STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155170	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village Muncie Inc	5801 W Bethel Ave Muncie, IN 47304

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was served in a method to prevent possible cross contamination and/or foodborne illness for 56 of 56 residents who ate meals served in the skilled unit facility kitchen. Findings include: During a lunch meal service, on 5/6/26 from 11:35 a.m. to 11:40 a.m., the following food service concerns were observed:Cook 5 was wearing disposable gloves. Using her gloved hands, she touched resident meal tickets, clean dishes, scoops, tongs, sweat potato fries, and a sandwich. She repeated this process touching meal tickets, the outside of the bread bag, fries, sandwich wraps, and plate rims. She left the steam table area, and using the same soiled gloves, she took a hot dog out of bag and placed it on an electric griddle. She returned to the food service line, and using her soiled gloved hands, touched meal tickets, plates, sweet potato fries, and wrap sandwiches. She then went over to the grill, and with the same soiled gloves, touched the wrapper on a bag of hot dog buns, removed the bun from the bag, and picked up the dog off of the grill using her gloved fingertips. She placed the hot dog in the palm of her soiled gloved hand and carried it from the grill area to the steam table service area. She used her soiled gloved hands and placed the hot dog on the plate. She continued to touch meal tickets, sweet potato fries, and wrap sandwiches. She continued this method for the service of nine meal trays. She removed her soiled gloves. During an interview, on 5/6/26 at 11:40 a.m., [NAME] 5 indicated printed meal tickets were taken in packets to the units, where staff carried the forms to residents and helped them complete their food orders. The paper forms were handled by both staff and residents before arriving back in the kitchen. She had not considered that touching unclean items, such as meal tickets and bread bag wrappers, contaminated her gloves and she would need to change her gloves before touching food. During an interview on 5/7/26 at 2:27 p.m., the DON indicated all of the 56 residents who lived in the skilled healthcare area of the facility ate food prepared in the facility kitchen.A current, undated, facility policy titled Bare Hand Contact with food and Use of Plastic Gloves, provided via email by the Chief Financial Officer on 5/6/26 at 1:15 p.m., indicated: Plastic gloves will be worn when food handling food directly with hands to ensure that bacteria are not transferred from the food handler's hands to the food product being served.3. Gloved hands are considered a food contact surface that can get contaminated or solid. If used, single use gloves shall be used for only one task.6. Remember gloves are just like hands. They get soiled.must be changes.During food preparation as often as necessary to remove soil and contaminated to prevent cross contamination when changing tasks.410 IAC (Indiana Administrative Code) 16.2-3.1 -21(i)(1)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP) and utilize proper hand hygiene during suprapubic catheter (urinary catheter inserted into the bladder via the abdomen) care for 1 of 2 residents reviewed for urinary catheters. (Resident 17)B. Based on observation and interview, the facility failed to properly handle medications utilizing infection prevention and control measures during medication administration for 2 of 4 residents reviewed for medication administration. (Resident 37 and Resident 40)Findings include:A1. During an observation, on 5/6/26 at 11:38 a.m., Resident 17 was in his bed. The urinary catheter drainage bag and tubing were directly against the floor. An EBP sign was hung on the right side of the doorway above the canister of personal protective equipment. The sign indicated everyone must clean their hands before entering and when leaving the room. Providers and staff must wear gloves and a gown for high-contact care activities such as urinary catheter device care or use. Resident 17's clinical record was reviewed on 5/7/26 at 3:33 p.m. Diagnoses included obstructive uropathy, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, and Alzheimer's disease.Current orders included enhanced barrier precautions related to suprapubic catheter every shift (9/20/25), Suprapubic catheter size 14 French 10 cc (12/22/25), and cleanse suprapubic catheter site with soap and water then apply a thin layer of bacitracin (antibiotic ointment) around the tube site for redness once a day (3/19/26).A 3/29/26, annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. Resident 17 required substantial assistance from staff for toileting hygiene, toileting transfers, and walking. The resident had an indwelling urinary catheter. Skin interventions included application of ointments/medications. Resident 17's current care plans included the following:A current care plan, last reviewed on 3/31/26, indicated the resident required a suprapubic catheter related to obstructive uropathy, urethral stricture, and urinary retention. Interventions included nursing staff to provide catheter care as ordered each shift, and as needed (5/29/25), and utilize principles of infection control and universal/standard precautions (5/29/25).A 6/11/25 problem of enhanced barrier precautions related to his suprapubic catheter. Interventions included proper hand hygiene (6/11/25) and catheter care every shift (6/11/25). A progress note, dated 3/23/26 at 9:52 p.m., indicated the resident continued an antibiotic related to the resident's catheter site. The resident's catheter site continued to have brown drainage. During a catheter care observation, on 5/11/26 from 10:52 a.m. to 11:03 a.m., Resident 17's room had an EBP sign to the right of the resident's door. LPN 7 entered the resident's room with catheter care supplies, moved the resident's overbed table, and placed the supplies directly on top of the resident's personal papers on his