DHSS/DLTCRP

AUG 1 5 2014

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

PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING ~~WILMINGTON OFFICE~~ B. WING	C 07/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	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	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from July 12, 2014 through July 23, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 53 . The sample size included three (3) active records and two (2) closed records. Abbreviations used in this 2567 are as follows: DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; NHA- Nursing Home Administrator; PTA- Physical Therapy Assistant; SW- Social Worker LCSW- Licensed Clinical Social Worker MDS - Minimum Data Set (standardized assessment forms used in nursing homes).	F 000	**F 250** A. Resident's #R2 and R5 were referred to Psychologist. B. An audit will be completed by Social Services Director for current residents to identify need for psychology services and appropriate referral will be completed. C. NHA will educate the Social Services Director on assessing residents who may need psychological services and ensuring that appropriate referrals are in place. Social Service Director will identify residents with psychology needs during her assessments/ clinical meeting and make appropriate referrals.	8/26/14
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and	F 250		

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

E Josiah RN DON / Linda Messersmith NHA 8/15/14

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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F 250	Continued From page 1 observations it was determined that for two (2) of five (5) residents reviewed (R2 and R5) the facility failed to provide medically-related social services to attain or maintain the highest practicable psychosocial well-being for each resident. Staff identified that R2 had mood and adjustment issues but no social services to address these issues were being provided at the time of the survey. R5 had a long history of requiring psychological services but these services were discontinued in June 2014 due to the counselor becoming unavailable. The facility failed to provide social services and failed to make arrangements for continued services with another counselor. Findings include: Cross-refer F279 and F319. 1. The 7/3/14 MDS assessment for R2 revealed mood issues, rejection (refusal) of care, and a lack of bathing (did not occur during the assessment period). Interview with E4 (RN) on 7/17/14 at 11:30 AM revealed that R2 had a lot of frustration related to his condition and nursing home admission. Interview with E8 (SW) on 7/17/14 at 1:10 PM revealed that all new admissions (including R2) should be seen by a psychologist at the time of admission since that was the facility's usual practice. Record review, however, revealed that this had not occurred for R2. E8 stated that R2 was resistant to care at times and that a psychologist consultation was appropriate for him. The facility failed to provide a psychological screening of R2 when he was admitted on 6/20/14 although it was the facility's usual practice to have all new admissions screened. The facility then failed to identify that the screening had been missed when R2 exhibited frustration and resistance to care.	F 250	D. Social Services Director will audit current residents 5*/wk. until 100% compliance is achieved. Quarterly QA committee will monitor needs and trends for continued compliance. Attachment #1	

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F 250	Continued From page 2 Findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 7/23/14 at approximately 4:10 PM. 2. R5 had a psychological counseling visit on 6/16/14 by E9 (LCSW) . According to the note from this visit, long term goals of treatment included stabilization of depressed, anxious / irritable mood using various counseling approaches. "Final visit" was written on this note. Interview with E10 (psychologist) on 7/17/14 at 12:10 PM revealed that it was the "final visit" because E9 was no longer providing services to facility residents and her (E9's) caseload did not automatically transfer to E10. E10 stated that she was familiar with R5's long history of psychological issues and believed continued psychological services were needed. Interview with E11 (CNA) at 12:15 PM on 7/17/14 revealed that R5 spent much of her time in the bathroom washing and re-washing herself which was a long-standing behavior. A current physician's order for "psychology consult and treat as needed" was present in R5's clinical record. E9 wrote a recommendation in the note dated 6/16/14 that R5's hearing aids be put in to improve communication and that R5 may benefit from a speech therapy consultation to improve cognitive functioning including organization. Surveyor observation on 7/17/14 at 12:15 PM revealed that R5 was not wearing hearing aids and had difficulty speaking with the surveyor. R5 was observed again at 12:40 PM and again had no hearing aids. R5 apologized several times to the surveyor stating that she wasn't sure why her hearing aids weren't in and that sometimes they (hearing aids) didn't feel right.	F 250	**F 279** **A.** Resident'#R2's care plan has been created and updated to reflect psychology needs. **B.** Social Services Director will complete an audit on current residents to identify psychosocial needs have been identified. Care plans will be developed to reflect those needs. **C.** RNAC will educate Social Service Director on completing care plans for residents needing psychological needs. Social Service Director will identify residents with	8/26/14

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F 250	Continued From page 3 E2 confirmed on 7/23/14 at 3:20 PM that the recommended speech therapy consultation for R5 had not occurred but R5 would now be screened by the speech therapist. E2 also confirmed that R5's hearing aids were available for her use. The facility failed to provide continuity of psychological services to R5 and failed to implement recommendations made by E9 in a 6/16/14 mental and behavioral health visit note. Findings were confirmed with E1 (NHA), E2, and E3 (ADON) at the exit conference on 7/23/14 at approximately 4:10 PM.	F 250	psychology needs during her assessments/ clinical meeting and make appropriate referrals. **D.** Social Services Director will review care plans for meeting psychosocial needs weekly for until 100% compliance is achieved. Variances will be corrected and results presented to the QAPI committee. Attachment #2	
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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 4	F 279		
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined that for one (1) of five (5) residents reviewed (R2) the facility failed to develop a comprehensive care plan to meet the psychosocial needs (mood issues and refusal of care) identified in the comprehensive assessment. Findings include: Cross-refer F250, example 1 and F319. R2's MDS assessments dated 6/26/14 and 7/3/14 identified mood issues that were impacting R2's life including feeling down and hopeless; feeling bad about himself; and little interest or pleasure in doing things. No care plan addressing these issues was found when R2's care plan was reviewed by the surveyor. A care plan was subsequently initiated by E8 (SW) to address R2's mood and adjustment to nursing home admission. Findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 7/23/14 at approximately 4:10 PM.		F 281 A. Resident #3 was not negatively affected by deficient practice. B. An audit was completed of current care plans of those residents who are risk for falls. Appropriate interventions are in place. C. Residents determined to be at risk for falls on admission will be reviewed to determine appropriate level of supervision required. Interim care plan will reflect this determination. Education was provided to the RNACs by the DON on this process. Education regarding this process has also been provided to the licensed staff by the SDC/designee	8/26/14
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it	F 281		

