

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

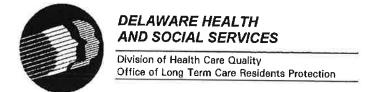
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NAME OF FACILITY: Westminster Village Assisted Living

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 Sur-		
	vey was conducted at this facility from April		
	21, 2022, through April 28, 2022. The defi-		
	ciencies 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		1
	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;		1
	ED - Executive Director;		
	LLAM – (Limited lay administration of medi-		
	cations) 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		1
	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;		1
	Bilateral - involving two sides;		
	Cognitively impaired - abnormal mental pro-		
	cesses; 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 im-		
	pairment characterized by memory loss, dif-		
	ficulty with abstract thinking, and disorienta-		
	tion or loss of mental functions such as		

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



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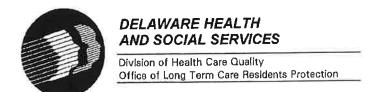
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NAME OF FACILITY: Westminster Village Assisted Living

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	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 under- stand.		
	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 Multy Alluad, NHA Title Executive Duicton Date 1/3/2022



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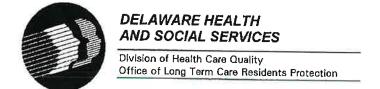
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STATEMENT OF D SECTION SPECIFIC	DEFICIENCIES DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Based on record redetermined that for ident reviewed for an assisted living for make arrangement to a skilled nursing tensive care needs vascular wounds (a ing practitioner). For the control of the con	st revised 1/3/20) entitled ersonal Discharge Proceommunity will coordinate dent to another location, another level of care." inical record revealed: pre-admission UAI docuhad open blisters to both admission was cognitively impaired. An admission nursing promented: "Resident (R14) andages on b/I (bilateral) ved dressings. Right footing open area to top of footinght heel noted to have an chan a quarter. Right great bed is black. Resident's left pen area to top and lateral has a small open area, and eral legs weeping, edema-old. Feet rewrapped with	 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 Wexdiffluad, NHA

___ Title Executive Director Date 10/3/2022



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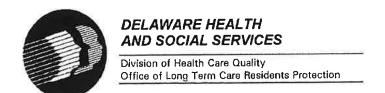
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DATE SURVEY COMPLETED: April 28, 2022

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	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. Rewrapped feet and put slipper-socks on. Told him several times more that he is not to get	CORRECTION OF DEFICIENCIES	DATE
	up without help, use pendent, and he was not allowed to remove bandages nor have a shower Removed knife from apt. (apart- ment)."		
	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		27

Provider's Signature Wexclifthuad, NHA

Title Executive Durctor Date 1/3/2022



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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
	extensiveness of his foot wounds. E2 con-		
	firmed 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 inter-		
	view 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 rehabili-		
	tation facility records lacked evidence that		
	this order had been discontinued. E2 con-		
	firmed 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 oc-		
	curred 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		1
	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 sur-		
	veyor if the facility had ever investigated in-		
	surance 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 as-		
	sessed his needs, she knew that the resident		
	was not appropriate for assisted living at the		

Provider's Signature Wendylluad NHA Title Executive Director Date 16/3/2022



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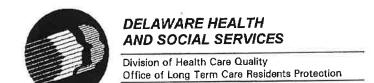
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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
facility. E6 reported that when R14 had a fron 4/14/22, and was sent to the hospital, shad spoken with the doctor in the Emergent Room and had requested that R14 not it 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 states "They (the hospital) sent him back to assisted living anyway." The facility failed to thoroughly assess R1 prior to admission for appropriate placement related to R14's extensive wounds to his fee which required a higher level of care. 4/28/22 - Findings reviewed with E1 (ED), E (RSD), and E9 (Corporate Nurse by phone) at the exit conference starting at 2:30 PM. Service Agreements A service agreement based on the need 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 sixteer 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 oper blisters on both of his feet, had a memory problem and required supervision to walk.	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	6/24/2022

Provider's Signature Werdyllwad, NHA

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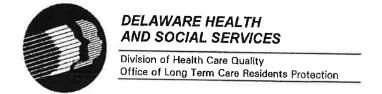
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DATE SURVEY COMPLETED: April 28, 2022

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 – 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. 4/14/22 – R16 sustained a fall and was sent to the hospital.	SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
to the hagnital	SECTION	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 – 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.		

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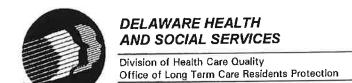
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	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
4/14/22 - R14's service agreement addendum was updated to again encourage R16 to use his pendent to call for help, not wear sandals, and put his sandals on the top shelf of the closet. 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. The service agreement shall be reviewed when the needs of the resident have		VIII.

Provider's Signature Wendy Merad, NHA

Title Executive Durotos Date 6/3/2022



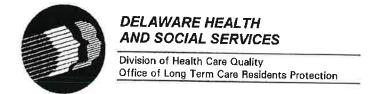
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Provider's Signature Wexdelluad, NHA Title Executive Director Date 6/3/2022

and sustained a hematoma over his right eye.



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NAME OF FACILITY: Westminster Village Assisted Living

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Provider's Signature Mendell Mund, NHA

ther falls.

Title Eposteri Director Date 10/3/2022



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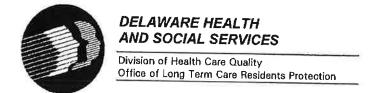
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The facility failed to assess for and implement new interventions to prevent R6 from further falls.		
	2. Review of R2's clinical 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.	9	
	2/24/21 – A Physician progress note created by E6 (DO) documented R2 "is becoming un- safe to both herself and those around her, and the staff. Will also ask psychiatry to eval- uate 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 Wouldfluad, NHA

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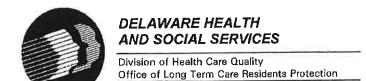
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	2/27/21 - A nursing progress note docu-		— V — V — V — V — V — V — V — V — V —
	mented that R2 "was screaming and shouting		
	in the hallway, trying to get into another res-		
	ident's room. R2 became very agitated with		
	staff, several attempts were made to calm		
	her down but were unsuccessful. Another		1
	resident (R3) was talking to R2 whom began		
	to shout at R3 and hit her. The behavior con-		
	tinued to escalate, 911 was called and R2 was		
	transferred to the hospital for evaluation."		
	2/27/21 – A facility incident report docu-		
	mented 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 inci-		
	dent of aggression for R2 since admission. R2		
	was transferred to the hospital for evalua-		
	tion.		
	3/1/21 - A nursing progress note docu-		
	mented; 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 hos-		
	pital, received treatment there and dis-		
	charged on 4/6/21 at 9:00 AM with a diagno-		
	sis of major neurocognitive disorder with de-		
	lusional PTSD.		
	4/6/21 – R2 was readmitted to the facility.		
	4/6/21 - R2's service agreement failed to in-		
	clude interventions related to aggression or		
	wandering.		
-	4/7/21 through 6/6/21 - Review of the be-		
	havior/intervention monitoring monthly flow		
1:	sheets indicated to monitor for aggression		
	towards residents and staff every shift and		





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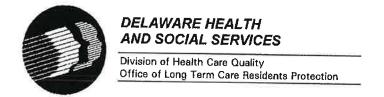
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	document. There was no documentation for 127 out of 168 shifts. Furthermore, the monitoring of wandering into other rooms was missing for 136 out of 168 shifts. 5/9/21 5:15 PM — A nurse's incident statement reported that R2 had followed another resident 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.		

Provider's Signature Mendy Mund, NHA

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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.		