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

DHSS - DHCQ
Cambridge Building
263 Chapman Road Suite 200
Newark, DE 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Assisted Living **DATE SURVEY COMPLETED: April 28, 2022**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from April 21, 2022, through April 28, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was fifty-five (55). The survey sample totaled 16 residents. **Abbreviations/definitions used in this report are as follows:** CNA - Certified Nursing Assistant; Doppler – a test that uses high-frequency sound waves to measure the amount of blood flow through your arteries and veins; ED - Executive Director; LLAM – (Limited lay administration of medications) trained unlicensed personnel that gives prescribed medication to residents; RSD - Resident Services Director; Alzheimer's Disease – degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Antidepressant – drug to counter depression; Anxiety – general term for several disorders that cause nervousness, fear, apprehension and worrying; Bipolar Disorder – mood disorder; Bilateral - involving two sides; Cognitively impaired - abnormal mental processes; thinking or mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Dementia – a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation or loss of mental functions such as		

Provider's Signature Wendy M Read, NHA Title Executive Director Date 6/3/2022

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	memory and reasoning that is severe enough to interfere with a person's daily functioning; Disoriented – confused and unable to think clearly; Edematous – retention of fluid into the tissue resulting in swelling; Psychoactive Medication – a medication that contains a chemical substance that changes the nervous system and results in alterations in perception, mood, consciousness, cognition, or behavior; PTSD (post traumatic stress disorder) – a mental condition that results in a series of emotional and psychical reactions to individuals who have either witnessed or experienced a traumatic event; Rehabilitation – the action of restoring someone to health; Saturated - thoroughly soaked; Service agreement - a resident's plan of care; UAI – (Uniform Assessment Instrument is a tool used to collect information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs); Unintelligible speech – impossible to understand. This requirement is not met as evidenced by the following:		
3225.0	**Regulations for Assisted Living Facilities**		
3225.11.0	**Resident Assessment**		
3225.11.6	**If the needs of a resident exceed the care which the assisted living can provide and a waiver has not been requested, the facility shall assist the resident in making arrangements for an appropriate transfer within 30 days.**		

Provider's Signature Wendy Mead, NHA Title Executive Director Date 6/3/2022

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	This requirement is not met as evidenced by: Based on record review and interview, it was determined that for one (R14) out of one resident reviewed for appropriate placement in an assisted living facility, the facility failed to make arrangements for R14 to be transferred to a skilled nursing center related to the extensive care needs for R14's lower extremity vascular wounds (as suggested by the attending practitioner). Findings include: A facility policy (last revised 1/3/20) entitled Assisted Living/Personal Discharge Procedure included: "Community will coordinate discharge for resident to another location, environment, or to another level of care." Review of R14's clinical record revealed: 3/21/22 – R14's pre-admission UAI documented that R14 had open blisters to both lower extremities. 3/23/22 – R14 was admitted to the facility. 3/23/22 – A mental evaluation on admission revealed that R14 was cognitively impaired. 3/23/22 3:52 PM – An admission nursing progress note documented: "Resident (R14) noted to have bandages on b/l (bilateral) feet. Nurse removed dressings. Right foot noted to have a large open area to top of foot and side of foot. Right heel noted to have an open area larger than a quarter. Right great toe intact but nail bed is black. Resident's left foot has a larger open area to top and lateral foot, left pinky toe has a small open area, and heel is open. Bilateral legs weeping, edematous, and very cold. Feet rewrapped with clean dry dressings."	A. R14 no longer resides at this community. B. Newly admitted residents have the potential to be affected by this practice. An audit of all current residents was conducted by the RSD to ensure that all resident needs do not exceed the care provided in assisted living. C. A root cause analysis revealed the need for RSD re-education on facility policy, "Assisted Living/Personal Discharge Procedure". D. The RSD/designee will conduct a Resident Care audit on all residents, including those newly admitted, to ensure all care provided meet the care level of assisted living. These audits will be conducted weekly x4 weeks until 100% compliance is verified, then, monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for review and recommendation.	6/24/2022

