

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 01/20/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility to ensure the kitchen equipment, floors, and meal carts were clean and sanitary. This deficient practice affected 64 of 64 residents who currently received meals from the kitchen. Findings Include: 1. During the initial kitchen tour, on 1/13/26 at 9:00 a.m., the following areas of concern were observed: -The dish machine had three areas of long white lime streaks going down the front of the dish washer. -The steam table machine had a heavy soil of yellow, brown and black material inside the two doors at the bottom. The same soil was observed along the sliding edge of the two doors and along the edge below the five control knobs. -Inside the two closed food carts, there were multiple brown and white spills on the bottom of the carts. One cart had lunch trays set up waiting for the food. -The floor underneath the flat top grill, had multiple brown spills and grease on it. -The fryer had a moderate amount of brown particles in the oil and along the inside shelf of the fryer. The fryer was greasy and sticky to the touch along the front and two sides. -The conveyor toaster had a moderate amount of brown crumbs inside and on the turning racks. The four slicer toaster had a heavy amount of brown and black crumbs inside the bottom of the toaster. -The cart which held the slicer had brown crumbs around the slicer. Both sides of the cart had brown and white streaks going down the sides of the cart. -Inside the bottom of the hot box there was a large amount of tan and white crumbs. -There was one box of cod filets open to air in the walk in freezer. No ice was observed on the fish and it was observed that fish was on the lunch menu today. 2. During a tour of the kitchen and meal observation, on 1/13/26 at 11:40 a.m., the following concerns were observed: -The area under the flat top grill remained with brown soil and grease. -The fryer remained with the crumbs inside the oil and the shelf. -The flat top grill had dried yellow egg on it and the inside edges of the flat top all around it had brown food and grease crumbs in the creases. -Two of two closed food carts and two of two open shelf food carts had brown and white particles on the inside bottoms of the cart and on the tray shelves. -The dish washer food traps under the machine and on the top left side of the machine had a heavy amount of brown and yellow food pieces in it along with pieces of plastic and bread ties. -The top of the dishwasher had a heavy amount of tan and brown particles on it. -The dish washer had the same three streaks running down the front of the machine. There were also brown and tan particles in the streaks. -There was a moderate amount of eggs, cucumbers and oatmeal on the side after the items came out to the clean side of the machine. Steam table pans were observed in the racks above the food particles. -The hot plate machine had streaks which went down the sides of it. The top around the openings of the dish storage had white spots. 3. During an observation in the kitchen, on 1/16/26 at 11:25 a.m., the following concerns were observed: -Heavy food particles in the trap in front of the entrance to the dish machine and in the trap below - the items consisted of green beans, red pepper, pieces of paper, bacon, sausage and egg pieces. During an interview with the Dietary Manager at this time, she indicated the machine was drained and all food traps were cleaned every night. If it was a bad day, then it would be changed sooner. -The slicer had a light amount of pink substance on the slicer blade. When shown to the Dietary Manager, she indicated it was last used 2 weeks ago but someone must have used it since then without cleaning it. The pink substance on the slicer blade was not present on (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 1/13/26 at 9:00 a.m. observation.-The top convection oven had a heavy soil of small black particles inside the bottom which were able to be wiped away.-The right outer side of the convection oven had a heavy soil of small brown and black particles on it.-The four slice toaster remained with the heavy build up of brown food crumbs in the bottom.-The inside of two closed food carts and two open shelf carts had brown and white spills on the shelf edges and bottom. Trays were already set up on the carts waiting for the meal plate.-The fryer oil was clean but the shelf inside remained with brown food crumbs. The three sides of the fryer remained greasy and sticky to the touch.-The inside of the hot box had a large amount of tan and white food crumbs on the bottom. Two pans of baked sweet potatoes were inside uncovered. Review of the Daily Role Based Daily Cleaning Schedule for Week 1/11/26 through 1/16/26, indicated the following equipment was signed off as having been cleaned daily: clean top oven, clean stove top/grill, clean Healthcare steam table, clean warmer 2, clean oven bottom, and clean fryer. Review of the Daily Kitchen/Food Service Observations between 11/10/25 and 1/8/26, completed by the Dietary Manager, indicated the following areas were marked as completed with no issues: -Food Surfaces were thoroughly cleaned and sanitized.