hospital stay. The facility should have assessed the resident to determine if a significant change MDS assessment needed to be completed instead of completing a new admission MDS. An interview on 9/24/15 at 11:25 AM with E12 revealed that she was unaware that a new admission MDS assessment should not be done when residents return from the hospital. These findings were reviewed with E1 (NHA) and E2 (DON) on 9/24/15 at 2:30 PM. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 272			
F 278 SS=D		F 278			

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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)	(X6) COMPLETION DATE
F 278	<p>Continued From page 9 resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accuracy of the quarterly assessment to reflect the resident's status for one (R2) out of 30 sampled residents. Findings include: R2 experienced a fall without injury on 5/26/15. 6/14/15 quarterly MDS assessment incorrectly</p>	F 278	<p>F 278</p> <p>A. MDS modified and submitted to CMS.</p> <p>B. No other residents were affected by this deficient practice. RNAC completed audit for all falls since 9-24-15 to ensure MDS coded correctly.</p> <p>C. RNAC educated by Corporate RNAC on utilizing the roster during clinical meetings and to review resident progress notes for review period to capture falls that may have occurred within assessment period. <i>Attachment 9</i></p> <p>D. RNAC will perform audit on 20% of census weekly until 100% compliance achieved. RNAC will then perform audit every two weeks until 100% compliance achieved. RNAC will complete audit monthly until 100% compliance achieved. <i>Attachment 10</i> Variances will be monitored and trended monthly in QAPI meetings for continued compliance.</p>	10/24/15

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 278	Continued From page 10 documented no fall since the prior assessment.	F 278	F 280 A. Care plan modified to show current incontinence status.	10/24/15
F 280 SS=D	This findings was confirmed with E12 (RNAC) on 9/24/15 at 11:35 AM. E12 stated the systems do not speak to each other so there is no flag or alert for knowing when a resident falls. This finding was reviewed with E1 (NHA) and E2 (DON) on 9/24/15 at 2:30 PM. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R28) out of 30 sampled	F 280 B. No other residents were affected by this deficient practice. An audit has been completed by the RNAC to determine current residents' continence/incontinence status and ensure care plans reflect this accurately. C. RNAC educated by Corporate RNAC on revision of care plans to reflect actual resident care needs by utilizing the roster during clinical meetings and to review resident progress notes for review period to reflect actual resident care needs. <i>Attachment 11</i> D. RNAC will audit care plans for 20% of census weekly to ensure continence status is accurate until 100% compliance achieved. RNAC will audit care plans every two weeks to ensure continence status is accurate until 100% compliance achieved. RNAC will than audit care plans monthly to ensure continence status is accurate until 100% compliance achieved. <i>Attachment 12</i> Variances will be monitored and trended monthly in QAPI meetings for continued compliance		

