DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Health

DATE SURVEY COMPLETED: September 16, 2024

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 September 12, 2024 through September 16, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census was fifty-nine (59) on the first day of the survey. They survey sample was three (3).	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**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 September 16, 2024: cross refer: F607 and F609.	Cross Refer to the CMS 2567-L survey completed September 16, 2024: cross refer: F607 and F609.

Provider's Signature Isaiah Shaw Title NHA Date 9/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD DOVER, DE 19904

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from September 12, 2024 through September 16, 2024. The deficiencies contained in this report are based on observation, interviews, review of clinical records and other facility documentation as indicated. The facility census was fifty-nine (59) on the first day of the survey. The survey sample was three (3). Abbreviation/definitions used in this report are as follows: CNA- Certified Nursing Assistant; DON- Director of Nursing; ED- Executive Director; EMR- electronic medical record; LPN - Licensed Practical Nurse; LTC- long-term care; MD- doctor of medicine; meds- medications; NHA - Nursing Home Administrator; NP- nurse practitioner; RN- Registered Nurse.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		10/9/24

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

Electronically Signed | 09/25/2024

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F 607	Continued From page 1 paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R1) out of three residents reviewed for Abuse, the facility failed to implement their written abuse policy by failing to notify R1's physician of the abuse allegation. Findings include: Facility Policy- " ...Abuse, Neglect or Exploitation ...Guidelines: ...3. In health care centers, alleged violation of abuse ...the facility MUST report the allegation to the Department of Health IMMEDIATELY but no later than 2 hours after the allegation is made ... 10. In the health centers, assisted living/personal care staff will notify the resident's attending physician, medical director and family member or designated person of all allegations of abuse, neglect or misappropriation of property ...".	F 607	R1 still resides in the facility. R1's attending physician was notified in person of R1's rape allegation on 9/10/2024. Current residents residing in the facility who had an allegation of abuse have the potential to be affected by this practice. Residents who had an abuse allegation within the last 6 months were reviewed to ensure that the physician was notified. No other residents were identified. A root cause analysis revealed the need for re-education of the nursing staff on the facility's written abuse policy. The nursing staff will be re-educated by the DON/Designee on following the Abuse Neglect and Exploitation policy with an emphasis on physician reporting. Education will be completed by 10/9/2024. DON/designee will conduct an audit on	

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F 607	Continued From page 2 9/9/24 11 PM - The facility's incident report documented that R1, who was diagnosed with profound dementia, allegedly made a claim to E5 (RN) that a man raped her. Of note, 9/9/24 was a Monday. 9/10/24 11:32 AM - Review of text conversation between E7 (MD) and E8 (Medical director) provided in screenshots provided by E7 (MD) revealed: - E7 (MD) texted, "Have you heard the latest RE: [R1]?" - E8 (Medical Director) replied, "No! I'll go to [facility on-call service computer reporting system]." -E7 (MD) replied, "I put details there." 9/10/24 1:18 PM - The State agency received a report from the facility stating, "Incident Date/Time: 9/10/24 @11:00 ...Incident Description: 89 years old female resident with diagnosis of dementia with inappropriate behaviors reported to a nurse that she was sexually assaulted by a caregiver ... [town] PD (police department) notified ...". 9/10/24 2:13 PM - The facility's investigation statement from E5 documented that after receiving report and checking her patients on 9/9/24 night shift, E5 (RN) went to the other nursing unit to find the nursing supervisor, who was not available at that time. It was documented that E5 left a message with another staff member stating that E5 needed to speak with E6 (RN Nursing supervisor). 9/11/24 10:25 AM - The facility's interview/statement form from E6 (RN nursing	F 607	residents with complaints of abuse of any type to ensure that physician notification has occurred. Audits will be conducted daily X 5days until 100% compliance is verified, then weekly X 4 until 100% compliance is verified, then monthly X 3 until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and recommendations	

