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	11/24/2025

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure written discharge and bed hold information was provided directly to the resident and the resident's representative upon transfer for 4 of 5 residents reviewed for hospitalization. (Resident 7, 13, 1 and 4)Findings include: 1. The clinical record for Resident 7 was reviewed on 11/18/25 at 3:16 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, personality disorder, mild neurocognitive disorder, spinal stenosis, dysphagia, hypertensive heart disease with heart failure, congestive heart failure, and type 2 diabetes mellitus. a. A progress note, dated 9/28/25 at 2:31 p.m., indicated Resident 7 was sent to the hospital. It did not indicate the son was notified. A transfer/discharge form, dated 9/28/25, indicated the form was sent with Resident 7. A progress note, dated 9/29/25 at 1:21 p.m., indicated the facility placed a call to the son regarding the bed hold policy since the resident was currently in the hospital. The call was unanswered, so the facility left a voicemail message and asked him to call back. A bed hold policy, dated 9/29/25, indicated the Medical Record Coordinator called Resident 7's brother and left a voice message regarding the bed hold policy. b. During an observation, on 11/18/25 at 11:00 a.m., Resident 7 was not located in the facility and had been transferred to the hospital for shortness of breath. A progress note, dated 11/18/25 at 10:37 a.m., indicated Resident 7's oxygen saturation levels ranged between 70% and 84% on 5 liters of oxygen. The resident had a bluish tint to her lips and oral cavity and increased drowsiness. The resident was sent to the emergency room to be evaluated and treated. The son was called twice, and the facility left a voicemail. A progress note, dated 11/18/25 at 11:05 a.m., indicated Resident 7 had been sent to the emergency department for evaluation and treatment. A transfer/discharge form, dated 11/18/25, indicated Resident 7 was sent to the hospital with low oxygen saturations. The form did not indicate the bed hold policy and written transfer information was given to the resident and the resident's representative. A progress note, dated 11/20/25 at 9:54 a.m., indicated the facility placed a call to the son regarding the bed hold policy and plan to return to the facility. There was no answer, so the facility left a voice (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	message to call back. A nursing progress note, dated 11/21/25 at 1:31 p.m., indicated the facility placed another phone call to the son (emergency contact #1) and left a voice message to call back regarding an update and the bed hold information. A nursing progress note, dated 11/21/25 at 1:36 p.m., indicated the facility called Resident 7's daughter (emergency contact #2) to discuss the bed hold policy. The daughter indicated to hold the bed and the plan was for Resident 7 to come back to the facility after the hospital stay. During an interview, on 11/24/25 at 9:35 a.m., the Associate Executive Director indicated the facility's transfer procedure was to send the discharge paperwork and bed hold policy in the medical record packet with the resident to the hospital. The Medical Record Coordinator then called the resident's representative to determine their choice regarding the bed hold. The written bed hold policy was given to the resident or representative on admission, but at the time of a transfer, it was just a verbal decision. The written transfer information was not given directly to the resident or family at the time of transfer unless the resident was discharged home. During an interview, on 11/17/25 at 1:45 p.m., Resident 7 indicated she never received any written information when she was transferred to the hospital. 2. The clinical record for Resident 13 was reviewed 11/18/25 at 3:11 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction which affected the right dominant side, bipolar type schizoaffective disorder, severe vascular dementia with agitation, behavioral disturbance and psychotic disturbance, post-traumatic stress disorder, and neuroleptic induced Parkinsonism. A Brief Interview for Mental Status (BIMS) assessment, dated 1/31/25, indicated the resident had severe cognitive impairment. A physician's order, dated 1/21/25, indicated to send the resident to the emergency room to evaluate the mental status change. A nursing progress note, dated 1/21/25 at 7:05 p.m., indicated the facility called 911 and the resident was taken to the hospital. The resident's family was called when the resident left. During an interview, on 11/18/25 at 9:57 a.m., the Director of Nursing (DON) indicated she did not find documentation the resident's representative was given a written bed hold policy and transfer paperwork. The transfer paperwork Resident 13 was placed in the packet which was given to the transporters for the receiving facility. It was not given directly to Resident 13. 