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

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 C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 280	Continued From page 11 residents the facility failed to revise the care plan to reflect actual care needs. Findings include: Review of R28's care plan documented the following problems and approaches dated 7/29/15: Resident is frequently continent of bladder and bowel functions. -ensure adequate bowel elimination. Resident has a significant change in status. Resident used to be continent of both bladder and bowel function, resident is now incontinent of both and requires limited assistance with toileting. -staff provide incontinent care as well as toileting assistance as required. An interview on 9/22/15 at 3:00 PM with E6 (RN) and E12 (RNAC) about the conflicting care plans revealed that both the care plans were carried over when the resident was readmitted to the facility after a hospital stay. It was confirmed that the resident was now more incontinent of bowel and does not urinate due to a medical condition. E6 and E12 stated the care plan would be revised to reflect the actual care needs of R28.	F 280			
F 309 SS=E	483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the necessary care and services were maintained in accordance with the plan of care for two (R2 and R28) out of 30 sampled residents. R2 experienced seven episodes of moderate pain without intervention and the facility failed to conduct a reassessment of the resident's pain management regimen after pain became more severe. R28 failed to receive the necessary care and services when R28's bowel movements were not adequately monitored to prevent constipation. Findings include: 1. R2's physician order from 4/5/14 included Tylenol to be given every 4 hours if needed for pain 6/24/14 - 3/25/15 R2 was ordered a narcotic pain medication that could be administered every 4 hours as needed after surgery for cancer. 12/22/14 (reviewed quarterly but not revised) care plan interventions for pain included: monitor for indicators of pain; assess location and duration of pain and any contributing factors; administer pain medications as ordered and assess effectiveness; monitor every shift for breakthrough pain. 6/14/15 Quarterly MDS assessment documented that R2 received no PRN pain medication in the prior 5 days. Resident had mild pain that occurred rarely and had no effect on sleep or	F 309	F 309 A. 1. R2's pain was reassessed to determine baseline. 2. R28's bowel assessment was completed and does not indicate signs and symptoms of constipation. R 28 is being monitored for the absence of Bowel movements. B. 1. No other residents were affected by this deficient practice. A pain assessment audit has been completed to determine baseline pain level for residents. 2. No other residents were affected by this deficient practice. A BM audit has been completed for residents who have a diagnosis of constipation. C. 1. Staff Development Coordinator/Designee will educate charge nurses on managing resident pain, relative to pain level and physician orders. <i>Attachment 13</i> 2. Staff Development Coordinator/Designee will re-educate nursing staff on documentation of BMs. <i>Attachment 13</i> D. 1. R.N. Supervisors/Designee will audit pain scores to ensure residents' pain is managed daily until 100 % compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance. <i>Attachment 13a</i> 2. Charge Nurses/Designee will audit BM documentation daily until 100 % compliance is achieved. <i>Attachment 14</i> Variances will be monitored and trended monthly in QAPI meetings for continued compliance.	10/24/15

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 309	<p>Continued From page 13 limiting activities.</p> <p>9/14/15 Annual MDS assessment (in progress, not yet submitted) documented the resident experienced pain almost constantly with an intensity of 8 (severe) on the pain rating scale. Performing ADLs increased the amount pain and medication relieved the pain. R2's pain goal was 5 and it was very important to eliminate the pain.</p> <p>Review of R2's 2015 July, August and September eMARs, pain assessment monitoring (conducted daily at 12:00 AM, 9:00 AM and 4:00 PM), physician notes and nursing notes revealed:</p> <ul style="list-style-type: none"> * July - resident's pain assessment had no instances of pain; received Tylenol four (4) times for mild pain (with relief) between documented pain assessments. * August - pain assessment with no instances of pain during the first half of the month. On August 22, 27 and 29 R2 received Tylenol with relief for moderate pain. The resident's pain assessment documented mild pain at 9:00 AM on August 16 and moderate pain at 9:00 AM on August 31 without evidence that staff provided intervention / medication for either episode of pain. * September - pain assessment documented R2 had moderate pain nine (9) times and severe pain one (1) time. There was no evidence in the record that the resident received intervention / medication for five (5) episodes of pain (Sept 6, 9, 14, 15, and 17). R2 also received Tylenol six (6) times for pain between documented pain assessments. <p>There was no evidence of a medical assessment or re-evaluation of current medication treatment</p>	F 309		
-------	---	-------	--	--

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 309	<p>Continued From page 14</p> <p>for this resident who went from having four (4) episodes of mild pain in July 2015 to fifteen (15) episodes of primarily moderate/severe pain in September 2015.</p> <p>9/21/15 Interview at 12:10 PM the resident stated his back was "hurting me bad". The resident said he had Tylenol before, but it "only works for about an hour".</p> <p>9/21/15 Interview at 12:17 PM when asked if the nurse was aware of the resident's current pain, E14 (RN) stated that when R2 "does not go to dialysis he just lays in bed all day" and that she had just given him something for constipation which might be contributing to his pain".</p> <p>On 9/24/15 at 9:15 AM E2 (DON) confirmed the seven instances of moderate pain without intervention and the increasing intensity of R2's pain without a re-evaluation of the resident's pain management regimen.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 9/24/15 at 2:30 PM.</p> <p>2. The facility's policy for Bowel Management Program last approved 2/18/15 documented that if a resident does not have a bowel movement (BM) per normal routine follow facility specific bowel protocol or physician order.</p> <p>R28 had a diagnosis of constipation and received a daily medication to prevent constipation.</p> <p>7/29/15 care plan included an approach to ensure adequate bowel elimination. However, no interventions were specified.</p>	F 309			