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F 607	Continued From page 3 supervisor) documented that at approximately 1:00AM on 9/10/24 while dropping off a specimen in the LTC (long term care) unit, E6 approached E5 (RN) and was informed about R1's allegation. 9/12/24 9:15 AM - Review of text conversation between E7 (MD) and E8 (Medical Director) revealed: -E8 (Medical Director) texted, "Hey! Did you see [R1] for the evaluation of 'the allegation'?" -E7 (MD) replied, "Yes, I did (check out my last note- Tuesday)." -E8 replied, "I saw a lot of talk about the SI (suicidal ideation) but not the other. I'll read it in more detail." -E7 replied, "You might note my frustration in that note but I have [hospital] backing on it when they said she's low risk for carrying out a plan." -E8 then replied, "Did you address the rape allegation?" -E7 replied, "Indirectly- I asked her if she remembers anything that happened a few days back." New text stated, "she said, 'no'." -E8 replied, "I don't see that documented. The state is here to investigate." -E7 then replied, "Didn't want to asking a leading W." Next text said "Q". Then the next text stated, "Best one to answer is [staff]- she got the initial issue." Of note, "W" is located right next to "Q" on a mobile phone text keyboard. -E8 then replied, "Nobody from nursing leadership called me. Nobody. Her response was '[E7] was here and assessed her'." 9/12/24 10:31 AM - E7 documented in R1's electronic medical record (EMR) as a Late Entry Addendum to 9/10/2024 Progress Note, " ...[R1]	F 607		

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F 607	Continued From page 4 allegedly made a statement a few days back (just received information on 9/10/24 aroun (sic) noon after I finished my notes that day) that she was allegedly "raped". I sought her out and saw her at the lunch table at the Dining Hall, and before she had companions with her at the table, I asked her if she recalls if something happened a few days back. Her forehead furrowed in a questioning manner, so I redirected the questions- I asked again- 'did anyone harm you a few days ago?' She answere (sic) "no". so I did not pursue it. With the alleged incident, if there was high suspicion, a pelvic exam would be warranted (and, ideally within a few hours of the incident- i.e. - E.R (emergency room) evaluation with a rape kit), but with a negative response, a pelvic would be disastrous to her mental state." 9/16/24 9:50 AM - During a telephone interview, E7 (MD) stated, "I was writing my notes. I had already seen R1 to assess her for a follow up after her suicidal ideation admission from the previous week. I overheard the [staff] discussing [R1]'s allegation that she had been raped. After questioning the staff, I went back to see [R1] again and spoke with [R1] and her husband in the dining room ... [R1] has advanced dementia and a lot of hallucinations ...Where is the connection with the provider? I had not even been informed of this allegation by the facility. They (the staff) did not even write it in the blue doctor communication book. The doctor communication book is over on the other nursing unit. It is where the staff write down any concerns that the nurses/staff want the providers to address when they see the resident. I texted [E8 (Medical Director)] to see if she knew about this rape allegation ..." During this interview, E7 clarified that the "Q" in	F 607		

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F 607	Continued From page 5 this text series refers to the word "question". E7 also stated that he only works part-time. He works in the facility on Tuesdays and Thursdays. E7 further explained that E9 (NP) works in the facility on Monday, Wednesday, and Friday and that [medical practice] provides on-call service for off hours overnight and on weekends. He added that E8 is the Medical Director and "she was not notified of the allegation until I told her." 9/16/24 11:25 AM - During an interview, E9 (NP) stated, "I was never told about R1's allegation by the facility ... The doctor's communication book is on that table there." 9/16/24 11:27 AM - Review of the Doctor's communication book revealed that there were no entries regarding R1 in the log between the dates of 9/8/24 and 9/15/24 (two pages of the logbook). 9/16/24 11:50 AM - During a telephone interview, E8 (Medical Director) stated, "I was notified (of the allegation) by E7 (MD) on Tuesday (9/10/24) around midday. R1 is demented and has behavioral challenges. She can be physically and verbally aggressive. She has been a challenge. She was recently sent to the hospital for a psychiatry evaluation after making an allegation that she was going to hurt herself. That was why E7 was seeing her on Tuesday to follow up after her hospital admission ... I am new to this facility...have been the medical director for a few months. Typically, I am on-site on Thursdays ... The medical practice has an on-call NP (nurse practitioner) who keeps a log of all the incoming calls. I did review the call log from that night. There was no indication that the facility called. I did not see anything from on-call that it was called into on-call."	F 607		

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F 607	Continued From page 6 The facility lacked evidence that the staff had notified the medical team or the facility's medical director of R1's abuse allegation for more than twelve hours after the initial allegation was made. 9/16/24 12:35 PM - The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Executive Director) at the exit conference.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		10/9/24