Provider's Signature Wendy Menard, NHA Title Executive Director Date 6/3/2022

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	3/31/22 11:00 AM – A doctor's order included: Consult wound care (wound clinic or surgeon who is available as soon as possible.) 3/31/22 2:15 PM – A doctor's progress note documented: "Skin (on) bilat (both) feet noted with ulcerations on top and lateral (side) heel of each. Bandages all saturated with amber colored fluid." 3/31/22 2:21 PM – A nursing progress note documented: "[E6] (Doctor) saw resident today. N.O. (new order to consult wound care (wound clinic or surgeon who is available asap [as soon as possible]) and Bilat Arterial Doppler w ABI (vascular studies) of legs re (related to): non healing wounds." 4/12/22 6:28 PM – A nursing progress note documented: "Resident found by CNA/LLAM cutting bandages off his feet with a dinner knife. Resident states he was not told that they could not be remove(d) and all he wanted was a shower. He had been told a half-hr (hour) prior that he was not allowed to shower tonight, per MD orders. Re-wrapped feet and put slipper-socks on. Told him several times more that he is not to get up without help, use pendent, and he was not allowed to remove bandages nor have a shower... Removed knife from apt. (apartment)." 4/26/22 11:10 AM - During an interview E2 (RSD) confirmed that the resident was admitted from a rehabilitation facility, and they told the facility that R14 only had open blisters to his feet while at the rehab. E2 stated that when he was admitted to the facility, he had multiple foot wounds. E2 stated that she would not have admitted him if she knew the		

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	extensiveness of his foot wounds. E2 confirmed that she did not go to the rehab to evaluate him for appropriate placement for assisted living. 4/26/22 11:30 – 11:43 AM – During an interview E2 (RSD) confirmed that there was an order from the previous rehabilitation center that included: 3/7/22 - "I certify this resident continues to require skilled level of care. The above orders are in effect for 30 days unless otherwise indicated." Review of the rehabilitation facility records lacked evidence that this order had been discontinued. E2 confirmed that she did not note this order prior to admission to the facility. When asked by the surveyor if they could have transferred him to the skilled nursing facility onsite, E2 stated that they could have, but he was only supposed to be at the assisted living facility for a 30-day respite. 4/26/22 2:53 PM – During an interview E2 (RSD) stated that a conversation had occurred with R14's doctor, and the doctor had stated that the resident should be in a skilled unit not assisted living related to the severity of the wounds. E2 stated that she thought since he had just been discharged from a skilled rehabilitation center to the assisted living facility that he may have exhausted his insurance coverage. When asked by the surveyor if the facility had ever investigated insurance coverage to go to the skilled unit at the facility, she stated that she had not. 4/26/22 4:08 – 4:20 PM – During a telephone interview, E6 (MD) confirmed that when she examined the resident on 3/31/22 and assessed his needs, she knew that the resident was not appropriate for assisted living at the		

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	facility. E6 reported that when R14 had a fall on 4/14/22, and was sent to the hospital, she had spoken with the doctor in the Emergency Room and had requested that R14 not be sent back to the assisted living facility related to R14 was not appropriate, required a higher level of care, and needed to go to skilled facility to be medically managed. E6 stated, "They (the hospital) sent him back to assisted living anyway." The facility failed to thoroughly assess R14 prior to admission for appropriate placement related to R14's extensive wounds to his feet, which required a higher level of care. 4/28/22 - Findings reviewed with E1 (ED), E2 (RSD), and E9 (Corporate Nurse by phone) at the exit conference starting at 2:30 PM.	A. R14 no longer resides at this community. B. Current residents have the potential to be affected by this practice. An audit of all resident service agreements was conducted by the RSD to ensure that the resident needs identified in the UAI were completed and updated timely. Additionally, an audit of the fall service agreement addendum was conducted to ensure accurate and timely updating. The location of the service agreements has been changed to ensure staff access to the care and interventions outlined. C. A root cause analysis revealed the need for RSD and licensed staff re-education on the service agreements. Additionally, the licensed and certified staff education on the location of the service agreement binder which includes the fall service agreement addendums. D. The RSD/designee will conduct a Service Agreement audit on all current residents' service agreements to ensure they are completed and updated timely, as well as located in the designated area for accessibility.	6/24/2022
3225.13.0 **3225.13.1**	**Service Agreements** **A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission.** Based on record review and interview, it was determined that for one (R14) out of sixteen residents reviewed for service agreements, the facility failed to complete a service agreement for R14 based on the needs identified in the UAI. Findings include: Review of R14's clinical record revealed: 3/21/22 – E2 (RSD) completed R14's initial UAI which documented that R14 had open blisters on both of his feet, had a memory problem and required supervision to walk.		

Provider's Signature Wendy Mead, NHA Title Executive Director Date 6/3/2022

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	3/23/22 – R14 was admitted to the facility. 3/23/22 - R14's admission fall risk score was completed with a risk score of 12. A score of 10 or more indicates that a resident is at high risk for falls. The facility lacked evidence of a service agreement completed on admission to address R16's risk of falling. 3/25/22 – A doctor's order included: (Bilateral feet) Rinse with wound cleaner, apply non-adhesive dressing (a nonstick bandage), cover with ABD (a thick bandage to soak up drainage from the wound) and wrap with gauze every other day and as needed if dressings are saturated. 3/31/22 2:15 PM – A doctor's progress note documented: "Skin (on) bilat (both) feet noted with ulcerations on top and lateral (side) heel of each." The facility lacked evidence of a service agreement to manage R16's wounds throughout his entire time of residing in the assisted living at the facility 3/28/22 3:04 PM - R14 sustained a fall. 4/3/22 5:56 PM – R14 sustained a fall. 4/3/22 – A service agreement addendum for R16 for at risk for falls was initiated six days after the first fall at the facility. Although R16 had dementia, the fall risk intervention was to encourage R16 to use pendent to call for help. 4/7/22 – R16 sustained a fall. 4/14/22 – R16 sustained a fall and was sent to the hospital.		