3. The clinical record for Resident 1 was reviewed on 11/20/25 at 3:24 p.m. The diagnoses included, but were not limited to, idiopathic pulmonary fibrosis, acute and chronic respiratory failure with hypoxia, and interstitial pulmonary disease. A hospital document, dated 11/17/25, indicated Resident 1 was transferred to the emergency room for respiratory distress and would be admitted to the hospital for close monitoring. A progress note, dated 11/17/25, indicated the Medical Record Coordinator had placed a call to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's power of attorney (POA) to discuss the bed hold policy. No one answered the call, and a voice message was left. A progress note, dated 11/18/25, indicated the facility attempted to contact Resident 1's POA again regarding the bed hold policy. An email correspondence, dated 11/18/25, indicated the facility had verbally communicated with Resident 1's POA regarding the bed hold policy. A discharge document indicated Resident 1 was transferred or discharged on 11/17/25 to the hospital. The document was dated to have been issued on 11/18/25. There was no documentation in the clinical record that the resident or resident's representative had been given the bed hold policy or notice of transfer/discharge in writing, prior to or within a 24-hour period (in the event of an emergency hospitalization). During an interview, on 11/21/25 at 11:11 a.m., the Associate Executive Director indicated, on 11/18/25, a follow-up telephone call was placed to the POA regarding the bed hold policy which was documented on a bed hold agreement form at that time. The discharge form was completed with the issue date of 11/18/25 at the time of the telephone conversation. 4. The clinical record for Resident 4 was reviewed on 11/21/25 at 11:58 a.m. The diagnoses included, but were not limited to, repeated falls, fracture of an unspecified part of the neck of the left femur, and fracture of the sacrum. a. The clinical record indicated Resident 4 was transferred to the hospital after a fall on 10/25/25 and returned to the facility on [DATE]. A progress note, dated 10/27/25, indicated the facility contacted Resident 4's POA via telephone to discuss the bed hold policy. b. A progress note, dated 11/20/25, indicated Resident 4 had been transferred to a follow-up appointment and was admitted to the hospital from the appointment for a procedure. A progress note, dated 11/21/25, indicated the facility contacted Resident 4's POA via telephone to discuss the bed hold policy. There was no documentation in the clinical record that the POA had been given the bed hold policy or notice of transfer/discharge in writing, prior to or within a 24-hour period (in the event of an emergency hospitalization) for the two hospitalizations. During an interview, on 11/21/25 at 12:49 p.m., the Associate Executive Director indicated the resident's representative would be provided with the bed hold policy on admission and if a therapeutic leave would extend longer than 24 hours. If the therapeutic leave was unexpected, like from a doctor's appointment, a follow-up call would be placed to the POA. A current facility policy, titled discharge: Bed Hold, dated 5/28/25 and received from the Associate Executive Director on 11/21/25 at 11:00 a.m., indicated .Residents or their designated representative shall be informed of this policy in writing at admission, at the time of transfer to a hospital [(unless (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an emergency)], or at the time of a therapeutic leave which extends beyond twenty-four [(24)] hours. Written notification at the time of transfer shall include the Notice of Transfer and Discharge and a copy of this policy.In the event of an emergency hospitalization, the resident and/or a family member or legal representative shall be notified by written notice, within 24 hours, and asked to provide the facility with their decision regarding the resident's return. 3.1-12(25)(A) 3.1-12(25)(B) 3.1-12(26)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the clinical record did not contain conflicting physician's orders related to code status for 2 of 2 residents reviewed for advanced directives. (Resident 23 and 117)Findings include:1. The clinical record for Resident 23 was reviewed on [DATE] at 2:33 p.m. The diagnoses included, but were not limited to, paraplegia, lumbar spina bifida with hydrocephalus, and chronic osteomyelitis with draining sinus. An active physician's order, dated [DATE], indicated the resident was a full code. An active physician's order, dated [DATE], indicated the resident's preference was do not resuscitate with limited interventions.The clinical record contained two active physician's orders with conflicting code status. 