

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER Westminster Village Kentuckiana		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 Greentree N Clarksville, IN 47129	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>34231</p> <p>Based on observation, interview and record review, the facility failed to ensure residents (Resident B and Resident C) were served meals on appropriate dinner ware for 2 of 3 residents reviewed for resident rights.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 2/12/24 at 1:22 p.m. The diagnosis included, but was not limited to, left sided hemiplegia and hemiparesis.</p> <p>On 2/12/24 at 1:15 p.m., the resident was observed resting in bed with her eyes open, call light in reach and lunch at bedside in a styrofoam container with plastic eating utensils. Meals had been served in styrofoam for well over a year. She just thought that was how all the meals were served. She thought it would be wonderful if they would serve the meals on regular plates with good silver ware. She could not cut anything up without the plastic utensils breaking. She only had one good hand and the Styrofoam makes it harder to eat.</p> <p>During an interview on 2/13/24 at 10:45 a.m., the Assistant Dietary Manager indicated they were using Styrofoam because the company, whom they contracted with, left. When they left, they took all of the dish ware. They ordered dishes in October and then there was a supply issue. They do have plates but were currently waiting on the plate warmers that were ordered. If the residents ate in their rooms, they usually send all disposable utensils and styrofoam.</p> <p>During an interview on 2/13/24 at 11:40 a.m., the Executive Director (ED) indicated they did have plates, but were waiting on the bases (plate warmers). If the residents eat in their rooms, the meals are sent in styrofoam. They were currently waiting on tray carts. The previous contracted company they had left before the contract was up in late December of 2022 and took a lot of the supplies. On 2/14/24 at 1:45 p.m., the ED indicated they had been ordering supplies all along but just did not have enough. They thought they could get more residents to go to the dining room, but that did not happen. They had several other expenditures and the meal cart was put on the back burner. She did, however, order the cart today as well as the dish ware.</p> <p>2. The clinical record for Resident C was reviewed on 2/12/24 at 1:47 p.m. The diagnosis included, but was not limited to, left sided hemiplegia and hemiparesis.</p> <p>(continued on next page)</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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER Westminster Village Kentuckiana		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 Greentree N Clarksville, IN 47129	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/12/24 at 1:05 p.m., there were styrofoam meal containers on the resident's bedside table.</p> <p>During an interview on 2/12/24 at 2:20 p.m., the resident indicated his meals had been served in styrofoam for quite sometime. He sometimes had problems eating due to the high edges of the container the meals are served in.</p> <p>Review of the meal service and supplements policy, dated October 2022, indicated disposable dining dishes and flatware would be used to serve meals as needed during emergency meal service. The emergency meal service was defined as a serious weather condition, a power outage, or a significant staff shortage, etc.</p> <p>On 2/14/24 at 2:55 p.m., the ED provided a current copy of the document titled Resident Rights dated December 2016. It included, but was not limited to, Federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to .dignified existence .dignity</p> <p>This Citation relates to Complaint IN00428146</p> <p>3.1-3(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2024
NAME OF PROVIDER OR SUPPLIER Westminster Village Kentuckiana		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 Greentree N Clarksville, IN 47129	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34231</p> <p>Based on interview and record review, the facility failed to ensure quarterly smoking assessments were completed for 2 of 3 residents reviewed for quality of care. (Residents B and C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 2/12/24 at 1:22 p.m. The diagnoses included, but were not limited to, left sided hemiplegia and hemiparesis, bipolar and major depressive disorder.</p> <p>The care plan, dated 12/21/21, indicated the resident required supervision with smoking and to update the smoking assessment quarterly and as needed.</p> <p>Review of Resident B's smoking risk assessments indicated a quarterly assessment was last completed on 8/17/23.</p> <p>The clinical record lacked documentation of a quarterly assessment for November 2023.</p> <p>During an interview on 2/12/24 at 2:48 p.m., the Director of Nursing indicated when the quarterly assessments were set up in the new system, the smoking assessments were not included. RN (Registered Nurse) 3 indicated per facility policy, smoking assessments were to be completed quarterly.</p> <p>2. The clinical record for Resident C was reviewed on 2/12/24 at 1:47 p.m. The diagnoses included, but were not limited to, left sided hemiplegia and hemiparesis and dementia.</p> <p>The care plan, dated 2/17/22, indicated the resident was at risk for injury related to smoking and to update the smoking assessment quarterly and as needed.</p> <p>Review of Resident C's smoking risk assessments indicated a quarterly assessment was completed on 8/17/23.</p> <p>The clinical record lacked documentation of a quarterly assessment for November 2023.</p> <p>On 2/12/24 at 2:48 p.m., the Director of Nursing provided a current, undated copy of the document titled Smoking Policy - Residents. It included, but was not limited to, Policy Statement .It is the policy of this facility to be administered, in accordance with City, County, State and Federal Regulations related to smoking .A resident's ability to smoke safely will be re-evaluated quarterly</p> <p>This Citation relates to Complaint IN00425548</p> <p>3.1-37</p>		