Provider's Signature Wendy Mead, NHA Title Executive Director Date 6/3/2022

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	4/14/22 - R14's service agreement addendum was updated to again encourage R16 to use his pendent to call for help, not wear sandals, and put his sandals on the top shelf of the closet. 4/24/22 – R14 sustained a fall and was sent to the hospital where he was found to have multiple brain bleeds. 4/26/22 1:45 PM – During an interview, E6 (RSD) reported that the initial service agreement was in a binder at the nursing station. R16 did not have a service agreement in the binder. E6 confirmed that the facility lacked evidence of an admission service agreement being completed to address R14's needs of being at risk for falls and wound management while R14 was at the facility, and the other needs that R14 had at the time of admission and during his stay at the facility. E6 also confirmed that the fall service agreement addendum was behind a locked closet. Any interventions for the CNAs to carry out for R16 would be in the initial service agreement at the nursing station for them to implement, and that the CNA's did not have access to the locked closet to look at any addendums. 4/28/22 – Findings reviewed with E1 (ED), E2 (RSD), and E9 (Corporate Nurse by phone) at the exit conference starting at 2:30 PM.		
3225.13.6	**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 and assessment, the resident and the assisted living facility shall execute a revised service agreement. The regulation was not met as evidenced by:**		

Provider's Signature Wendy K Mead, NHA Title Executive Director Date 6/3/2022

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	Based on record review, interview, and review of other facility documentation, it was determined that for two (R2 and R6) out of sixteen sampled residents the facility failed to ensure the Service Agreement was reviewed, updated, and implemented. Findings include: 1. An undated facility policy included: -Residents will be reassessed for (fall) risk annually as part of the resident's assessment, with any significant change, and within 72 hours after sustaining a fall. -Any resident (new or in-house) identified as having a fall risk will have interventions added to their support plan. The support plan needs to have interventions re-evaluated after each fall. Review of R6's clinical record revealed: 12/9/13 – R6 was admitted to the facility. 2/17/18 – R6 had a service agreement initiated for at risk for falls. 6/2/21 – R6's readmission fall risk assessment was completed with a risk score of 24. A score of 10 or more indicates that a resident is at a high risk to fall. 12/7/21 6:53 AM – R6 fell and hit his head and was sent to the hospital. 12/8/21 3:40 AM – R6 returned from the hospital. 12/8/21 6:00 AM – R6 fell and hit his head and sustained a hematoma over his right eye.	A. R2 no longer resides at this community. R6 continues to reside at this community. A review of R6's service agreement was conducted by the RSD with updates implemented. B. Current residents have the potential to be affected by this practice. An audit of all resident service agreements was conducted by the RSD to ensure that they were reviewed, updated, and implemented timely and according to policy. C. A root cause analysis revealed the need for RSD and licensed staff re-education on the service agreement review when the needs of the resident have changed and, minimally in conjunction with each UAI with a new revision of the service agreement implemented within 10 days of the assessment.	6/24/2022

Provider's Signature Wendy Kilcullen, NHA Title Executive Director Date 6/3/2022

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	12/8/21 10:30 AM – R6 returned from the hospital. 12/8/21 11:00 AM – R6 fell again face down and was again bleeding from the hematoma above his right eye. R6 was again sent to the hospital. 1/18/22 8:00 AM – R6 had fallen again and was sent to the hospital where he was found to have a broken right hip. Review of R6's service plan revealed that the facility did not update the service agreement with interventions following the aforementioned four falls. After each fall, the facility also failed to reassess R6 by completing a fall risk assessment. 1/20/22 – R6 returned from the hospital to the rehabilitation unit after a surgery to repair his broken right hip. Although there were four revisions to R6's fall risk service agreement on 3/24/19, 11/26/20, 3/23/21, and 8/9/21, R6's record lacked evidence of review, revision, further assessment, and interventions after the four aforementioned falls to attempt to prevent falls that occurred thereafter. 4/22/22 12:15 PM – During an interview, E2 (RSD) confirmed the service agreement did not have any new fall interventions after each sustained fall. 4/22/22 2:12 PM – During an interview E2 (RSD) confirmed that 6/21/21 was R6's last fall assessment completed, and that there were no new interventions in R6's service agreement after his falls to help prevent further falls.	D. The RSD/designee will conduct a Service Agreement Update audit on all current residents to ensure they are completed and updated timely. These audits will be conducted weekly x4 weeks until 100% compliance is verified, then, monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Process Improvement team for Review and recommendation.	6/24/2022