2. The clinical record for Resident 117 was reviewed on [DATE] at 11:34 a.m. The diagnoses included, but were not limited to, persistent vegetative state, chronic obstructive pulmonary disease, and chronic kidney disease.An active physician's order, dated [DATE], indicated the resident was a full code.An active physician's order, dated [DATE], indicated do not resuscitate and comfort measure care.The clinical record contained two active physician's orders with conflicting code status. During an interview, on [DATE] at 8:33 a.m., LPN 2 indicated if there was a physician's order for both a full code and a do not resuscitate it needed to be clarified with the physician.A current facility policy, titled GUIDELINE FOR CARDIOPULMONDAY RESUSCITATION-CPR, dated [DATE] and received from the Executive Director on [DATE] at 2:50 p.m., indicated .the resident's Advance Directives and/or code status will be obtained .Once physician order is received related to Code Status, order will be added to the banner (in the record system) .3.1-4(f)(5)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a new Preadmission Screening and Resident Review (PASSAR) level I was completed after antipsychotic medications were initiated for 2 of 5 residents reviewed for PASSAR. (Resident 124 and 28)Findings include:1. The clinical record for Resident 124 was reviewed on 11/19/25 at 1:57 p.m. The diagnoses included, but were not limited to, anxiety disorder, dementia with psychotic disturbances, and hallucinations.A PASSAR level I, dated 3/27/25, indicated Resident 124 did not require a level II screen because there was no evidence of an intellectual/developmental disability or a serious behavioral health condition. The screening indicated if there was a change in condition or if new information refuted the findings, a new screen must be submitted. The PASSAR level I indicated Resident 124 did not currently or in the past 6 months take any mental health medications.A care plan, dated 4/26/25, indicated Resident 124 used psychotropic medications related to anxiety, restlessness, agitation, hallucinations, and insomnia.A care plan, dated 4/26/25, indicated Resident 124 would remain free of psychotropic drug related complications and to administer psychotropic medications as ordered by the physician.A psychiatric visit note, dated 4/29/25, indicated Resident 124's current psychotropic medications included quetiapine (an atypical antipsychotic medication) 50 milligrams (mg) started on 4/24/25, mirtazapine (an atypical antidepressant medication) 7.5 mg started on 4/24/25, and Depakote (a mood stabilizing medication) 250 mg started on 4/10/25.A physician's order, dated 5/29/25, indicated to administer olanzapine (an atypical antipsychotic medication) 10 mg every evening for dementia with psychotic disturbances.2. The clinical record for Resident 28 was reviewed on 11/18/25 at 3:25 p.m. The diagnoses included, but were not limited to, major depression disorder, dementia with mood disturbances, dementia with agitation, and dementia with psychotic disturbances.A PASSAR level I, dated 11/21/24, indicated Resident 28 did not require a level II screen because there was no evidence of an intellectual/developmental disability or a serious behavioral health condition. The screening indicated that although Resident 28 had a diagnosis of major depression, there were no indicators identified which would signify the need for further evaluation at that time. If Resident 28's symptoms increased or other information suggested a potential serious mental illness, then the nursing facility must submit an updated screen to reevaluate the need for a PASRR level II behavioral health evaluation.The clinical record indicated Resident 28 experienced increased disruptive behaviors, hallucinations, and aggression which required a psychiatric hospital stay for a mental health evaluation and medication adjustment.A hospital document indicated Resident 28 was admitted for a psychiatric evaluation on 8/5/25 and discharged with new antipsychotic medications on 8/18/25.A care plan, dated 8/18/25, indicated Resident 28 received psychotropic medications for dementia with behavioral disturbances prescribed during a psychiatric hospital stay from 8/5/25 to 8/18/25.A physician's order, dated 8/18/25, indicated to administer Risperdal (an atypical antipsychotic medication) 0.5 mg, by mouth, two