-Equipment (e.g. food grinders, choppers, slicers, toasters, fryers, microwave, can opener, oven, stove burners, stove top, vents, drip pans and mixers) were clean.-Dishware was stored in a clean, dry location and not exposed to splash, dust or other contamination, and covered or inverted.-Cleaning schedule for the kitchen and food service equipment was followed.-All cleaning logs were completed and initialed by staff assigned.-Deep fryer is clean to include area around the deep fryer was clean, free of debris and grease. There were a few days on the form when the cleaning schedule needed initialing during the first few days of monitoring. There were no further observations of the kitchen by the Dietary Manager after 1/8/26. The facility's current policy on Kitchen Sanitation included, but was not limited to, Cleaning and Sanitation of Dining and Food Service Areas: Policy: The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. Procedure: 1. 2. The director of food and nutrition services will determine all cleaning and sanitation tasks needed for the department. Tasks shall be designated to be the responsibility of specific positions in the department. 3. Staff will be trained on the frequency of cleaning as necessary. 4. The methods and guidelines to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. 5. The methods and guidelines to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks completed. 6. Staff will be held accountable for cleaning assignments. 3.1-21(i)(3)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure glucometers were cleaned per guidelines for infection control when obtaining blood sugar readings for 4 of 4 residents observed for glucometer use. (Residents 71, 45, 33, and 7) Findings include: 1. During an observation, on 1/14/26 at 10:59 a.m., Licensed Practical Nurse (LPN) 4 indicated that each resident had their own glucometer. The LPN entered Resident 71's room and completed the accu-check (blood sugar monitoring). The resident's blood sugar reading indicated 296 milligrams per deciliter (mg/dL). The LPN administered the required dosage of Lispro insulin. The LPN had placed the glucometer back into the resident's glucometer holder in the top drawer of the medication cart, without cleaning it. There was no visible blood or stains on the glucometer. During an interview, on 1/14/26 at 11:02 a.m., LPN 4 indicated the glucometers were usually cleaned after he had obtained all of each resident's blood sugar readings during the day. I can clean it if you want me to. He obtained the Sani-Cloth wipe and cleaned the glucometer within 15 seconds and placed it back into the resident's glucometer holder. He indicated he cleaned it for 30 seconds and let it dry in the resident's holder for 2 minutes. He opened the glucometer holder and indicated it was still wet. The record for Resident 71 was reviewed on 1/16/26 at 10:56 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, anemia, morbid obesity due to excess calories, and hyperlipidemia. The Health Status note for the admission review, dated 1/15/26, included, but was not limited to, the resident had diabetes with routine accu-checks and insulin administration. 2. During an observation, on 1/15/26 at 11:02 a.m., LPN 5 entered Resident 45's room to obtain a blood sugar reading which indicated 193 mg/dL. The LPN cleaned the glucometer by wrapping it in a Sani-Cloth wipe and set it on the medication cart on a tissue. The LPN indicated she would let it set for over 2 minutes. There was no visible blood or stains on the glucometer. The record for Resident 45 was reviewed on 1/16/26 at 11:43 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, morbid obesity due to excess calories, and pure hypercholesterolemia. During an interview, on 1/15/26 at 11:43 a.m., LPN 5 indicated the glucometer would be cleaned after the blood sugar reading was obtained. It should be cleaned for 2 minutes. She should use the Sani-Wipes to wash and rub it or wrap it in the Sani-Wipes. She would leave it there for 2 minutes. She didn't feel that the glucometer would be cleaned well if she just wrapped it and did not wipe it. 3. During an observation, on 1/15/26 at 11:14 a.m., Resident 33's accu check was completed by LPN 3. The Glucometers for each resident requiring an accu checks were in the top drawer of the medication cart, but the LPN used a glucometer laying freely in the cart. The LPN cleaned the glucometer for 15 seconds prior to checking the resident's blood sugar. The result was a blood sugar reading of 184 mg/dL. The LPN indicated she would clean the glucometer but laid it on the medication cart and left to get another resident to test in the Main Dining Room. There was no visible blood or stains on the glucometer. She returned and cleaned the glucometer for 10 seconds and laid it on the medication cart on a tissue for two minutes. The LPN indicated the resident did not want to leave a game she was playing in the dining room. She would test another resident's blood sugar. The record for Resident 33 was reviewed on 1/16/26 at 11:15 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, acute kidney failure, and hydronephrosis. 