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F 281	Continued From page 5 was determined that for one (1) of five (5) residents reviewed (R3) the facility failed to provide services that met professional standards of quality. The facility identified that R3, a newly admitted resident, was at high risk for falls but failed to identify in the admission care plan how staff would supervise R3 to prevent falls. Findings include: R3's admission care plan included the problem of potential for falls due to unsteady gait, weakness, a history of falls, and decreased cognitive (thought process) status. The interventions to address this problem did not include a supervision plan for staff to follow. During the surveyor's initial tour of the facility on 7/12/14 at approximately 4:40 PM, E5 (wife of R3) stated that R3 had just been admitted the previous day (7/11/14) and she was very concerned about R3 falling because he forgets to use the call bell to call for staff assistance. E5 stated that R3 had fallen in the hospital prior to admission to the nursing home. A nursing note dated 7/11/14 and timed 7 PM documented that R3 required assistance with transfers (moving from one position to another such as from the bed to a chair) and was unsteady when walking. Interview with E6 (RN) on 7/12/14 at 6:45 PM confirmed that R3 needed staff assistance with transfers and that a call bell was provided for R3 to call for staff assistance. E7 (RN) was present for this interview and told E6 that R3's use of the call bell was "hit or miss" (inconsistent). A supervision plan was then initiated by the staff following this interview. The facility failed to develop and implement an immediate supervision plan for R3 at the time of admission to address his identified fall risk	F 281	D. Care plan audits to ensure appropriate interventions for fall risk will be completed by the RNAC 5*/wk., until 100% compliance is achieved. The NHA/designees to ensure compliance. Variances will be corrected and results will be reported to the QA committee for review. Attachment #3	

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F 281	Continued From page 6 factors. Findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 7/23/14 at approximately 4:10 PM.	F 281		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined that for one (1) of five (5) residents reviewed (R2) the facility failed to provide appropriate treatment and services to correct psychosocial adjustment difficulty. Staff assessed and documented indicators of adjustment difficulty, however, the facility failed to use the information to develop and implement a plan to address this problem. Findings include: Cross-refer F250, example 1 and F279. R2's clinical record contained the following indicators of psychosocial adjustment difficulty: -MDS assessments dated 6/26/14 and 7/3/14 documented mood issues including feeling down / hopeless and feeling bad about himself; -a nursing note dated 7/8/14 timed 6:26 PM documenting that R2 refuses care at times and	F 319	**F 319** **A.** R2's psychosocial needs have been addressed and care plan updated to reflect current interventions **B.** An audit will be completed by Social Services department for residents with adjustment difficulties. Appropriate services will be provided as needed. **C.** NHA will educate the Social Services Director on assessing residents, who may need psychological services and ensuring that appropriate referrals are	8/26/14

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F 319	Continued From page 7 swears (curses) at staff; and -a care plan addressing R2's routine refusal care. Staff interviews revealed the following indicators of psychosocial adjustment difficulty: -Interview on 7/15/14 at 5:25 PM with E12 (LPN) revealed that R2 "snaps" at (gets upset with) the staff and then apologizes; -Interview on 7/17/14 at 11:30 AM with E13 (RN) revealed that R2 has a lot of frustration and refused care often; and -Interview on 7/17/14 at 10:30 AM with E14 (PTA) revealed that R2 was upset about things including family issues and his overall health condition. No care plan addressing mood, psychosocial issues, or adjustment difficulty was found for R2 when his record was reviewed by the surveyor. Interview with E10 (psychologist) on 7/17/14 at 10:30 AM revealed that she normally gets a referral to screen all new admissions but that she never received one for R2. The facility failed to use documented assessment information as well as information known by staff members to plan for and provide R2 with treatment and services to address his adjustment difficulty. Findings were confirmed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 7/23/14 at approximately 4:10 PM.	F 319	in place. Social Service Director will identify residents with psychology needs during her assessments/ clinical meeting and make appropriate referrals. **D.** Social Services Director will review care plans for meeting psychosocial needs weekly for until 100% compliance is achieved. Variances will be corrected and results presented to the QAPI committee.	

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

DATE SURVEY COMPLETED: July 23, 20

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint survey was conducted at this facility from July 12, 2014 through July 23, 2014. The deficiencies cited in this report are based on record reviews, staff interviews, observations and review of other facility documentation as indicated. The census the first day of the survey was 53. The sample size included three (3) active records and two (2) closed records.	Cross Reference F 250 8/26/14 A. Resident's #R2 and R5 were referred to Psychologist. B. An audit will be completed by Social Services Director for current residents to identify need for psychology services and appropriate referral will be completed. C. NHA will educate Social Services Director on assessing residents who may need psychological services and ensuring that appropriate referrals are in place. Social Service Director will identify residents with psychology needs during her assessments/clinical meeting and make appropriate referrals. D. Social Services Director will audit current residents 5*/wk. until 100% compliance is achieved. Quarterly QA committee will monitor needs and trends for continued compliance. See Attachment #1
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 7/23/14, F250, F279, F281 and F319.	

Provider's Signature Anda Messersmith Title NHA Date 8/22/14

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3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 7/23/14, F250, F279, F281 and F319.	

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3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 7/23/14, F250, F279, F281 and F319.	

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3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed 7/23/14, F250, F279, F281 and F319.	

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