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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, it was determined that for one (R16) out of one resident reviewed for accidents, the facility failed to notify a physician of a significant injury of unknown source that was determined to be a right fifth toe fracture. 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 4:00 PM - A progress note documented that R16 was transferred to the hospital after a fall in the facility.8/1/25 11:40 PM - A progress note documented R16 returned from the hospital after a fall with the following: purple bruising to the right fifth toe and right flank, scattered bruising to the left lower leg.8/2/25 12:35 AM - A progress note documented bruising to R16's right fifth toe.8/4/25 2:58 PM - A mobile X-ray provider performed an X-ray of R16's right foot at the facility. The X-ray report revealed a fracture at the base of the right fifth toe. 8/4/25 3:00 PM - A doctor's order was documented to complete an X-ray of R16's right foot. There was a lack of evidence that the facility consulted the doctor for R16 from 8/1/25 to 8/3/25 of significant bruising to the right fifth toe.12/15/25 11:35 AM - During an interview, E4 (supervisor) stated that the expectation with an unwitnessed fall with injuries would be that the nurse would call the supervisor to assess the resident at that time. E4 confirmed that she would have notified the doctor, family, completed the incident report, and reported to the state agency.12/15/25 3:05 PM - During an interview, E2 (DON) confirmed no call was made to the physician for R16 when there was an injury of unknown source to his 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 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview it was determined that for one (R8) out of two residents reviewed for limited ROM the facility failed to develop a care plan that addressed the residents limited ROM and interventions to prevent further contractures. Findings include: Review of R8's clinical record revealed: 4/14/22 - R8 was admitted to the facility with multiple diagnoses including dementia and an impairment to the right middle finger. 7/8/25 - A physician's order was written for R8 to have a rolled washcloth placed in the right hand. Completion of the task was signed by nurses in R8's TAR. 12/11/25 10:05 AM - Review of R8's care plans lacked evidence of a care plan that addressed R8's contractures and the rolled wash cloth intervention used. 12/11/25 10:21 AM - During an interview E2 (DON) confirmed there was no care plan to address R8's contractures. E2 stated, there is no care plan because she is on hospice E2 then initiated a care plan for R8's contracture and use of the rolled washcloth. 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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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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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. **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 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review it was determined for one (R31) out of one resident sampled for respiratory care the facility failed to provide professional standards of practice by ensuring R31's BiPap equipment was stored in a protective plastic bag when not in use. Findings include:A review of R31's clinical record revealed: 11/5/25 - R31 was admitted to the facility with a diagnosis of chronic obstructive pulmonary disease, congestive heart failure and obstructive sleep apnea. 11/5/25 - A physician's order for R31 documented BiPap application off in the AM and on at night at bedtime assist with application of BiPap to use with 3L (liters) oxygen. R31's treatment administration record lacked evidence of an order to place the respiratory equipment in a plastic bag. 11/11/25 - A review of a five-day MDS admission assessment documented R31 was cognitively intact. 12/10/25 9:35 AM - During an interview E6 (RN) reported [R31's] respiratory equipment should probably be in a plastic bag but it probably isn't. E6 went to R31's room and confirmed the respiratory equipment was not in a plastic bag E6 stated, Nope it's not in a plastic bag. E6 changed the tubing and place the BiPap mask and tubing in a plastic bag. 12/10/25 9:50 AM - An interview and observation with E2 (DON) confirmed R31's BiPap and tubing was not in a plastic bag. 12/10/25 10:27 AM - R31's treatment administration record was updated with a new order Ensure BiPap mask in bag when not being utilized every shift. 12/16/25 4:00 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (ED).