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F 609	Continued From page 7 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for two (R1, R3) out of three residents reviewed for Abuse, the facility failed to report an allegation of abuse within the 2 hour time frame. For R1, the incident alleging sexual assault was reported to staff on 9/9/24 at approximately 11 PM but was not reported to the State Agency until 9/10/24 at 1:18 PM. For R3, the incident alleging emotional abuse was reported to the facility on 4/4/24 at 11 AM but was not reported to the State Agency until 4/8/24 5:18 PM. Findings include: 1. Review of R1's clinical record revealed: 9/9/24 approximately 11 PM - R1, who was diagnosed with profound dementia, allegedly made a statement to E5 (RN) that a man raped her. 9/9/24 approximately 11:35 PM - After counting the narcotics and checking her patients, E5 (RN) went to the other nursing unit to find the nursing supervisor, who was not available at that time. 9/10/24 approximately 1 :00 AM - E6 (RN nursing supervisor) approached E5 (RN) on the dementia unit and was informed about R1's allegation. 9/10/24 1:18 PM - The State agency received a report from the facility stating, "Incident Date/Time: 9/10/24 @11:00 ...Incident Description: 89 years old female resident with diagnosis of dementia with inappropriate behaviors reported to a nurse that she was	F 609	R1 and R3 still resides in the facility. R1's allegation of sexual assault was reported to the State Agency on 9/10/2024 at 1:18 PM. R3's allegation of emotional abuse was reported to the State Agency on 4/8/2024 at 5:15 PM. Current residents residing in the facility with who had an allegation of abuse have the potential to be affected by this practice. All resident who had an allegation of abuse within the last 6 months were reviewed to ensure that the State Agency was notified. No other residents were identified. A root cause analysis revealed the need for re-education of the nursing staff on facility's written policy title Abuse, Neglect or Exploitation with an emphasis on timely reporting to the State Agency. The nursing staff will be re-educated by the DON /designee on the facility's written Abuse, Neglect or Exploitation policy. Education will be completed by 10/9/2024. DON/designee will conduct an audit on all residents with complaints of abuse of any type to ensure that physician notification had occurred. Audits will be conducted daily X 5days until 100% compliance is verified, then weekly X 4 until 100% compliance is verified, then monthly X 3 until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Committee for review and recommendations	

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F 609	Continued From page 8 sexually assaulted by a caregiver ... [town] PD (police department) notified ...". Of note, the incident date/time reported to the state agency was the time that the facility's nursing leadership became aware of R1's allegation. The allegation was actually made known to facility staff members, who were agents of the facility, on 9/9/24 at approximately 11 PM. 9/12/24 12:34 PM - During a telephone interview, E5 (RN) stated, "I punched in at 10:53 PM. As I walked into the unit, R1 was in the TV room (a community room on the right-hand side of the building) in a recliner. R1 was calling out so I went over to her. R1 calls out a lot. When I leaned down to talk with her, R1 said, 'A man raped me.' I asked, "Are you hurt?' and R1 responded, 'Not hurt but I am scared.' I told her that I was with her tonight and she did not need to be afraid ...After counting narcs (narcotics) and checking my patients, I went to TCU (the other nursing unit) to talk with E6 (RN nursing supervisor) but she had patients and was busy giving meds (medications). So I asked the other staff to tell her to come down to dementia unit to see me when she was able ... E6 did come over to the dementia unit around 1 AM and I told her that R1 had alleged that a man raped her. This is my first job in long-term care. I started working here in May 2024. I worked for 38 years in the hospital setting. I assumed E6 would tell the day shift supervisor. Then I got busy in the early morning. I had a 6 AM transfer to the hospital and found a wound. When I got home, I realized that I had not told the day shift supervisor so I called into the unit and left a message for her to call me. Sometime around 9:30- 10 AM, [day shift supervisor] called me and told her what R1 had	F 609		

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F 609	Continued From page 9	F 609		

said ...They [the facility] wanted me to come in to write aa statement but I had had two glasses of wine so we agreed that I would sleep for a few hours and come in around 2 PM to make a statement."

9/13/24 10:56 AM - During a telephone interview, E6 (RN Nursing supervisor) stated, " ...Around 1 AM, I went over to that side (the dementia unit across the lobby from the unit E6 was working on) as I was told that E5 (RN) wanted to talk with me ... All I was told was there was an incident involving R1 and she was uncomfortable with male caregivers ... that word was never used." When asked for clarification what was meant by "that word", E6 stated "rape. If that word had been used, I would have called [E2]. But since it was night shift and R1 was asleep and had 2 female aides, I would report it to the day shift supervisor." When asked if E6 clarified what was meant by "an incident", E6 responded, "No, I didn't." E6 also stated that she started as the night shift nursing supervisor on April 9, 2024 but prior to that she worked "for years" at [facility] as a supervisor.

9/13/24 12:10 PM - During an interview, E1 (NHA) stated, "The supervisors have access to the State website. There is no facility sign on needed in order to make a report on the State agency website. They also can call the Administrator on-call. We are available 24/7."

