STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village North	11050 Presbyterian Dr Indianapolis, IN 46236

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent a cognitively impaired resident from leaving a secured memory unit unsupervised for 1 of 3 residents reviewed for dementia care. (Resident B)Findings include: The clinical record for Resident B was reviewed on 8/18/25 at 11:10 a.m. The diagnoses included, but were not limited to, vascular dementia and anxiety. She resided on the secured memory care unit. A care plan, last revised on 5/7/25, indicated Resident B had behavior problems related to repetitive movements such as pacing and rummaging, rearranging her room, taking and leaving items in others rooms, wandering, and exit seeking. The goal was for her to have fewer behavioral episodes. The interventions included, but were not limited to, address wandering behavior by walking, redirect from inappropriate areas, engage in diversional activity, be calm and self-assured and anticipate and meet Resident B's needs.An Elopement Evaluation, with an effective date of 7/8/25, indicated she had a history of elopement or attempted while at home and while at the facility. She wandered aimlessly or non-goal directed. Her wandering behavior was likely to affect the privacy of others. A score value of 1 or higher indicated being at risk for elopement.A Quarterly Minimum Data Set (MDS) assessment, completed 7/8/25, indicated she did not speak. She was sometimes able to make herself understood and sometimes able to understand others. She had poor short- and long-term memory. She could not recall the season, location of her room, staff names or faces and did not know she was in a long-term care facility. She had severely impaired decision-making abilities. She wandered without purpose for one to three days during the look back period of the assessment. She was able to walk 150 feet with supervision.An Incident Note, dated 7/25/25 at 6:15 p.m., indicated Resident B was observed sitting on a bench outside by staff. When staff spoke with Resident B she pointed toward the unit stating, that's my home. Resident immediately brought back inside. Resident assessed head- to- toe for injuries. No injuries were noted. The Director of Nursing, Executive Director, Nurse Practitioner and Power of Attorney were notified of the incident. A care plan, initiated 7/28/25, indicated Resident B was an elopement risk/ wanderer related to impaired safety awareness. The goal was for her safety to be maintained. The interventions were to distract her from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Engage her in purposeful activities. Provide care in a calm and reassuring manner and provide clear simple instructions. Resident may attempt to follow others out of the door. Redirect her by offering to listen to music or watch television.On 8/18/25 at 1:00 p.m., the Executive Director (ED) provided the Incident Report, submitted to the Indiana Department of Health on 7/25/25, and the investigation file of the incident. The Incident Report, dated 7/25/25, indicated that Resident B had been observed by a staff member sitting on a bench outside. When the staff member asked Resident B what she was doing, Resident B stated that she needed to go back there and pointed toward the building. Resident B had been observed sitting in the building approximately 10 minutes prior to being found outdoors. Her elopement risk score was five on 7/8/25. The preventative measures, on 7/26/25, were an assessment of the unit revealed that the automatic closure of the doorway had an extended delay. The delay was immediately shortened to a five second egress. The codes for all doors on the unit were changed. All families were notified to ask for assistance when exiting the unit. Elopement risks had been completed for all residents residing on the unit. The follow up, added 7/30/25, indicated elopement assessments for all residents in the facility were completed. Care plans were updated as needed related to elopement risk. Elopement Risk Alert forms were completed for all residents at risk for elopement and elopement books were updated on all units. All staff were in-serviced regarding the elopement policy, elopement protocol, and elopement risk alert forms. Resident B continued to show no signs of injury and had no noted signs of psychosocial distress and no exit seeking. During an interview on 8/18/25 at 1:58 p.m., Registered Nurse (RN) 2 indicated, on 7/25/25, Resident B had been found outside of the secured memory care unit unsupervised. The facility security cameras were reviewed. The family member of another resident had left and used the handicap button to open the door. The family member had not paid attention, and Resident B had followed them out at 4:03 p.m. When staff found Resident B, she told the staff member she needed to go back in the same door she had used to leave. The family members had been educated, and the door had been changed to close more quickly. Family members no longer had the codes to the doors and staff were to let them in and out. On 8/18/25 at 3:45 p.m., the exit doors of the secured memory unit were observed with Licensed Practical Nurse (LPN) 3. LPN 3 opened the first exit door of the unit using a code and pushing the handicap accessible

