STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village Kentuckiana	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 1 of 3 residents reviewed for misappropriation. (Resident B)Findings include:The clinical record for Resident B was reviewed on 9/2/25 at 2:24 p.m. The resident's diagnoses included, but were not limited to, diabetes, depression and chronic pain.The physician's order, dated 6/3/25, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg (milligrams) every 6 hours as needed for pain.Review of the pharmacy delivery receipt, dated 8/16/25 at 6:45 p.m., indicated the resident's 30 Hydrocodone-Apap (acetaminophen) 5-325 mg were delivered and signed for by LPN 6.The incident report, dated 8/16/25, indicated on 8/19/25 Registered Nurse (RN) 7 called the pharmacy to find out why a narcotic medication that was ordered for Resident B had not been delivered. The pharmacy reported that 30 tablets of the narcotic pain medication was delivered on 8/16/25. The pharmacy sent over the signature page which showed the narcotic pain medication was signed for by Licensed Practical Nurse (LPN) 6. The LPN (6) reported she did sign for the medication and gave it to LPN 9, who was responsible for Resident B's medication. An investigation was initiated.During an interview, on 9/3/25 at 9:52 a.m., Qualified Medication Aide (QMA) 5 indicated he had noticed the resident was getting low on her pain medication. He called the pharmacy for a refill, and the pharmacy told him they would send the medication out as the resident had a current script on file. At the change of shift on 8/16/25 at 6:30 p.m., QMA 5 informed LPN 9 he had ordered the pain medication for Resident B and she was to keep an eye out for it. On 8/17/25 at 7:15 a.m., QMA 5 was about 45 minutes late after the normal shift change and did not count the narcotics in the cart with LPN 9. LPN 8 had counted the narcotics in the cart with LPN 9. QMA 5 checked the cart to see if Resident B's pain medication had arrived and he could not locate the resident's pain medication. Since LPN 8 counted the cart with LPN 9, QMA 5 asked LPN 8 if the medication for Resident B had arrived. LPN 8 indicated to QMA 5 the medication was not there when she counted with LPN 9. QMA 5 figured it had not arrived yet. LPN 9 called the facility at 5:30 p.m. on 8/17/25 and told them she had quit. At the end of QMA 5 shift, on 8/17/25, LPN 11 and QMA 5 counted the narcotics in the cart. QMA 5 advised LPN 11 he had ordered Resident B's pain medication but it had not arrived to the facility yet. On Monday, 8/18/25, Resident B's pain medication had not arrived and it was reported it to RN 7 by QMA 5. RN 7 called the pharmacy and was advised the pain medication was sent on Saturday 8/16/25 at 6:45 p.m.During a telephone interview, on 9/3/25 at 10:53 a.m., LPN 6 indicated, on 8/16/25, she had seen the pharmacy delivery person at the nurse's station. She did not see LPN 9 on the hallway anywhere. She went to the nurse's station for the medication delivery and signed for Resident B's 30 Hydrocodone's tablets. The protocol was to sign for the medication and place a signed copy in a file, which she did. LPN 6 found LPN 9 and gave LPN 9 the medication for her to put in the residents medication cart.During a telephone interview, on 9/3/25 at 12:34 p.m., RN 7 indicated on Monday, 8/18/25, QMA 5 reported to her that he had ordered pain medication for Resident B early on 8/16/25 and as of 8/18/25 the pain medication had not arrived. RN 7 called the pharmacy and was advised the medication was sent to the facility on 8/16/25 and was signed by a facility staff member. RN 7 asked the pharmacy if they could send over a copy of the requisition on who had signed for the narcotic pain medication. The pharmacy sent over the requisition which was signed in by LPN 6. When RN 7 discovered the resident's medication was missing, she then notified the Director of Nursing that somewhere between Saturday night, 8/16/25 and Sunday morning, 8/17/25, Resident B's narcotic pain medication disappeared.During a telephone interview, on 9/4/25 at 10:00 a.m., LPN 8 indicated on the morning of Sunday, 8/17/25, when she arrived to work, LPN 9 asked her to count the narcotics with her so she could leave. LPN 8 and LPN 9 counted the narcotics in the medication cart and the residents' medication cards and sheet counts were correct.During an interview, on 9/3/25 at 12:02 p.m., the Director of Nursing (DON) indicated she was notified by RN 7 about the missing narcotic pain medication for Resident B. The DON initiated an investigation and requested a drug screen for QMA 5, LPN 6, RN 7, LPN 8, and LPN 11, which were all negative. LPN 9 had refused the drug screen via text message. On 9/2/25 at 10:22 a.m., the Director of Nursing provided a current copy of the document titled Resident Rights dated 12/2016. It included, but was not limited to, Policy Interpretation and Implementation .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to .be free from .misappropriation of property The Past noncompliance began on 8/16/25. The deficient practice was corrected by 8/20/25 after the facility implemented a systemic plan that included the following actions: A 30-day look back narcotic audit was