4. During an observation, on 1/15/2026 at 11:25 a.m., Resident 7's blood sugar reading was obtained by LPN 3. The same glucometer was used to test the resident as was used for the other residents requiring accu checks on the hall. The result of the accu check indicated a blood sugar reading of 213 mg/dL. 5 units of Lispro were required per sliding scale order. The glucometer was laid on the top of the medication cart. There was no visible blood or stains on the glucometer. The insulin was administered by vial and syringe. The glucometer was left on the medication cart as the LPN left to check on the previous resident to see if she was ready to leave her game for the blood sugar check without cleaning it. The LPN indicated she wiped off the glucometer, which the LPN had not done. The LPN (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed the glucometer in the medication cart's top drawer uncleaned. The record for Resident 2 was reviewed on 1/16/26 at 12:15 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, dementia, Alzheimer's disease, morbid obesity, dysphagia, and hyperlipidemia. During an interview, on 1/15/26 at 11:38 a.m., LPN 3 indicated she should clean the glucometer for two minutes or one minute. The glucometer should stay wet for 15 or 30 seconds. The Sani-Cloth wipe was used to clean the glucometer. She indicated she probably didn't clean the glucometer between the residents. Typically, the residents don't share the same glucometer, but they were out of strips for their own glucometers. The LPN was told those couldn't be located. She should clean the glucometer before the blood sugar was obtained and after it was obtained. The LPN then pulled the glucometer from the top drawer of the medication cart and wiped it down. During an interview, on 1/15/26 at 1:10 p.m., the Director of Nursing (DON) indicated the staff should clean the glucometer after each use. They could let the glucometer lay wrapped in the Sani-Cloth wipe to keep it moist. She wanted to check the manufacturer guidelines. During an interview, on 1/15/25 at 1:58 p.m. the Infection Preventionist (IP) indicated for cleaning the glucometer, the nurse would place a clean paper towel on the surface and clean the glucometer with the Sani-cloth thoroughly. She indicated by thoroughly; she would turn the glucometer front and back to clean with the Sani-cloth and then lay it to dry on the paper towel. It had to be cleaned first before wrapping the glucometer. They couldn't just wrap the glucometer. For one glucometer to be used for all residents, it should be allowed to dry before going to the next resident. The current manufacturer guidelines for Germicidal Disposable Wipe use, included, but were not limited to, . To Disinfect and Deodorize Hard, Nonporous Surfaces: If present, use a wipe to remove visible soil prior to disinfecting. Unfold wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry. The Environmental Protection Agency [EPA] Regulatory [Reg]. Number [No].: was 9480-4, EPA Establishment [Est]. No.: 9480-NY-1. The Cleaning and Disinfection of Resident-Care Items and Equipment policy, revised July 2014, included, but was not limited to, . d. Reusable items are cleaned and disinfected or sterilized between residents. (1) Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards. The current Infection Control for Glucose Testing policy, included, but was not limited to, . Utilize Sanicloth to clean glucometer. Contact time for Sanicloth is 2 minutes. glucometer must stay wet with Sanicloth for those 2 minutes. To achieve this, wrap glucometer with Sanicloth and glucometer in dedicated container. Each resident should have their own glucometer and supplies (if applicable) located in individual containers to ensure proper infection control. Each glucometer must be label with resident's name.3.1-18 (j)3.1-18 (l)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, record review, and interview, the facility failed to ensure residents' choices for likes, dislikes and requests for special food items on their food trays cards were honored at every meal. This deficient practice affected 19 of 64 residents reviewed for tray cards. (Residents 7, 8, 9, 10, 13, 17, 20, 34, 38, 40, 51, 55, 57, 58, 62, 63, 64, 65, and 66) Findings include: During an interview with Resident 7 on 1/13/26 at 9:45 a.m., she indicated that she frequently did not receive what was ordered on her tray card. During an interview with Resident 51 on 1/13/26 at 9:50 a.m., she indicated the kitchen was not following what was written on their tray cards. She indicated that her tray card, under dislikes, listed No Sausage or Eggs, but she still received them every morning anyway. She sent them back every time as she did not eat them. Observation of her tray card at this time, indicated sausage and eggs were listed under the dislike section. Observation of her plate indicated she received sausage and eggs for breakfast. During an observation of the main dining room lunch tray cards, on 1/13/26 between 12:45 p.m., and 1:30 p.m., the following concerns were observed: Resident 17's tray card indicated no green beans; she was given pureed