9/13/24 1:20 PM - During a telephone interview, E10 (CNA) stated, " ...When E5 (RN) came in that night (9/9/24), she went over to R1 and kissed her on the face. They had a conversation that we (the CNAs standing across the room) could not hear. E5 came up to the group of us

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(CNAs) and stated that R1 had said that someone raped her. We all went 'What?? She (R1) has been in the common area the whole shift.' E5 then told E13 (CNA) that he should not care for R1 without witnesses. That bothered me ... She (E5) should not have said that in front of all the CNAs. It was not professional ... E5 was going to talk to the nursing supervisor."

9/13/24 2 :17 PM - During a telephone interview, E11 (LPN) stated that she had worked evening shift on 9/9/24 and gave report on the residents at the nurses' station to E5 (RN) who had come in for night shift. E11 (LPN) stated, "R1 spends most of her time in the common area with he TV in a recliner because she screams and has behaviors. Usually we can settle her with snacks or cookies. That night she had been hollering until about 9:30 PM but then she settled down after we gave her some cookies. When E5 (RN) came in to get report, she stopped in the common area to talk with R1. E5 sat on the arm of R1's recliner and they (R1 and E5) had a close conversation that no one else could hear ... A little bit later, E10 (CNA) came up to me and asked, 'Do you know what [E5] is saying about [R1]?' I told E10 that I would hear about it during report with E5. E5 never told me what R1 had said to her. E5 usually tells you every little thing during report. If I knew, I would have reported it the supervisor immediately. An incident report has to be done ..."

9/13/24 3:02 PM - During a telephone interview, E12 (CNA), who had worked on evening shift on 9/9/24, stated, "E5 (RN) walked onto the unit and went straight for R1, who was in a recliner in the common area. At that time, R1 was not screaming; she was kind of sleeping. ... E5 then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. BUILDING _____ B. WING _____	C 09/16/2024

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 609	Continued From page 11 came up to the group and said that R1 was talking about rape. I thought 'Wow' and I asked 'When?' but E5 did not answer. Sometimes E5 jokes around, I was not sure if it was a joke." 9/13/24 4:09 PM - During a telephone interview, E13 (CNA) stated, "We (CNAs) were standing around the dining table (in the common area). E5 (RN) came up and asked who was caring for R1. She said that she [R1] claimed that she was raped by a man. I said, No, no. no. I just changed her shirt to a nightgown in the common area bathroom. R1 had told me that she was dry so I did not even change her brief. E5 stated that she was going to talk to the nursing supervisor." 9/16/24 9:55 AM - During a telephone interview, E14 stated, "After coming out of morning meeting, there was a message for me to call E5 (RN). It was around 9:30- 10 AM. I called her back and E5 told me that she wanted to be sure that E15 (LPN) the day shift supervisor got the message that R1 said she was raped. I had the phone on speaker. I told E5 that I needed to let Administration know and that I would call her back ... I also called E6 (night shift supervisor) and left a message for her to call the facility ... I went with E15 (LPN) and a CNA and we completed a total body assessment of R1 in the common area shower room. We checked her upper body and then with R1 standing holding onto a grab bar, we checked her vaginal, anal and bilateral thigh areas with a flashlight. I had E15 check too. There were no secretions or drainage, and no markings that looked like trauma. She [R1] was cooperative ...". From 11 PM on 9/9/24 (the time of the initial allegation) until approximately 9/10/24 9:30 AM,	F 609		

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F 609	Continued From page 12 six staff members (2 RNs, 1 LPN and 3 CNAs) were aware of an incident involving R1, with the term "rape" being admitted as used in conversations with four of these staff members (1 RN, 3 CNAs). The facility failed to report this allegation until 9/10/24 at 1:18 PM, approximately twelve hours after the initial allegation. 2. Review of R3's clinical record revealed: 3/20/24 - R3 was admitted to the facility with diagnoses including but not limited to, congestive heart failure, obesity and walking problems. 4/4/24 11:00 AM - R3's daughter complained to the facility that E16 (CNA) was disrespectful and rude to her mother (R3). The facility responded to this allegation by initiating an investigation and placing E16 on Administrative leave for the duration of the investigation. 4/8/24 5:18 PM - E1 (NHA) submitted a facility reported incident to the State agency (web intake #84760) regarding this allegation that stated, "Incident Type: Abuse, Incident Subtype: Emotional, Accused: Staff ...". This report was filed five (5) days after the facility was made aware of the allegation. 9/16/24 12:35 PM - The findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Executive Director) at the exit conference.	F 609		