times a day related to dementia with psychotic disturbances.A physician's order, dated 11/6/25, indicated to administer Risperdal 37.5 mg, 1 unit intramuscularly, once a day, every 14 days, related to dementia with psychotic disturbances.During an interview, on 11/20/25 at 12:01 p.m., the Social Service Director (SSD) indicated a new level I PASSAR should be submitted when a resident had new or increased mental health behaviors and when a resident was started on a new antipsychotic medication. She reviewed Resident 124 and 28's level I PASSAR and indicated both should have had a new level I submitted.A current facility policy, titled Social Service Policy, dated as last revised 4/25/23 and received from the SSD on 11/20/25 at 3:28 p.m., indicated .It is the policy.to provide medically-related social services to assist residents in attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.Social Service shall.Update the PASSAR with diagnosis and medications as needed with changes.3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure regularly scheduled care plan meetings were held with the resident or resident's representative and documented in the clinical record for 1 of 2 residents reviewed for care plan conferences. (Resident 23)Findings include: The clinical record for Resident 23 was reviewed on 11/17/25 at 2:33 p.m. The diagnoses included, but were not limited to, paraplegia, lumbar spina bifida with hydrocephalus, and chronic osteomyelitis with draining sinus.There were no progress notes, documents, or assessments in the clinical record to indicate a care plan meeting had been held with the resident or resident's representative.During an interview, on 11/19/25 at 10:17 a.m., the Social Service Designee indicated she could not find information on a care plan meeting for Resident 23.During an interview, on 11/20/25 at 1:51 p.m., the Social Services Designee indicated she did not have any notes or documentation for a care plan meeting for Resident 23.A current facility policy, titled Care Planning-Resident Participation, dated 6/4/25 and received from the Administrator on 11/19/25 at 1:05 p.m., indicated .The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conference 3.1-35(d)(2)(B)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure a resident's preferences were reevaluated to ensure the resident maintained the highest practicable level of mental and social needs for 1 of 1 resident reviewed for activities of daily living care. (Resident 8)Findings include:During an observation and interview, on 11/17/25 at 11:36 a.m., Resident 8 was in her room, wearing a hospital style gown, lying in bed, and watching television. She indicated she had not been out of bed since she was admitted to the facility and indicated if a staff member would ask if she wanted to get up, she would. She relied on assistance from the staff to get up because she could not do it on her own. She received meals in her room and bed baths on her shower days. There was a high back wheelchair in her room and a blue Hoyer pad in the wheelchair. She indicated she was unaware the wheelchair was in the room, as it sat next to a half wall which separated the bedroom and sitting room and was out of her sight.During an observation and interview, on 11/18/25 at 10:11 a.m., Resident 8 was in her room, wearing a hospital style gown, and lying in bed. She indicated she was feeling lonely and would like to talk to her sister. A puzzle book was noted on a shelf, adjacent to the foot of her bed.During an observation and interview, on 11/19/25 at 10:45 a.m., Resident 8 was in her room, wearing a hospital style gown, lying in bed, and tearful. She indicated she did not sleep very well the previous night and was feeling like a sad sack today. She would like a change of scenery and felt very lonely. She used to be a very sociable person, she felt like her room was so far away from everyone else and would like to be around people more often. Resident 8 was asked if a staff member came to help her get out of bed, would she get up? Resident 8 indicated she would very much enjoy getting out of bed.During an observation, on 11/19/25 at 10:58 a.m., Resident 8's room was 1 of 4 rooms noted to be at the end of the hall, furthest away from the nurse's station, furthest away from the activity and lounge area and the only room of the 4 at the end of the hall to be occupied.The clinical record for Resident 8 was reviewed on 11/19/25 at 11:14 a.m. The diagnoses included, but were not limited to, anxiety disorder, muscle weakness, and chronic congestive heart failure.An admission progress note, dated 10/30/25, indicated at the time of arrival at the facility, Resident 8 was crying out and grabbing