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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/16/2025 |
| NAME OF PROVIDER OR SUPPLIER Westview Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1510 Clinic Dr Bedford, IN 47421 | |

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) |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the bathroom seat riser was cleaned for 1 of 3 resident bathrooms reviewed for environment. (room [ROOM NUMBER]) Findings include: On the following dates and times, the toilet seat riser in the bathroom of room [ROOM NUMBER] was observed to have a dry, brown substance on the surface and within the opening to the seat riser: On 12/11/25 at 10:40 a. m., 2:10 p.m., and 3:15 p.m. On 12/15/25 at 11:40 a.m., 1:45 p.m., and 3:25 p.m. During an interview on 12/15/25 at 3:30 p.m., the Administrator indicated the toilet seat riser was soiled and needed to be regularly cleaned. On 12/16/25 at 11:30 a.m., the Administrator provided the Resident Rights, revised 01/2025 and indicated these were the resident rights currently used by the facility. A review of the Resident Rights indicated, .The resident has the right to a safe, clean, comfortable, and homelike environment . 3.1-19(f)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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