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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 interview and record review, the facility failed to ensure an assessment was completed by a licensed nurse and authorization given to administer an as needed narcotic pain medication by a qualified medication aide for 1 of 3 residents reviewed for quality of care. (Resident C)Findings include:The clinical record for Resident C was reviewed on 9/3/25 at 9:55 a.m. The resident's diagnoses included, but were not limited to, fibromyalgia, depression and pain.The physician's order, dated 6/20/25, indicated the resident was to receive oxycodone with acetaminophen (narcotic pain medication) 7.5 mg (milligrams) every 4 hours as needed for pain.The August controlled drug record indicated the resident received the as needed pain medication on the following dates and times by Qualified Medication Aide (QMA) 10: 7/31/25 at 8:00 p.m., 8/01/25 at 12:00 a.m. and 4:00 a.m., 8/09/25 at 9:15 p.m., 8/10/25 at 12:30 a.m., 4:00 a.m. and 8:00 p.m., 8/11/25 at 12:00 a.m. and 4:00 a.m., 8/13/25 at 9:00 p.m., 8/14/25 at 12:00 a.m., 4:00 a.m. and 8:00 p.m., 8/15/25 at 12:00 a.m. and 4:00 a.m., 8/20/25 at 8:00 p.m., 8/21/25 at 12:00 a.m. and 4:00 a.m., 8/23/25 at 8:00 p.m., 8/24/25 at 12:00 a.m. and 4:00 a.m., 8/27/25 at 8:00 p.m., and 8/28/25 at 12:00 a.m. and 4:00 a.m. The clinical record lacked a resident assessment, by a licensed nurse, for the as needed pain medication and an authorized signature on the controlled drug record.During an interview, on 9/4/25 at 10:15 a.m., QMA 5 indicated a licensed nurse must assess the resident when the need for the as needed narcotic pain medication was requested and co-sign with the QMA on the controlled drug record.On 9/3/25 at 3:15 p.m., the Director of Nursing provided a current, undated copy of the document titled Qualified Medication Aide Scope of Practice. It included, but was not limited to, The following tasks are within the scope of practice for the QMA unless prohibited by facility policy .Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following .Document in the resident record symptoms indicating the need for the medication and the time the symptoms occurred .Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact .Obtain permission to administer the medication each time the symptoms occur in the resident .Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift This Citation relates to Intake 26031163.1-37

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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 interview and record review, the facility failed to ensure a resident's (Resident C) medication administration record accurately reflected the administration of narcotic pain medication for 1 of 3 residents reviewed for documentation.Findings include: The clinical record for Resident C was reviewed on 9/3/25 at 9:55 a.m. The resident's diagnosis included, but was not limited to, fibromyalgia.The physician's order, dated 6/20/25, indicated the resident was to receive oxycodone with acetaminophen, 7.5 mg (milligrams) every 4 hours as needed for pain.The August 2025 controlled drug record indicated the resident received the medication on the following dates and times:-8/02/25 at 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/03/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m. and 4:00 p.m.-8/08/25 at 10:00 p.m.-8/09/25 at 2:00 a.m., 6:00 a.m., 10:15 a.m., 2:15 p.m. and 9:15 p.m.-8/10/25 at 12:30 a.m. and 12:00 p.m.-8/11/25 at 12:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/12/25 at 12:00 a.m., 4:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/13/25 at 12:00 a.m., 4:00 a.m., 12:00 p.m. and 9:00 p.m.-8/14/25 at 12:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/15/25 at 12:00 a.m., 12:00 p.m. and 8:00 p.m.-8/16/25 at 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/17/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/18/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 6:00 p.m. and 10:00 p.m.-8/19/25 at 12:00 a.m., 6:00 a.m. and 8:00 p.m.-8/20/25 at 12:00 a.m., 4:00 a.m. and 8:00 p.m.-8/21/25 at 12:00 a.m., 8:00 a.m. and 8:00 p.m.-8/22/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/23/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/24/25 at 12:00 a.m., 8:00 a.m., 12:00 p.m. and 4:00 p.m.-8/25/25 at 12:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/26/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.-8/27/25 at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m.08/28/25 at 12:00 a.m., 8:00 a.m., 4:00 p.m. and 8:00 p.m.The August 2025 medication administration record for Resident C lacked documentation of the administration of the narcotic medication on the above dates and times.During an interview, on 9/4/25 at 2:18 p.m., Licensed Practical Nurse (LPN) 12 indicated when a resident's as needed pain medication was administered, the medication should be signed out on the controlled drug record and the medication administration record.On 9/4/25 at 12:24 p.m., the Director of Nursing provided a current copy of the document titled Documentation of Medication Administration dated 4/2007. It included, but was not limited to, The facility shall maintain a medication administration record to document all medications administered .A Nurse or Certified Medication Aide .shall document all medications administered to each resident on the resident's medication administration record .Administration of medication must be documented immediately after (never before) it is given .Documentation must include .Signature and title of the person administering the medication This Citation relates to Intake 2603116 3.1-50(a)(2)