green beans. Resident 20's tray card indicated he was to receive power mashed potatoes (fortified) and gravy; gravy was not on the tray. Resident 64's tray card indicated she was to have gravy with her meal; no gravy was served. Resident 62's tray card indicated no beans; was served green beans. Resident 58's tray card indicated he was to have extra gravy or sauce; gravy not on the meal tray. Resident 65's tray card indicated she was to receive a bowl of gravy with her meals; no gravy was on the tray. Resident 63's tray card indicated he wanted a grilled cheese and extra gravy with his meal; he did not receive either item. Resident 38's tray card indicated no green vegetables and extra gravy; he was given green beans and did not receive the gravy. Resident 34's tray card indicated the resident was to have peanut butter with every meal; he did not receive the peanut butter. An observation on 1/13/26 at 1:35 p.m. of Resident 40's tray card and meal tray indicated the tray card listed he did not want pasta. He was served puree pasta on his tray. During an observation of room meal trays and tray cards on 1/14/26 between 8:15 a.m. and 8:40 a.m., the following was observed: Resident 51's tray card indicated she was to get peanut butter with all meals. No peanut butter was on the tray. The resident at that time indicated she kept a stash of peanut butter because it was frequently not always on her tray as ordered. Resident 57's tray card indicated she did not like scrambled eggs and was crossed out on the card. Observation of her tray at that time indicated she was served scrambled eggs. The resident indicated that happened frequently that the kitchen served her items she had indicated she did not like. She also indicated that that was also the reason she had a lot of her food brought in from the outside. Resident 58's tray card indicated he was to have yogurt on his tray for breakfast. No yogurt was observed on the tray. After discussing the missing item from his tray with LPN 7 (Licensed Practical Nurse), she indicated she would go get him some yogurt. During the Resident Council meeting on 1/14/26 at 11:00 a.m., the residents indicated the kitchen was not honoring their food preferences and dislikes. The Resident Council President Resident 8 also indicated he ordered corn flakes every morning on his tray card and had never gotten it like he wanted. During an observation of room lunch meal trays and tray cards on 1/14/26 between 12:45 pm and 1:10 p.m., the following was observed: Resident 10's tray card indicated he was to receive fortified pudding at lunch and supper. No fortified pudding was on his tray. Resident 51's tray card indicated she was to receive power potatoes at lunch and supper every day. No potatoes were on her tray. She indicated at that time that she wondered what the power potatoes were and that she would have eaten them if they were on her tray. Resident 66's tray card indicated she was to have power potatoes. No potatoes were on her tray. LPN 7 indicated at that time that they were getting her some potatoes since they were not on her tray. Resident 58's tray card indicated he was supposed to have one cup of milk and extra gravy or sauce with his lunch. Neither item were on his meal tray. A random interview on 1/15/26 at 9:50 a.m. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 57 indicated she again received scrambled eggs on her tray even though it was listed as a dislike. When asked if she had notified anyone that she was continuing to receive scrambled eggs every morning and sent it back to get something else, she indicated she had not, as she did not want to been seen as a pest. On 1/15/26 at 1:05 p.m., Resident 55's family member voiced her concern over the resident having difficulty eating due to not following the items listed on his tray card. The card indicated he was a vegetarian who disliked eggs, gravy and meat. The family member indicated the resident did not eat meat and that previously, the facility used to send him tomato soup, but had since stopped. Now all they offered was chicken noodle soup which he could not eat. No other soup was offered. The family member indicated she had told several management staff about the issue but the kitchen continued to only offer chicken noodle soup. She also indicated that the company the facility used to stock food items, had little cans of tomato soup at one time. The family member indicated she would gladly heat up the soup for the resident when it came on his tray. The family member also indicated that it was extremely difficult to feed the resident his grilled cheese sandwich without being able to dunk it in the tomato soup to soften it. Right now she was having to dunk the sandwich in water to soften it. During an interview with the Dietary Manager, on 1/16/25 at 11:45 a.m., she was asked if it was possible to order small cans of tomato soup from their food distributor. She indicated that she could just place the soup on the order sheet and would come on the next truck in a few days. She did not know why it had been stopped being ordered. Also spoke with her regarding Resident 55's family request for tomato soup as the only soup