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 309	<p>Continued From page 15</p> <p>Review of electronic medical record data for July, August and September 2015 determined time frames with no BM:</p> <p>7/1 - 7/6: 15 shifts no BM 7/9 - 7/12: 11 shifts no BM 9/3 - 9/7: 12 shifts no BM 9/7 - 9/11: 12 shifts no BM 9/14 - 9/18: 10 shifts no BM</p> <p>Review of nurses' notes in the EMR lacked evidence that R28 was assessed for constipation during the above dates. Review of nurses notes lacked evidence that the physician was contacted when the resident went three days / nine shifts with no BM. There was no evidence of assessment or intervention after multiple shifts with no BMs. The resident had no PRN medications ordered for constipation.</p> <p>An interview on 9/24/15 at 11:02 AM with E2 and E3 (ADON) revealed a bowel monitoring system used by the facility was described as an audit every three days that looked at a report of residents with no BMs for the past six shifts. The practice failed to capture the lack of bowel movements for over 9 shifts or 3 days for R28 on five (5) occasions between July and September 2015. E2 confirmed that there was no evidence that an assessment was done when R28 had no BMs documented for three days and no evidence that any interventions for constipation were conducted. It was also revealed that the facility did not have a facility specific bowel protocol. If a resident needed an intervention for constipation the doctor would need to be contacted for an order.</p> <p>These findings were reviewed with E1 and E2 on</p>	F 309		
-------	--	-------	--	--

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

PRINTED: 10/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 309	Continued From page 16 9/24/15 at 2:30 PM.	F 309		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R61) out of 30 sampled residents the facility failed to ensure the resident received a therapeutic diet. R61 was provided with a drink that was not properly thickened. Findings include: 8/14/15 - Physician order to change R61's diet from honey thick liquids to nectar thick liquids. 9/22/15 at 2:52 PM - resident was observed with a blue cup in his hand and was coughing. The cup was about 1/3 filled with a clear liquid that did not look thickened. The surveyor made E6 (RN) aware of the incident. R61 was then offered another cup containing a thickened liquid and began drinking without coughing. At 3:09 PM E6 told the surveyor that E13 (LPN) had provided R61 with the water and added some thickener but	F 325	F 325 A. R61 was re-assessed and his increased thickening of water was tolerated well. B. No other residents were affected by this deficient practice. An audit has been completed by dietician for residents who require thickened liquids. Dietary staff will provide pre thickened liquids for the residents. C. Staff Development Director/Designee will educate nursing and dietary staff on administering thickened liquids per physician. <i>Attachment 15</i> D. Charge Nurse/Designee will audit residents on thickened liquids to ensure they get the appropriate consistency daily until 100% compliance is achieved. <i>Attachment 16</i> Variances will be monitored and trended monthly in QAPI meetings for continued compliance.	10/24/15

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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 325	Continued From page 17 It must not have been enough, she was re-educated on using the thickening agent.	F 325		
F 514 SS=E	These findings were reviewed with E1 (NHA) and E2 (DON) on 9/24/15 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for five (R61, R110, R85, R49, and R90) out of 30 sampled residents the facility failed to maintain accurate and complete clinical records. Findings include: 1. R61's admission Nutritional Assessment dated 3/5/15 documented a weight of 120 pounds (#). A quarterly Nutritional Assessment dated 9/6/15 incorrectly documented the resident's admission weight as being 110.8 pounds. 2. R110's EMR documented on 9/14/15 a height	F 514	F 514 A. 1. R61 weight was obtained and his nutritional assessment was corrected. 2. R110 had no corrective action of height due to discharge on 10/7/2015. 3. R49 height was obtained and his EMR was corrected. 4. R85 did not have corrective action due to discharge on 6/25/2015. 5. R90 did not have corrective action. Resident expired 7/24/2015. B. 1. No other residents were affected by this deficient practice. An audit has been completed by dietician to ensure accuracy of resident weights. 2. No other residents were affected by this deficient practice. An audit has been completed by dietician to ensure accuracy of resident heights. 3. No other residents were affected by this deficient practice. R.N. Supervisor runs a missed ADL documentation report on every shift. 4. No other residents were affected by this deficient practice. Medical record audit "nurse aide documentation" prior to closing the medical record. C. 1. RNAC/Designee will educate dietician on correctly documenting weight during nutritional assessment. <i>Attachment 17a</i> 2. Staff Development Director/Designee will educate nursing staff on correct process for obtaining heights. <i>Attachment 18a</i>	10/24/15