care givers, would push care giver's hand away, and was resistive to being turned or repositioned in bed. Staff had difficulty gaining cooperation with assessments and difficulty gaining Resident 8's attention. Resident 8 could not answer questions regarding medications, code status, allergies, or needs/desires.An initial activity assessment, dated 10/30/25, indicated Resident 8 enjoyed watching television, movies, and working on puzzles. The questions asking if Resident 8 wished to participate in activities while in the facility or to participate in group activities were answered unknown.A care plan, dated 10/31/25, indicated Resident 8 had a terminal prognosis/life limiting illness and received hospice services. Interventions included, but were not limited to, adjusting her activities of daily living to compensate for her changing abilities, and to encourage her participation to the extent she wished to participate.A care plan, dated 11/4/25, indicated Resident 8 had little activity involvement related to her physical limitations, was able to communicate her needs and would benefit from individualized 1:1 room visits from staff for stimulation, emotional, social, and physical support. Interventions included, but were not limited to, providing her with leisure supplies upon her request, such as word search puzzles and reading material. Her preferred activities were listed as: watching CNN, Animal Planet and Hallmark movies.A care plan, dated 11/14/25, indicated Resident 8 had a self-care performance deficit related to hospice care, mobility, and cognitive status. Interventions included, but were not limited to, for the staff to anticipate her needs, she was able to communicate her needs, to encourage her to participate in her care, and she required assistance from 1 to 2 staff members for transfers between surfaces.A skilled nursing evaluation assessment, dated 11/4/25, indicated Resident 8 did not refuse care.An admission Minimum Data Set (MDS) assessment, dated 11/6/25, indicated Resident 8 had normal cognitive function.An admission care plan meeting, dated 11/6/25, did not have Resident 8 documented to have (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been in attendance. It did indicate nursing, social service, activities, and family members were present. Resident 8 was experiencing increased anxiety. The family had requested a change in her anxiety medication. A recreation goal was placed to increase the 1:1 visits in her room from staff and encourage family visitation.The behavior monitoring and interventions reports for Resident 8, dated 10/31/25 to 11/20/25, were reviewed and indicated Resident 8 had not refused any care provided or offered.During an interview, on 11/19/25 at 11:00 a.m., the Nurse Navigator indicated Resident 8 was a hospice patient and refused to get out of bed.During an interview, on 11/19/25 at 1:29 p.m., Resident 8's friend indicated they visited Resident 8 often and since her admission into the facility, they had not seen Resident 8 out of bed.During an interview, on 11/20/25 at 11:05 a.m., CNA 13 indicated if a resident refused care, she would document the refusal on the behavior monitoring and interventions report and report the refusal to the nurse.During an interview, on 11/20/25 at 11:10 a.m., Physical Therapist (PT) 12 indicated she had not worked with Resident 8 because the resident was on hospice but indicated she had not observed Resident 8 out of bed since being admitted into the facility.During an interview, on 11/20/25 at 12:10 p.m., the Social Service Director (SSD) indicated Resident 8 was placed on 1:1 visits with the social service staff yesterday and Resident 8 had been receiving 1:1 visits from the activity staff.During an interview, on 11/20/25 at 3:36 p.m., the Director of Nursing (DON) indicated Resident 8 refused to get out of bed a lot and preferred for staff to sit in her room with her. The staff should be documenting Resident 8's refusals and should be asking Resident 8 more than once if she would like to get up because she would refuse the first attempt.During an interview, on 11/20/25 at 3:36 p.m., the DON indicated the facility did not have a policy regarding accurate documentation and indicated the facility followed all State and Federal regulations.A nursing job description, dated last revised 3/24/25, indicated the duties and responsibilities included responsibility for admission and assessment of new residents and to document pertinent information in the residents' medical record according to the departmental policy and applicable State Department of Health regulations.A current facility policy, titled Activities of Daily Living [(ADL)], Supporting, dated a revised 3/2018 and received from the SSD on 11/20/25 at 3:28 p.m., indicated .