Provider's Signature Wendy Mynard, NHA Title Executive Director Date 6/3/2022

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	The facility failed to assess for and implement new interventions to prevent R6 from further falls. 2. Review of R2's clinical record revealed: 2/4/21 – R2 was admitted to the facility. 2/4/21 – An initial UAI assessment documented R2 had a diagnosis of Alzheimer's/dementia with behaviors. Also, R2 had multiple psychiatric diagnoses including anxiety disorders, bipolar disorder, and mood disorder due to PTSD. 2/4/21 – A Resident Service Agreement documented R2 had a diagnosis of dementia with behaviors including combativeness, undressing, exit seeking, collecting and pacing. Also, it was documented R2's cognition was severely impaired. There were no interventions for redirection when R2 was exhibiting the above-mentioned behaviors. 2/24/21 – A Physician progress note created by E6 (DO) documented R2 "is becoming unsafe to both herself and those around her, and the staff. Will also ask psychiatry to evaluate her if there is another agent which can help keep her safe along with those around her." 2/25/21 – The following were added to the Behavior/mental status/psychological section of the service agreement: combativeness, undressing, exit seeking, collecting and pacing. Also, it was documented R2's cognition was severely impaired. There were no interventions for redirection when R2 was exhibiting these behaviors.		

Provider's Signature Wendy Mead, NHA Title Executive Director Date 6/3/2022

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	2/27/21 – A nursing progress note documented that R2 "was screaming and shouting in the hallway, trying to get into another resident's room. R2 became very agitated with staff, several attempts were made to calm her down but were unsuccessful. Another resident (R3) was talking to R2 whom began to shout at R3 and hit her. The behavior continued to escalate, 911 was called and R2 was transferred to the hospital for evaluation." 2/27/21 – A facility incident report documented a resident-to-resident altercation described as R2 screaming and shouting in the hallway, trying to get into R3's room and hit R3 on her left arm. This was the third incident of aggression for R2 since admission. R2 was transferred to the hospital for evaluation. 3/1/21 – A nursing progress note documented; the psychiatrist made a referral for R2 to be transferred to a behavioral hospital for treatment. 3/2/21 - R2 was admitted to a behavioral hospital, received treatment there and discharged on 4/6/21 at 9:00 AM with a diagnosis of major neurocognitive disorder with delusional PTSD. 4/6/21 – R2 was readmitted to the facility. 4/6/21 – R2's service agreement failed to include interventions related to aggression or wandering. 4/7/21 through 6/6/21 – Review of the behavior/intervention monitoring monthly flow sheets indicated to monitor for aggression towards residents and staff every shift and		

Provider's Signature Mindy Muad, NHA Title Executive Director Date 6/3/2022

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	document. There was no documentation for 127 out of 168 shifts. Furthermore, the monitoring of wandering into other rooms was missing for 136 out of 168 shifts. 5/9/21 5:15 PM – A nurse's incident statement reported that R2 had followed another resident to their room and when R16 refused to let R2 into her room E8 (LPN) witnessed R2 hitting R16 in the back. 5/10/21 5:10 PM – A nursing progress note documented that R2's aggressive behaviors and wandering continue. 5/11/21 10:04 AM – A Psychiatrist assessment documented that R2 was taking an antidepressant and a psychoactive medication and if the aggressive behaviors continued the plan was to adjust the medications or for R2 to return to the hospital for further treatment and evaluation. 4/25/22 11:25 AM – During an interview, E3 (AL Assistant) confirmed that she had witnessed R2 becoming agitated and aggressive several times. E3 also stated that R2 would continuously wander into other residents' rooms. When asked if R2 was ever assigned a 1:1 for safety to self and others, she replied "sometimes an agency person would come in." 4/25/22 11:34 AM – During an interview, E5 (LPN) confirmed that R2 exhibited aggressive behaviors, threatening other residents and staff and only recalled a 1:1 assigned one time and that person was from an outside agency.		

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	4/26/22 9:50 AM - During an interview E2 (RSD) confirmed that the service agreement had not been reviewed and updated to reflect an accurate picture of R2's behaviors and did not have any new interventions to protect R2 and the other residents on the unit. E2 also stated "I know we are not doing a good job with the service agreements; we need to do better." 5/5/21 – R2's service agreement was reviewed and updated to include an "Activity box.' 4/28/22 - Findings were reviewed with E1 (ED), E2 (RSD), and E9 (Corporate nurse via telephone) at the exit conference at 2:30 PM. R2's service agreement lacked evidence of review and new interventions to prevent further incidents of aggression and wandering. The facility failed to assess and implement new interventions to prevent further resident to resident altercations.		

Provider's Signature Wendy Mead, NHA Title Executive Director Date 6/3/2022