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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 514	<p>Continued From page 18 of 72 inches. Review of the admission Nutritional Assessment incorrectly documented a height of 60 inches.</p> <p>An interview with E6 (RN) on 9/23/15 at 11:45 AM revealed that based on the data in the hospital record, R61's height was 72 inches.</p> <p>3. Review of R85's EMR in the area where staff documented the assistance with ADLs it was found that in May, 2015 staff failed to document on day shift 5/6 - 5/10, 5/13 and 5/14/15 and evening shift 5/10/15.</p> <p>4. R49's EMR documented a height of 61 inches on 10/8/14. The resident appeared to be much taller than 61 inches in his bed.</p> <p>6/7/15 Quarterly MDS assessment documented the resident had no memory problems.</p> <p>9/23/15 - Interview at 11:45 AM E6 (RN) stated they don't measure heights, they obtain the height from the hospital record.</p> <p>9/24/15 - Interview at 9:50 AM R49 stated he had been 6 foot 1 inch tall (73 inches) but may have shrunk a little.</p> <p>The facility failed to record an accurate height for R49 when 61 inches was recorded for a resident who was 6 foot 1 inch tall.</p> <p>This finding was confirmed with E2 (DON) and E3 (ADON) on 9/24/15 at 10:30 AM.</p> <p>5. During record review on 9/22/15, the "Nurse Aide Documentation" form for R90 had no date anywhere on the documentation.</p>	F 514	<p>3. Staff Development Director/Designee will re-educate nursing staff on documenting on EMR as care is delivered. <i>Attachment 19a</i></p> <p>4. Staff Development Director/Designee will educate nursing staff and medical records staff to ensure dates and resident names are on medical records. <i>Attachment 20a</i></p> <p>D. 1. RNAC/Designee will audit weights on nutritional assessment weekly until 100% compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance. <i>Attachment 17b</i></p> <p>2. Dietician/Designee will audit heights upon admission weekly until 100% compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance. <i>Attachment 18b</i></p> <p>3. R.N. Supervisor will audit ADLs completion daily until 100% compliance is achieved. Variances will be monitored and trended monthly in QAPI meetings for continued compliance. <i>Attachment 19b</i></p> <p>4. Medical Records will audit closed charts to ensure documentation of dates and residents names are completed weekly daily until 100% compliance is achieved. <i>Attachment 20b</i> Variances will be monitored and trended monthly in QAPI meetings for continued compliance.</p>	

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

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/24/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1175 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 514	<p>Continued From page 19</p> <p>This was confirmed by E10 (Unit Clerk) on 9/22/15 at 11:18 AM and then with E2 on 9/22/15 at 11:47 AM.</p> <p>These findings were reviewed with E1 (NHA) and E2 on 9/24/15 at 2:30 PM.</p>	F 514		
-------	---	-------	--	--



**DELAWARE HEALTH
AND SOCIAL SERVICES**

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 Health Center

DATE SURVEY COMPLETED: September 24, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201 3201.1.0 3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from September 17, 2015 through September 24, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 58. The survey sample totaled thirty (30).</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed September 24, 2015. F241, F242, F246, F272, F278, F280, F309, F325, and F514</p>		

Provider's Signature *Sandy NWA* Title Administrator Date 11/18/15