DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Center Nursing Home **DATE SURVEY COMPLETED: October 8, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Visit and Extended Survey was conducted at this facility from October 02, 2025, through October 08, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census of the first day of the survey was sixty (60). The survey sample totaled six (6) residents		
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Nursing Facilities** **Scope** **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:** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 - L survey completed October 8, 2025: F689.	Cross Refer to the CMS 2567-L Survey completed on October 8, 2025: cross refer: F689.	10/3/2025

Provider's Signature [signature] Title Administrator Date 11/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	1175 MCKEE ROAD , DOVER, Delaware, 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
F0000	INITIAL COMMENTS An unannounced Complaint and Extended Survey was conducted at this facility from October 02, 2025, through October 08, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census of the first day of the survey was sixty (60). The survey sample totaled six (6) residents. Due to the federal government shutdown, the posting date of this CMS-2567 differs from the survey exit date. This adjustment allows the facility the appropriate time to prepare and submit its Plan of Correction (PoC). The discrepancy between the exit date and posting date is administrative in nature and does not reflect any delay by the facility. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; ED – Executive Director; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; Wander guard – special bracelet alerts staff/caregiver of resident attempt to exit facility via door/exit.	F0000		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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.

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

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F0689 SS = SQC-J	Continued from page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other facility documentation it was determined that for one (R1) out of four residents sampled for wandering and elopement the facility failed to ensure adequate supervision to prevent R1 from eloping putting the resident at serious immediate jeopardy and risk of a serious adverse outcome. R1, a resident that was confused was able to elope from the facility on 9/27/25 by climbing out of the window in R1's room. R1 walked across the facility's back parking lot and then proceeded to walk across a busy roadway to an area where there was a raised curb, a sloped hill with trees, shrubs and brush. R1 was missing for seven minutes. An immediate jeopardy (IJ) was identified starting on 9/27/25. Due to corrective measures following the incident, this is being cited as immediate jeopardy, past non-compliance with an abatement date of 10/1/25. Findings include: A policy titled "Elopement" last reviewed by the facility 12/24/24 documented "Facilities will identify residents at risk for elopement and develop a plan to prevent unauthorized resident absences from the facility. To prevent elopement and identify action steps to be taken in the event of an unauthorized resident absence from the facility." A policy titled "Wandering Management" last reviewed by the facility 12/21/23 documented "It is the policy of Presbyterian Senior Living" to identify residents at risk for wandering and to develop an individualized plan to prevent unauthorized exit from the community. Residents will be evaluated for potential wandering during an elopement evaluation completed on admission, quarterly and as needed for a change in condition." Review of R1's clinical record revealed: 9/18/25 – R1 was admitted to the facility with diagnoses including but not limited to congestive heart failure, anemia, falls and premature heartbeats. 9/18/25 – A review of a facility admission elopement evaluation documented R1 was not at risk for elopement. 9/22/25 3:08 AM – A facility progress note documented "[R1] found in the hallway all dressed up and carrying his bag trying to leave the facility, when asked 'where	F0689		

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F0689 SS = SQC-J	Continued from page 2 are you going' [R1] stated 'I thought everyone left already.' R1 was redirected back to the room. Wander guard placed to right hand." 9/22/25 7:10 AM – Review of a facility elopement evaluation revealed R1's wandering behavior was a pattern and goal directed. Further review of the evaluation revealed R1 wandered aimlessly, non-goal directed and behavior likely to affect privacy of others. 9/22/25 – A review of R1's care plan for elopement revealed "[R1] was at risk for wandering and disoriented to place and had impalred safety awareness. Wander guard to right risk at all times." The facility investigation documented the following timeline for R1's elopement on 9/27/25: 9/27/25 11:10 AM – A facility progress note documented "[R1] was alert, confused and fixated on paying taxes and redirected several times." 9/27/25 1:37 PM - The facility's security videotape recorded R1 walking by the back loading dock. 9/27/25 1:40 PM – R1 called F1 (Family) and reported to being held hostage by facility and wanted to call the police. F1 contacted E5 (RN) regarding the call. E5 proceeded to R1's room observed that the window screen was removed and initiated a search for R1. 9/27/25 1:42 PM – E6 (LPN) observed R1 outside while on lunch break. 9/27/25 1:43 PM – E9 (Receptionist) received a call from a driver that R1 was walking on the road waving for traffic to go around. 9/27/25 1:44 PM – E7 (Activity Staff) and E5 ran out of the building and observed R1 across the road with E6. 9/27/25 1:45 PM – R1 was combative with E5, E6 and E7. R1 refused to come back to the facility. 9/27/25 1:47 PM – A police officer drove past and turned around to see if assistance was needed. The officer asked R1 to sit in the back of the police vehicle and EMS was notified as R1 continued to refuse to return to the facility. 9/27/25 2:07 PM - EMS arrived to take R1 to the hospital for evaluation and treatment.	F0689		