overbed table. Previously opened cleansing wipes were retrieved from the resident's bathroom counter and placed on the overbed table. LPN 7 opened the lid of the wipes, donned gloves, and used both gloved hands to pull the resident's blankets and brief down below the suprapubic catheter cite. She removed the old dressing, which was soiled with purulent and blood-tinged drainage. The catheter insertion site contained purulent drainage and redness surrounding the catheter tubing. With the same gloves, she opened clean gauze and wiped away the drainage at the insertion site with her right hand. While holding the package of wipes with her left hand, she removed wipes with her right hand and performed supra pubic catheter care with the wipes in her right hand. Another wipe was pulled out with her right hand and used to cleanse the catheter tubing. A split gauze package was opened with the same gloves and placed around the catheter insertion site. LPN 7 doffed her gloves, opened the door, pulled keys out of her pocket, unlocked the medication door, and moved items around in the medication cabinet. Without hand hygiene, she re-entered the resident's room, donned clean gloves, and placed tape on the resident's split gauze around the catheter insertion site. LPN 7 placed the wipes back into the resident's bathroom, doffed her gloves, exited the room, pulled keys out of her pocket, and unlocked the [NAME] Court Unit medication cart. She used the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	keyboard and mouse to log into her computer and moved items around on her medication cart without hand hygiene. A gown was not worn at any time during the catheter care observation. Hand hygiene was not performed throughout the observation. During an interview on 5/11/25 at 11:03 a.m., LPN 7 indicated Resident 17 required enhanced barrier precautions. She should have worn a gown during the suprapubic catheter care to prevent cross contamination and infections. The resident's suprapubic catheter insertion site was reddened and contained purulent blood-tinged drainage. On 5/12/26 at 11:53 a.m., the DON indicated staff were required to follow enhanced barrier precautions for suprapubic catheter care. A lack of proper hand hygiene and following infection control practices placed the residents at risk for infection. A current facility policy, dated 1/25/26, titled Subrapubic [sic] Catheter Care, provided by the Administrator on 5/12/26 at 12:21 p.m., indicated the following: 1. Wash your hands thoroughly before handling the catheter and/or site. 2. Clean the catheter insertion site daily with mild soap and water.A current facility policy, dated 1/25/26, titled Hand Hygiene, provided by the Administrator on 5/12/26 at 12:21 p.m., indicated the following: Policy All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. A current facility policy, dated 1/25/26, titled Enhanced Barrier Precautions, provided by the Chief Financial Officer on 5/12/26 at 12:37 p.m., indicated the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.B1. During a random medication administration observation on 5/11/26 at 9:28 a.m., LPN 7 prepared Resident 37's medications for administration. The medications included: amiodarone hydrochloride (heart rhythm)100 mg tablet, biotin (supplement) 1000 mcg tablet, buspirone hydrochloride (anxiety) 5 mg 0.5 tablet, cholecalciferol (vitamin D3) 25 mcg tablet, dorzolamide-timolol (glaucoma) 22.3 - 6.8 mg/ml ophthalmic one drop to each eye, apixaban (blood thinner) 5 mg tablet, levothyroxine sodium (thyroid) 88 mcg tablet, prednisone (steroid) 5 mg tablet, and Viactiv (calcium supplement) 650 mg-12.5 mcg chewable tablet.On 5/11/26 at 9:42 a.m., LPN 7 took Resident 37's medications into her room and placed the medication cup on the overbed table. The medication cup spilled over, and two white pills spilled out onto the floor. LPN 7 used her right gloved hand, picked up the pills, placed the contaminated pills back into the resident's pill cup, and handed the cup to the resident. LPN 7 did not offer or attempt to replace the contaminated medications. Resident 37 took all the pills in the cup. B2. During a random medication administration observation on 5/11/26 at 9:56 a.m., LPN 7 prepared Resident 40's medications for administration. The medications included: aspirin 81 mg tablet, carvedilol (blood pressure/heart rate) 3.125 mg tablet, CoQ-10 (supplement) 100 mg two capsules, cyanocobalamin (vitamin B)1000 mcg capsule, fish oil (supplement) 1000 mg capsule, escitalopram (depression) 10 mg tablet, losartan potassium (blood pressure) 50 mg tablet, and pantoprazole (acid reflux) 40 mg delayed release tablet. On 5/11/26 at 10:06 a.m., LPN 7 handed Resident 40 his medications in a cup, in the hallway outside of the dining room. The resident poured the pills into his hand, dropping one pill on his wheelchair seat and one pill on the floor. LPN 7 picked up a pill from the resident's wheelchair and a pill from the floor with her right bare hand and placed them back into Resident 40's hand with the other medications. LPN 7 did not offer or attempt to replace the contaminated medications. Resident 40 took all the pills. During an interview, on 5/11/26 at 10:11 a.m., LPN 7 indicated she should not have administered the contaminated medications. The contaminated medications should have been identified and replaced. On 5/12/26 at 11:49 a.m., the DON indicated medications touched with bare hands, dropped on the floor, or contaminated in any way, should have been destroyed. They should not have been administered to any residents.A current facility policy, dated 1/25/26, titled Medication Administration, provided by the Administrator on 5/12/26 at 10:24 a.m., indicated the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: .14. Remove medication from source, taking care not to touch medication with bare hand. If a medication is dropped refer to medication destruction policy.410 IAC (Indiana Administrative Code) 16.2-3.1-18(l)410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)