being offered was chicken noodle soup which he could not eat. The Dietary Manager indicated everyone knew Resident 55 could not eat chicken noodle soup and that she would add tomato soup to his tray card when it came in. During this interview, the Dietary Manager also indicated the Registered Dietitian would see the resident right after admission or readmission or the next day or when changes occurred. She also indicated she saw each resident when first admitted to get their likes and dislikes and special requests. She indicated there was a check off sheet the dietary staff were supposed to follow to ensure all items were on the tray and the resident was not served something they did not like. When informed of there being several observations of the residents missing items on their tray or they were receiving food they did not like as listed on their tray card, she indicated the dietary staff must have been rushing when completing food trays and were not watching carefully. The Resident Rights given to all employees upon hire and yearly, indicated the following: .Living Accommodations and Care Rights: To receive care in a manner which promotes and enhances your quality of life. This includes food of the quantity and quality to meet your needs and preferences. The facility's current policy on Meal Identification and Preference Cards/Tickets, dated 2019, included, but was not limited to, Policy: A meal identification and food preferences card (meal ID card/ticket) will be used to properly identify each individual's needs including food and beverage preference. Procedure: 1. The Director of food and nutrition services or designee will visit a new admitted individual to obtain food and beverage preferences, dislikes and food allergies/intolerances before a permanent meal ID card/ticket is written. 3. The permanent meal ID card/ticket should include the name of the individual, diet order, beverages preferences, food dislikes and any other applicable information. 4. Meal ID card/tickets will be used during meal service to assure the correct diet is being served and food preferences are honored. 3.1-3(a)		

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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 who was incontinent of urine received the necessary care and services of brief changes before the brief and bed padding underneath the resident was not overly saturated with urine for 1 of 4 residents reviewed for Activities of Daily Living. (Resident 13) Findings include: During an observation, on 1/13/26 at 10:00 a.m., upon entering Resident 13's room, there was a strong odor of urine and feces present. Observation of Resident 13 in bed, indicated the resident was lying on a draw pad under her which was observed to have a light brown stain that covered the whole pad, within an inch of the edges. The resident's brief and pad was observed to be saturated with urine. A second observation of the resident's room, on 1/13/26 at 2:30 p.m., the soiled pad remained on her bed and was still wet to the touch. The resident was in an activity at this time. During an observation of the resident and her bed, from 1/14/26 to 1/21/26, with a confidential informant, the resident's brief was observed to be heavily saturated with urine as well as the pad underneath her. The confidential informant indicated the resident was soaked and that she was going to change the resident and her bed even though it wasn't her section. During the confidential interview, it was indicated that this happened more often than it should as it seemed like night shift was not changing the residents before they left for the day. The informant indicated that upon arrival to their shift, the staff were supposed to do a walk through and checked the residents before starting their duties. If a resident was wet, the person responsible for that resident's care was notified the resident needed to be changed. The record for Resident 13 was reviewed on 1/15/26 at 9:30 a.m. The resident's diagnoses included, but were not limited to, Parkinson's disease without dyskinesia, rheumatoid arthritis, dementia, chronic pain, and history of urinary tract infections (UTIs). The Quarterly Minimum Data Set (MDS) assessment, dated 10/30/25, indicated the resident had severe cognitive impairment; occasionally felt down or depressed; was dependent on staff for toileting hygiene; was always incontinent of bladder, and was at risk for the development of pressure ulcers. A care plan, with a revision date of 1/14/26, indicated the resident was always incontinent of bowel and bladder and had large amounts of urine. The goal was for the resident to remain free from skin breakdown due to incontinence and brief use. The approaches included, but were not limited to, check as required for incontinence and observe and document number of voids. The Braden Scale for Predicting Pressure Sores, dated 11/6/25, indicated the resident was at moderate risk for pressure sores; sensory perception was slightly limited; skin was often very moist with linens needing to be changed at least once a shift; could not bear own weight and needed assistance into a wheelchair; the ability to change and