| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085032 | A. Building<br>B. Wing | 10/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westminster Village Health | 1175 McKee Road<br>Dover, DE 19904 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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 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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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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 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 impaired 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. 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 |