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure a newly ordered medication was received timely from the facility contracted pharmacy and administered, as ordered by the physician, for 1 of 3 residents reviewed for unnecessary medications. (Resident E)Findings include: The clinical record for Resident E was reviewed on 8/18/25 at 11:17 a.m. The diagnoses included, but were not limited to, congestive heart failure. A Quarterly Minimum Data Set assessment, dated 6/9/25, indicated she was severely cognitively impaired. A Skin/Wound Note, dated 7/25/25 at 12:03 p.m., indicated Resident E had swelling present to the left lower extremity and foot. Upon assessment, Resident E's limb had redness with areas that appeared to be blistering. The Nurse Practitioner (NP) was notified and would assess.A physician's order, dated 7/25/25 at 1:16 p.m., indicated Resident E was to receive furosemide (a diuretic medication used to help remove excess fluids from the body) 20 milligrams (mg) given twice a day for edema (swelling) for four days. A Health Status Note, dated 7/26/25 at 6:24 a.m., indicated Resident E continued to have edema in left lower extremity with no complaints of pain or discomfort. A Health Status Note, dated 7/26/25 at 11:14 p.m., indicated Resident E continued to have edema in her left lower extremity with redness in both legs. She had no complaints of pain or discomfort. The July 2025 Medication Administration Record (MAR) did not contain documentation that the furosemide 20 mg was administered on 7/25/25 in the evening, or 7/26/25 in the morning or in the evening. The first dose of furosemide 20 mg was documented as being given on 7/27/25 in the morning. Resident E's clinical record did not contain information that the facility pharmacy had been contacted about the delivery of Resident E's furosemide.During an interview on 8/19/25 at 11:20 a.m., the DON indicated furosemide 20 mg was available for use in the Emergency Drug Kit at the facility. On 8/19/25 at 12:50 p.m., the Director of Nursing (DON) provided the Packing Slip Proof of Delivery form that indicated Resident E's furosemide 20 mg tablets were delivered to the facility on 7/27/25 at 6:31 p. m. The facility pharmacy was unavailable for interview.On 8/19/25 at 1:11 p.m., the DON provided the facility pharmacy instructions for ordering and reordering medications which indicated Monday through Friday new orders needed to be received by 7:00 p.m., Eastern Standard Time. On Saturday and Sunday, new orders need to be received by 3:00 p.m., Eastern Standard Time.During an interview on 8/19/25 at 1:11 p.m., the DON indicated the pharmacy required new orders to be sent to the pharmacy by the listed times to be included in the nightly drug delivery. She was unsure why Resident E's furosemide had not been delivered until 7/27/25. There was no documentation available that furosemide 20 mg had been removed from the Emergency Drug Kit machine for Resident E. This citation relates to Intake 2583098. 3.1-25(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure personal protective equipment (PPE) was worn during a wound treatment and to ensure hand hygiene was performed after doffing disposable gloves for 1 of 3 residents reviewed for wound care (Resident E).Findings include: The clinical record for Resident E was reviewed on 8/18/25 at 11:17 a.m. The diagnoses included, but were not limited to, congestive heart failure. A Quarterly Minimum Data Set assessment, dated 6/9/25, indicated she was severely cognitively impaired. A physician's order, dated 8/12/25, indicated to cleanse the area on the top of the right foot with wound cleanser, apply bacitracin to the wound bed, top with xeroform (petroleum gauze), cover with an ABD pad (type of wound dressing), wrap with kerlix (type of wound dressing) and secure with tape. On 8/19/25 at 10:05 a.m., Registered Nurse (RN) 2 was observed providing wound care to Resident E. RN 2 donned disposable gloves and removed the old dressing from Resident E's right foot. RN 2 went to the bathroom and removed her disposable gloves and applied a new pair. RN 2 did not perform hand hygiene after removing her used disposable gloves. RN 2 then cleansed the wound on the top of Resident E's right foot, applied xeroform gauze and wrapped Resident E's right foot with kerlix, securing the dressing with tape. RN 2 did not don a gown prior to beginning the treatment on Resident E's right foot. During an interview on 8/19/25 at 10:15 a.m., RN 2 indicated Resident E was in Enhanced Barrier Precautions (EBP) and she would normally wear a gown during a wound dressing change. Gowns were available on the back of the room door for use. She would normally perform hand hygiene after doffing a pair of gloves, prior to putting on a new pair of gloves. On 8/19/25 at 1:20 p.m., the Director on Nursing provided the current Enhanced Barrier Precautions Policy that indicated .It is the policy of the facility to ensure that additional and appropriate PPE [Personal Protective Equipment] is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms also known as MDRO's .Who is at 'High Risk' for acquiring or spreading a MDRO .Residents with wounds regardless of MDRO status .Examples of 'High Contact' Resident Care Activities at which time EBP is to be practiced are .Wound Care .Procedure: 1) When engaging in any of the afore mentioned 'High Contact' Resident Care Activities with a resident who has a known MRDO, or a colonized MRDO, or who would be at a high risk to contract a MRDO- use gloves and gowns [EPB] .This includes all required Hand Hygiene before and after donning/doffing gloves and gowns .3.1-18(b)(2)3.1-18(j)