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 Assisted Living **DATE SURVEY COMPLETED:** February 18, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility beginning February 13, 2025, and ending February 18, 2025. The deficiencies contained in this report are based on observation, interview, record review and a review of other facillty documentation. The facility census on the entrance day of the survey was fifty-four (54) residents. The survey sample size totaled eleven (11) residents. Abbreviations/definitions used in this state report are as follows: ED – Executive Director; LPN – Licensed Practical Nurse; RA – Resident Assistant; RSD – Resident Services Director;		
3225	**Assisted Living Facilities**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.1.3	**Food service complies with the Delaware Food Code**		
S/S - F	**3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.** **(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours,**		

Provider's Signature Wendy McMead, NHA Title Executive Director Date 2/27/2025

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	to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Based on observation and interview, it was determined that the facility failed to ensure food was stored and served in a manner that prevents foodborne illness to the residents. Findings include: 2/13/25 9:51 AM – During the kitchen tour, the surveyor found several items in the dry storage room that were not dated after being opened, including jars of ranch seasoning, parsley powder, red pepper and three (3) jugs of cooking wine. 2/13/25 9:59 AM – In the kitchen, the surveyor found an opened paper carton of milk and a plastic cup of potato salad that were undated in the standalone refrigerator. 2/13/25 10:08 AM – In the refrigerator in the memory care unit, there were several items unlabeled and undated including a piece of brownie in a plastic cup, a cup of apple sauce, three (3) paper cartons of milk, and a half pitcher	1. No residents were affected by this practice. All identified items in dry storage, standalone refrigerator, and memory care refrigerator that were not properly dated were immediately discarded. 2, Current residents have the potential to be affected by this practice. All stored food items have the potential to be affected. An audit of the dry storage and all refrigerators was conducted with no other issues were identified. 3. A root cause analysis revealed the need for re-education of the Assisted Living Dietary staff regarding safe, sanitary food storage including proper labeling and dating. The Dining Director will re-educate the Dietary staff regarding proper labeling and dating of food items stored in the dry storage area and the refrigerators. 4 . The Dining Director/designee will conduct an audit of all Assisted Living food storage areas, dry storage and refrigerators, to ensure accurate labeling and dating. Audits will be conducted daily X 5 days until 100% compliance is verified, then weekly X 4	3.15.2025

Provider's Signature Kimberly Mead, NHA Title Executive Director Date 2/27/2025

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	of cranberry juice. There was also an unlabeled and undated half cup of frozen Magic Cup ice cream in the freezer compartment of the refrigerator. The surveyor made all the above-mentioned observations with the company of E3 (Director of the Dining Services), and findings were confirmed with E3 on site. 2/13/25 2:33 PM – The above findings were reviewed with E2 (RSD). 2/18/25 2:30 PM – Findings were reviewed with E1 (ED) and E2 during the exit conference.	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.	
3225.13.0	**Service Agreements**		
3225.13.5	**The service agreement shall be developed and followed for each resident consistent with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.**		
3225.13.6 **S/S - D**	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** Based on observation, interview and record review, it was determined that for one (R2) out of eleven (11) sampled residents the facility failed to execute a		

Provider's Signature Wendy Minard, NHA Title Executive Director Date 2/27/2025

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	revised service agreement. Findings include: A review of R2's clinical record revealed: 4/2/2021 – R2 admitted to the facility on the memory care unit. 1/31/25 at 6:23 PM – A facility incident report documented that R2 was found on the floor in the hallway on the memory care unit. R2 was assessed and a bump was found on R2's forehead. R2 was sent to the hospital for evaluation. 2/3/25 – A significant change service assessment documented R2 as a '4' for the fall prevention interventions. A '4' documented that a resident is, "Dependent on total assistance. History of multiple falls. Cannot walk alone. Needs an assistant to accompany resident when walking even short distances..." In the aforementioned note, it was unclear of what updates were made to R2's individual assessment. 2/13/25 12:20 PM – An observation of R2 getting up from the dining table, pushing the chair in and walking down the hall from the common/dining area to her room without any standby assistance (approximately 100 feet). 2/13/25 12:48 PM – An observation of R2 walking from her room to the common/dining area without standby assistance (approximately 100 feet). Then	1. R2 continues to reside at this community with no further incidents that would require an update to the Resident Service Agreement. R2's updated Resident Service Agreement was immediately placed in the caregiver binder. 2. All residents have the potential to be affected by this practice. All Resident Service Agreements were audited and were found to be accurate, updated timely, and located in the caregiver binder. 3. A root cause analysis revealed the need for re-education of the AL-LPN staff regarding Resident Service Agreement updates to be timely and placed in the caregiver binder. The Resident Services Director will re-educate the LPN staff regarding the Resident Service Agreement timely updates and placement in the caregiver binder. 4. The Resident Services Director/designee will conduct an audit of the Resident Services Agreement for timely updates that are placed in the caregiver binder. These audits will be conducted daily x5 days until 100% compliance is verified, then weekly x4 weeks until 100% compliance is verified, then monthly x3 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement	3.15.2025

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	R2 turned around and walked back to her room without any standby assistance (approximately 100 feet). 2/18/25 10:18 AM – An observation of R2 walking from her room to the common area/dining room without standby assistance (approximately 100 feet). After 4 minutes, R2 sat down in a chair at a dining table. 2/18/25 10:25 AM – A review of the Resident Assistant Flow Sheets documented R2's mobility as independent from February 1, 2025 to February 18, 2025. The Resident Service Agreement Plan for R2 that was kept in the binder with the Resident Assistant Flow Sheets was dated 2/9/23 with R2's ambulation marked as independent. The boxes on the Resident Service Agreement for 'Stand-by Assist' and 'At Risk for Falls' were not marked. 2/18/25 10:50 AM – During an interview E4 (RA) stated that there weren't any changes with R2's assistance needs after the fall on 1/31/25. E4 stated that if there were changes for a resident's care that they are notified in their change of shift report and that Service Agreement Plan sheets will be changed in the binder by the nurse. 2/18/25 11:27 AM – During an interview E2 (RSD) stated that when a change happens with a resident's care, she updates the Service Agreement plan to put in the binder for the resident assistant to follow. E2 confirmed that R2 would not be independent for	team for review and recommendation.	

Provider's Signature Wendy Menard, NHA Title Executive Director Date 2/27/2025

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	ambulation and the sheet should have been updated. In the aforementioned interview, it was unclear what R2's needs were. 2/18/25 2:30 PM – Findings were reviewed with E1 (ED) and E2 during the exit conference.		

Provider's Signature Wendy Menard, NHA Title Executive Director Date 2/27/2025