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F0689 SS = SQC-J	Continued from page 3 9/27/25 2:20 PM – E5 notified F1 and physician of R1's elopement from the facility. 9/27/25 3:09 PM – R1 was discharged from the hospital in stable condition to home with family. 10/2/25 12:20 PM – During an interview, E5 reported R1 was fixated on leaving the facility to go and get taxes done. E5 redirected R1 at 1:15 PM and 1:20 PM. E5 added that F1 called to report a call from R1 about being held hostage and wanting to call the police. E5 went to R1's room and observed the screen was out of the window and started to search for R1. E5 heard E9 talking to the person that called and then ran out the facility to search for R1. E5 stated, "[R1] was across the street with [E6] and refused to come back to the facility. The police called EMS they took [R1] to the hospital." 10/2/25 12:31 PM – During an interview E6 reported while on lunch break a couple drove up and said, "there is an elderly man down by the school and thought [R1] was a resident from the facility. E6 asked them to notify the front desk, and I walked across the street to where [R1] was." 10/2/25 12:42 PM - During an interview, E12 (RN) reported R1 had periods of confusion and had been fixated on paying taxes and needed to be redirected several times. 10/2/25 1:03 PM – During an interview, E7 reported going outside and observed E6 across the road with R1, and that E5, E6 and E7 tried to assist R1 safely back across the road. R1 refused. 10/2/25 1:06 PM – An interview with R1's care giver E8 (CNA) revealed R1 was assisted with bathing and toileting that morning. E8 confirmed R1 was last seen around 1:30 PM after taking R1 to the room to rest. 10/2/25 1:29 PM - During an interview E2 (DON) reported R1 had a Wander guard device and stated, "we found that the order was not there for the Wander guard to be checked, R1's care plan reflected the risk for elopement and the Wander guard to be checked and on at all times." 10/3/25 9:09 AM – During an interview E9 reported receiving a call from a woman that didn't provide a name that R1 was walking down the road directing traffic around to cross the road. In addition, E9 stated, "[E5] heard me talking on the phone and ran out the facility." E9 then stated, "[R1] had to of climbed out the window, that would have been the only way to	F0689		

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F0689 SS = SQC-J	Continued from page 4 get out I was at the front desk. [R1] didn't come through the lobby." 10/3/25 9:43 AM – An interview with E10 (ESD) confirmed immediately following the elopement an audit was completed on R1's window the emergency restraint bar was noted to have been disengaged. The facility's root cause analysis of the elopement identified R1 removed and disengaged the safety latch on the window in the room and climbed out of the window. R1 possessed the physical ability to exit the building through the window without staff awareness. There was no alarm feature on window to alert staff. R1 possessed the physical strength and problem-solving ability to release the safety latch on the window and climb out without an alert to staff as windows are not alarmed. The facility's plan of correction included: Residents with wander guards and residents that possessed the physical ability to climb out of a window were all placed on 1:1 supervision and observation. Residents with wander guard devices had orders for checking placement and function. Window audits started immediately with R1's room and all other resident windows on 9/27/25 and completed by the maintenance department. Audits for elopement will be conducted weekly for four weeks, then monthly for two weeks. Random review of up to five resident records including newly admitted residents with high-risk elopement scores and care plan interventions to ensure accuracy. Window alarm sensors were ordered on 9/30/25 and were delivered to the facility 10/8/25. Installation to resident windows were started on 10/8/25 by the maintenance department. Residents at risk for elopement will remain on 1:1 supervision and observation until all window alarm sensors have been installed. 9/27/25 – 10/1/25 – Elopement drills, re-education and review of the facility's policy titled "Elopement" were validated and completed for all full-time, part-time, agency staff and PRN (As Needed Staff). 10/3/25 – Staff interviews with E4 (SW), E8 (CNA), E11	F0689		

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F0689 SS = SQC-J	Continued from page 5 (CNA) and E12 (CNA) confirmed staff education and elopement drills had been completed. Based on the review of the facility's thorough investigation, documented response, completion of in-service training and elopement drills, audits and staff interview the immediate jeopardy was determined to be past non-compliance with a correction date of 10/1/25. 10/8/25 3:30 PM – Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ED) at the exit conference.	F0689		