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and interview it was determined that for one (R7) out of five residents reviewed for unnecessary medication review the facility failed to adequately complete monitoring for side effects of a resident on psychotropic medications. Findings include: The facility policy on consultant pharmacist recommendations last updated 7/9/25 indicated Recommendations are acted upon and documented by the facility staff and/or the prescriber. Review of R7's clinical record revealed: 7/16/25 - R7 was admitted to the facility with multiple diagnoses including dementia with psychotic disturbance, psychotic disorder with delusions and schizophrenia. 7/16/25 - An AIMS assessment was completed for R7 that scored the resident as a 3, indicative of mild risk of side effects as a result of antipsychotic medications. 7/17/25 - A physician's order was written for R7 to receive quetiapine, an antipsychotic twice a day. 8/18/25 - A consultant pharmacist medication regimen review (MRR) completed for R7 recommended the following Resident is currently receiving quetiapine. Her baseline AIMS assessment completed 7/16/25 shows a score of three, which indicates abnormal movements were observed. Due to current antipsychotic therapy can, we have an order to repeat AIMS assessment? 8/21/25 - R7's primary care provided responded in agreement with the 8/18/25 MRR and documented Repeat AIMS. 12/12/25 - Review of R7's clinical record lacked evidence that a repeat AIM's assessment was completed. 12/12/25 1:19 PM - During an interview E2 (DON) confirmed the finding and stated, I was on vacation they did another psychiatric assessment instead. 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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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview it was determined that for one (R20) out of three residents reviewed for transmission-based precautions the facility failed to ensure that a physician was notified promptly of laboratory results. Findings include:Review of R20's clinical record revealed: 12/8/25 - A physician's order was written for R20 to have a urinalysis culture and sensitivity test completed. 12/11/25 - R20's urinalysis culture and sensitivity was collected by the contracted laboratory. 12/13/25 - The results of R20's urinalysis culture and sensitivity were relayed to the facility by phone to E24 (LPN). R20's progress notes lacked evidence that E24 relayed the results to R20's physician or nurse practitioner. 12/15/25 - A copy of the results of R20's urinalysis culture and sensitivity were reviewed by E23 (NP), two days after the results were known. 12/16/25 2:00 PM - During an interview E22 (ADON/IP) and E2 (DON) confirmed the facility the delay in notification without explanation. 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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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. Based on record review and interview it was determined that for one (R20) out of three residents reviewed for transmission-based precautions the facility failed to ensure that laboratory reports were filed in the clinical record. Findings include: The facility policy on diagnostic services last updated 12/24/24 indicated All test results will be maintained in the clinical record. Review of R20's clinical record revealed: 12/8/25 - A physician's order was written for R20 to have a urinalysis culture and sensitivity test completed. 12/11/25 - R20's urinalysis culture and sensitivity was collected by the contracted laboratory. 12/16/25 1:00 PM - Review of R20's clinical record lacked evidence of the results of R20's urinalysis culture and sensitivity was collected by the contracted laboratory on 12/11/25. 12/16/25 2:00 PM - During an interview E22 (ADON/IP) provided the surveyor with a copy of the results of R20's urinalysis culture and sensitivity and confirmed it was not in R20's clinical record. E22 stated, they were waiting to be filed. 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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview it was determined that the facility failed to ensure that food was stored and served in accordance with professional standards. Findings include:12/15/25 8:39 AM - During a tour of the facility's short-term unit refrigerator an undated unlabeled sandwich and an expired pudding cup dated 12/10/25 was discovered. 12/15/25 9:00 AM - Review of the facility's food temperature logs lacked evidence that temperatures were taken prior to serving the following meals:11/13/25 breakfast, lunch and dinner.11/20/25 lunch.11/26/25 dinner.11/28/25 dinner.12/4/25 lunch. 12/15/25 9:52 AM - During an interview E21 (DDS) confirmed the undated and expired foods. E21 then confirmed the unrecorded food temperature logs. 