STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085032	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village Health	1175 McKee Road 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined that for one (R16) out of four residents reviewed for accidents, the facility failed to report an injury of unknown source in timely manner. Findings include:A review of R16's clinical record revealed:7/15/25 - R16 was admitted to the facility with a diagnosis, including but not limited to CVA and abnormal gait.8/1/25 5:45 AM - A progress note documented R16 had a fall un-witnessed in the TV/dining room. 8/1/25 11:40 PM - A progress note documented R16 returned from the hospital with the following: purple bruising right fifth toe and right flank, scattered bruising to left lower leg.8/4/25 1:00 PM - A progress note R16 documented a stat order for x-ray of the right foot.8/4/25 - An X-ray report was performed and revealed a fracture at the base of the right fifth toe. 8/5/25:8:26 AM - A facility incident report documented R16 had a swollen right fifth toe that occurred on 8/1/25.12/15/25 11:35 PM - During an interview E4 (RN) confirmed that during an unwitnessed fall with injuries, she would get a call from the nurse, and they would assess the resident. E4 confirmed that she would have notified the doctor, R16's family, completed the incident report and reported to the state agency the same day regarding R16's fifth toe. E4 confirmed and revealed a supervisor's book that states incidents shall be submitted electronically to the Division of Long Term Care Residents Protection.12/15/25 3:05 PM - During an interview, E2 (DON) confirmed that the medical doctor on call was not notified when R16 returned on 8/1/2025 from the hospital with bruising and purple discoloration to the right fifth toe. 12/16/25 3:40 PM - Findings were reviewed with E1 (NHA), E2, and E3 (Executive Director) during exit conference.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview it was determined that for one (R67) out of two new admissions reviewed the facility failed to adhere of standards of practice when the initial care plan and admission assessment were not completed by a Registered Nurse. Findings include: The state of Delaware Board of Nursing Professional Regulations Decision Tree 2024 indicated that admission assessments and initial care plans must be completed by a Registered Nurse.Review of R67's clinical record revealed:11/14/25 - R67 was admitted to the facility.11/14/25 - A baseline care plan was created for R67 by E20 (LPN).11/14/25 - An admission assessment that documented the clinical details such as vital signs, skin condition, care needs and general condition of R67 upon arrival to the facility was completed by E20 (LPN).12/16/25 2:34 PM - During an interview E20 (LPN) confirmed she completed R67's admission assessment and initial care plans. E20 stated, Yes, I completed them and I did have an aide assist me with positioning for the skin assessment. 12/16/25 3:30 PM - During an interview E2 (DON) stated, LPNs are allowed to complete the admission and care plan according to our policy.12/16/25 3:45 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (ED).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for one (R67) out of three residents reviewed for hydration, the facility failed to offer sufficient hydration. Findings include:The facility policy on hydration last updated 12/24/24 indicated, To enable all residents to be hydrated. Facilities will have a process in place to ensure that all residents receive sufficient amounts of fluids, based on individual needs, to maintain proper hydration and health. Review of R67's clinical record revealed: 11/14/25 - R67 was admitted to the facility with multiple diagnoses including mild cognitive impairment. 11/14/25 - A baseline care plan created for R67 indicated a risk of hydration concerns. 11/15/25 6:04 PM - A progress note in R67's clinical record documented, Residents husband in facility and asked nurse to speak with son over phone call regarding a request for IV placement for nutrients until Monday due to resident not eating and drinking per son and husband, on call was made aware of request and gave order to have labs in AM, CBC and CMP and to call back when the results are received to determine further intervention and to assist resident in feeding and drinking at this time. Husband made aware and husband expressed that he is not sure why we cannot use labs from hospital and nurse expressed that these were the orders we received at this time and on call wants to review results tomorrow. husband verbalized understanding and is assisting resident with dinner at this time. 11/15/25 7:08 PM - A progress note in R67's clinical record documented, Resident ate approx. 75% of dinner with 240ml of fluids with husband assistance. 11/17/25 - A progress note in R67's clinical record written by E23 (NP) documented, [R67] was found resting in bed her son present concerned about decreased oral intake and hydration. Son stated patient had 20% of her lunch today. We discussed starting nutritional supplementation like Glucerna and he agreed .Decreased oral intake. Order for Glucerna three times a day Continue to monitor oral intake Assist with feeding monitor hydration. 11/17/25 4:00 PM - E30 (RD) completed a nutrition summary for R67 that documented a mini nutrition score of 6.0; with 0 - 7 points indicated malnourishment. 11/17/25 6:49 PM - A nutrition/dietary note in R67's clinical record documented, admission nutrition review: [AGE] year old female admitted with diagnosis of mild cognitive impairment. Decreased intake . Estimated nutrient needs are Fluids: 1500 mL. Nutrition intervention: RD would recommend adding 237 mL Glucerna supplement daily for optimal nutrient intake. 11/18/25 - A five-day MDS assessment documented that R67 had memory problems, cognitive impairment with a BIMS score of 00 and was dependent for assistance with eating/drinking. 11/18/25 - A physician's order was written for R67 to receive Glucerna, a diabetic liquid meal supplement three times a day. A day later than E31 (NP) progress note that indicated R67 should be started on the supplement. The order did not include measuring amount of supplement consumed. November 2025 - Review of R67's record of fluid intake for the following dates indicated less than the recommended amount of 1500ml daily:11/14 - 240 ml evening.11/15 - 540 ml total. 11/16 - 420 ml total.11/17 - 540 ml total.11/18 - 140 day morning and afternoon. 11/18/25 - R67 was sent to the hospital for evaluation after a fall and did not return to the facility. 12/15/25 11:07 AM - During an interview CG1 a relative of R67 stated, [R67] was malnourished and they didn't want to give an IV for fluids. They wanted to take labs first that isn't the only indicator of dehydration! Why wait when they know she wasn't taking much in. We had to feed her. 12/16/25 11:10 AM - During an interview E30 (RD) stated that drinking less than 1200 ml at least would be too little fluid per day. E30 then confirmed that R67's recommended amount was 1500 ml specific to [R67] I used her current body weight. I did an assessment on 11/17, and I saw she had decreased po intake and fluids. 12/16/25 1:50 PM - During an interview E31 (CNA) confirmed that R67 required assistance with eating and drinking. 12/16/25 2:34 PM - During an interview E20 (LPN) stated, When I came in the beginning of the shift, I got in report that they wanted IV fluids [E23 (NP)] was in the room with them, the labs came and she was like she's not dehydrated but wanted supplement and I said we can do the Glucerna. E20 confirmed that percentage of consumption is usually documented for supplements. There was no evidence that the facility monitored R67's fluid intake. 12/16/25 3:45 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (ED).