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living.refusal and information are documented in the resident's clinical record.appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with.mobility [(transfer and ambulation)].If residents with cognitive impairment.resist care, staff will.approach the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate.The resident's response to interventions will be monitored, evaluated and revised as appropriate.3.1-38(a)(2)(A)3.1-38(a)(2)(A)3.1-38(b)(4)3.1-38(b)(5)3.1-38(f)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to notify the physician of a weight gain as ordered and to hold a blood pressure medication according to the physician's parameters for 2 of 2 residents reviewed for quality of care. (Resident 2 and 5)Findings include: 1. During an observation, on 11/17/25 at 2:04 p.m., Resident 2 had mild swelling in both ankles. The clinical record for Resident 2 was reviewed on 11/18/25 at 3:14 p.m. The diagnoses included, but were not limited to, hypertensive heart disease with heart failure, chronic diastolic congestive heart failure, and paroxysmal atrial fibrillation. A physician's order, dated 11/19/24, indicated obtain a weight once a day for congestive heart failure and to notify the physician of a weight gain greater than 2 pounds a day. The Medication Administration Record (MAR), dated September 2025, indicated the following: On 9/24/25, the weight was 182.5 pounds.On 9/25/25, the weight was 185.6 pounds (a gain of 3.1 pounds). The MAR, dated October 2025, indicated the following: On 10/8/25, the weight was 177.8 pounds.On 10/9/25, the weight was 180 pounds (a gain of 2.2 pounds). On 10/10/25, the weight was 177.6 pounds. On 10/11/25, the weight was 180.4 pounds (a gain of 2.8 pounds). On 10/19/25, the weight was 173.4 pounds.On 10/20/25, the weight was 178.6 lbs. (a gain of 5.2 pounds). During an interview, on 11/19/25 at 11:25 a.m., the Director of Nursing (DON) indicated the physician should have been called for the increase in weight. The physician was not notified on 9/25/25, 10/9/25, 10/11/25, or 10/20/95. The facility did not have a specific policy regarding following the physician's orders for congestive heart failure monitoring but did follow the regulations on following physicians' orders. During an interview, on 11/21/25 at 11:49 a.m., LPN 5 indicated if a weight gain of more than 2 pounds in a day or 5 pounds in a week was recorded, the physician should be notified according to the order. 2. The clinical record for Resident 5 was reviewed on 11/18/25 at 1:43 p.m. The diagnoses included, but were not limited to, atrial fibrillation, chronic combined systolic and diastolic congestive heart failure, and hypertensive heart disease with heart failure. A physician's order, dated 8/31/23, indicated to administer Cardizem (a medication which lowers blood pressure and heart rate) 120 milligrams (mg) once a day but to hold it for systolic blood pressure less than 110. (continued on next page)

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	11/24/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR, dated August 2025, indicated Cardizem was administered with a systolic blood pressure of 90 on 8/7/25. The MAR, dated September 2025, indicated Cardizem was administered with a systolic blood pressure of 102 on 9/30/25. The MAR, dated October 2025, indicated Cardizem was administered with a systolic blood pressure of 104 on 10/26/25 and 108 on 10/30/25. During an interview, on 11/21/25 at 11:52 a.m., LPN 5 indicated vital signs were obtained prior to administering a medication which had parameters. If the vital signs were below or above the hold parameter, then the nurse would not administer the medication. During an interview, on 11/19/25 at 11:25 a.m., the Director of Nursing (DON) indicated the nurses were to follow the physician's orders and hold the medications based on the vital signs and parameters. A current facility policy, titled Administering Medications, dated as revised 4/2019 and received from the Assistant Executive Director on 11/24/25 at 12:50 p.m., indicated .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders. 3.1-37(a)

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	11/24/2025