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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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview it was determined that for two (R1 and R20) out of five residents reviewed for immunizations the facility failed to offer pneumococcal vaccination as required. Findings include: The facility policy on immunizations last updated 2/19/25 indicated, Each resident is offered a pneumococcal immunization. The residents medical record includes documentation that indicates the following: That the resident or resident's legal representative was provided education .That the resident either received the pneumococcal immunization or refusal. 1. 1/22/25 - R20 was admitted to the facility. 2. 6/25/25 - R1 was admitted to the facility. 12/15/25 12:35 PM - Review of resident's immunization records lacked evidence of pneumococcal immunization or declination for R1 and R20. Surveyor requested evidence of declination or consent from E2 (DON). 12/16/25 10:22 AM - During an interview E2 (DON) and E22 (ADON/ICP) provided consents dated 12/15/25 day of surveyor request. E2 confirmed that R1 and R20 had not been offered immunization prior. 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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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of other facility documentation it was determined that the facility failed to have a functioning call bell system. Findings include: 12/9/25 10:57 AM room [ROOM NUMBER] - During initial observations the surveyor discovered that the call bell was not functioning. There was no sound and the light outside of the doorway was not lit after the call bell was pressed. E25 (LPN) confirmed the finding.12/9/25 12:05 PM room [ROOM NUMBER] - During initial observations the surveyor discovered that the call bell was not functioning. E26 (CNA) confirmed the finding. E26 then notified E25 (LPN) who immediately placed a call to the maintenance department. The surveyor then tested the call bell function across the hall in room [ROOM NUMBER] and the call bell did not function. 12/9/25 12:07 PM room [ROOM NUMBER] - During initial observations the surveyor discovered that the call bell was not functioning. E27 (CNA) confirmed the finding. 12/9/25 12:08 PM room [ROOM NUMBER] - E28 (MT) arrived and changed the bulb to room [ROOM NUMBER]. The call bell continued to not function. 12/9/25 12:12 PM - The surveyor observed that all the call bells in the remaining rooms on the 400 hallway were tested and E25 (LPN) and E28 (MT) confirmed the call bells were not functioning. E28 radioed his supervisor E29 (Maint. Dir.). 12/9/25 12:15 PM - The surveyor observed that all the call bells on the 200 hallway were tested and E29 (Maint. Dir.) confirmed the call bells were not functioning. 12/9/25 12:19 PM - The surveyor observed that all the call bells on the 300 hallway were tested and E29 (Maint. Dir.) confirmed the call bells were not functioning. E29 (Maint. Dir.) stated, There was a power surge this morning that maybe the issue.12/9/25 12:23 PM - The surveyor observed that all the call bells on the 500 hallway were tested and the call bells were not functioning.12/9/25 12:27 PM - The surveyor observed that all the call bells on the 100 hallway were tested and E32 (CNA) confirmed the call bells were not functioning and that the personal pagers that alert the CNA's when a call bell is activated were also not functioning. 12/9/25 12:31 PM - During an interview E1 (NHA) confirmed that E29 (Maint. Dir.) notified him that the call bell system in the facility was not functioning. E1 stated I have reached out to the call bell company and I am reviewing the call bell logs. E2 (DON) is ensuring care of the residents. The surveyor requested a copy of the call logs. 12/9/25 12:33 PM - During an interview E2 (DON) stated, We are trying to locate small bells in the meantime, and we have all staff rounding on the floors. 12/9/25 12:53 - 1:05 PM - The surveyor accompanied E29 (Maint. Dir.) to tour all resident hallways and verified call bell system was functioning. E29 (Maint. Dir.) stated, we had to reboot the system. 12/9/25 1:39 PM - E1 (NHA) provided the surveyor with call bell logs. Review of the logs revealed a lack of call bell activation starting at 7:31 AM. 12/9/25 1:39 PM - E1 (NHA) provided the surveyor with a timeline response that documented the following:12:33 PM - Continuous monitoring was started on all the hallways and dining rooms. 12:49 PM - All call bells functional.12:50 PM - An audit was started and completed of all rooms and pagers. An hourly audit will be completed of random rooms for twenty-four hours to make sure call bells are working properly. 12/9/25 3:15 PM - The surveyor was provided with copies of continuous observation logs for all hallways that documented rounds during time that call bells were not functioning in the facility. 12/16/25 3:45 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (ED).