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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 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. Based on observation, interview and record review, the facility failed to ensure a gait belt was used during a transfer for 1 of 1 resident reviewed for accidents. (Resident 106)Findings include:During a random observation, on 11/17/25 at 3:11 p.m., Resident 106 was heard screaming no, no in their room. Upon entering the room with the Director of Nursing (DON), CNA 3 was observed behind Resident 106, who was on the floor. CNA 3 was observed wearing a gait belt around her waist. CNA 3 indicated she did not use the gait belt to transfer the resident.The clinical record for Resident 106 was reviewed on 11/21/25 at 12:48 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infraction (weakness and paralysis on one side of the body from a stroke), repeated falls, and vascular dementia.The care plans for Resident 106 did not address using a gait belt for transfers.During an interview, on 11/17/25 at 3:20 p.m., CNA 3 indicated she did not have her resident assignment sheet with her and it was on a table outside of the room. She left the room and obtained the sheet. Upon her return, CNA 3 indicated she did use the assignment sheet and the sheet indicated Resident 106 required maximum assistance of 1 staff member and a gait belt was to be used.During an interview, on 11/19/25 at 8:31 a.m., QMA 4 indicated she looked at the assignment sheet to determine how to transfer a resident and gait belts were to be used on all residents who were not on mechanical lift transfers.A facility document, titled Assignment #2 (3 CNAs), undated and received from the Director of Nursing on 11/17/25 at 3:42 a.m., indicated Resident 106 was to be transferred with one staff member and the use of a gait belt. The document also indicated directions for all residents were .GAIT BELTS WITH ALL TRANSFERS & WHEN WALKING RESIDENTS A current facility policy, titled Use of Gait Belt, dated 2024 and received from the Assistant Executive Director on 11/17/25 at 3:53 p.m., indicated .It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety 3.1-45(a)(2)

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	155167	A. Building B. Wing	11/24/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to ensure assessments were accurately documented for 1 of 1 resident reviewed for accurate assessments. (Resident 134)Findings include:During an observation and interview, on 11/17/25 at 11:14 a.m., Resident 134 had a gastrostomy tube (g-tube) with enteral feed (liquid nutrition administered directly into the stomach through the tube) running. Resident 134 indicated he was readmitted to the facility 2 weeks ago after having a feeding tube placed in the hospital. Since he had the feeding tube placed, he had not been able to eat or drink anything by mouth except ice chips.The clinical record for Resident 134 was reviewed on 11/20/25 at 8:34 a.m. The diagnoses included, but were not limited to, severe protein-calorie malnutrition, gastrostomy tube (a surgically placed tube inserted through the abdomen directly into the stomach for nutrition), and depression.A hospital document, dated 11/12/25, indicated Resident 134 was discharged back to the facility with a g-tube and was tolerating the enteral feeding at the time of discharge.A physician's order, dated 11/12/25, indicated Resident 134 had a NPO (nothing by mouth) diet and could have ice chips after oral care.A care plan, dated 11/17/25, indicated Resident 134 had potential for nutritional problems and was readmitted into the facility, on 11/12/25, with a g-tube. The resident was to continue the NPO diet but could have ice chips after oral care.A review of the eight (8) skilled nursing evaluation assessments, from 11/13/25 to 11/20/25, indicated the nursing staff had documented Resident 134's nutritional needs were being received and met through oral nutrition.The nutrition section on the skilled nursing evaluation assessments indicated the options available to select included, but were not limited to, enteral feeding, oral, tube feed, or NPO.During an interview, on 11/20/25 at 3:02 p.m., the Assistant Director of Nursing (ADON) reviewed Resident 134's skilled nursing evaluations and indicated the documentation was not accurate. The expectation of the nursing skilled evaluation charting was to be accurate to ensure anyone looking at the documentation would be aware of the resident's condition.During an interview, on 11/21/25 at 11:47 a.m., RN 7 indicated the skilled nursing evaluations gave a picture of how the resident was doing. The assessments and documentation would be different for each resident and should be accurate for the resident being assessed.A nursing job description, dated as last revised 3/24/25, indicated the duties and responsibilities included, but were not limited to responsibility for admission and assessment of new residents and to document pertinent information in the residents' medical record according to the departmental policy and applicable State Department of Health regulations.3.1-50(a)(2)