control body position was slightly limited as the resident could make slight changes in body or extremity position independently; food intake pattern was inadequate as she rarely completed a meal and generally ate only half of any food offered; and, also was able to maintain relatively good position in her chair or bed most of the time but occasionally slid down. The physician's order, dated 7/4/24, indicated staff were to apply the house barrier cream to the resident's perineal area and the buttocks after each incontinent episode as needed and a pressure relieving mattress (6 inch foam mattress). During an interview, on 1/14/26 at 8:15 a.m., with the Certified Nurse Aide (CNA) 8 she indicated she had changed the resident when she first came on duty at 6:30 a.m. and that the resident was frequently incontinent of a large amount of urine. On 1/20/26 at 9:21 a.m., the Director of Nursing (DON) provided the January 2026 Medication Administration Record (MAR) for Resident 13. Review of this form indicated a skin assessment was checked off as being completed. The record lacked an actual assessment of what the skin looked like. 3.1-41(a)(1) 3.1-41(a)(2)		

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with a history of Urinary Tract Infections (UTIs) was provided proper management of the urinary catheter drainage system by maintaining the drainage system off the floor for 1 of 4 residents reviewed for bowel and bladder. (Resident 33) Findings include: During an observation, on 1/13/25 between 12:00 p.m. and 1:00 p.m., Resident 33 had been in the dining room for 60 minutes with her urinary catheter collection bag and tubing sitting on the floor. The resident had been rolling in her wheelchair back and forth across the catheter tubing with the wheelchair wheels. There were multiple staff members in the dining room at that time. During an observation, on 1/15/26 at 8:30 a.m., Resident 33 was lying in bed and just finished eating her breakfast. Her foley catheter was sitting on the floor with no barrier between the indwelling urinary catheter collection bag and the floor. During an observation, on 1/15/25 at 1:00 p.m., Resident 33 was wheeling down the hall from the dining room dragging the indwelling urinary catheter collection bag and catheter tubing. During an interview, on 1/14/25 at 1:20 p.m., Licensed Practical Nurse 9 (LPN) indicated the resident's catheter was always falling to the floor. During an interview, on 1/15/25 at 1:40 p.m., the DON indicated therapy had gotten the resident a new wheelchair and she thought the chair was too low to the ground. The facility would be ordering urine drainage bags to hang on the back of the wheelchair to prevent the catheter collection bag from falling on the floor. The resident self-transferred herself to and from the chair. The DON told the staff to watch for the catheter bag and tubing, and made sure they hang it on the back of the wheelchair off the floor. The record for Resident 33 was reviewed on 1/15/26 at 10:25 a.m. The resident's diagnoses included, but were not limited to, obstructive and reflux uropathy, hydronephrosis, retention of urine, chronic kidney disease stage 3, and personal history of urinary tract infections. The care plan, dated 11/23/24, indicated the resident was at risk of complications related to Chronic UTIs. The interventions, dated 11/23/24, included, but were not limited to, encourage fluids as tolerated, observe for changes in output, observe for signs and symptoms of UTI. The care plan, dated 11/5/25 and revised 11/10/25, indicated the resident had an indwelling catheter upon readmission on [DATE]. The interventions, dated 11/5/25 and revised 11/10/25, included, but were not limited to, check tubing for kinks each shift, monitor for pain/discomfort due to the catheter, and monitor for signs of a UTI: pain, burning, blood tinged urine, cloudiness, increased pulse, increased temperature, foul smelling urine, chills, altered mental status, change in behavior. The care plans lacked documentation of any interventions related to placing a barrier between the indwelling urinary catheter collection bag and the floor. A physician's order, dated 11/5/25, indicated the resident was to have the indwelling urinary catheter collection bag changed, as needed for occlusion. A physician's order, dated 11/12/25, indicated the resident was to be in enhanced barrier precautions. The staff were to put on appropriate personal protective equipment (PPE) for all high-contact resident care followed by proper removal of the PPE and then complete handwashing. The Quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated that the resident was cognitively intact. The resident had an indwelling catheter and was always incontinent of stool. The resident required partial assistance for any transfers. A nurse's note, dated 1/10/26 at 11:28 a.m., indicated the resident pulled her catheter out. Resident 33 indicated to staff that she pulled her catheter out by accident. The catheter was then reconnected, and the resident was encouraged not to pull on her catheter. A nurse's note, dated 1/14/26 at 4:00 p.m., indicated that the resident came to the nurse's station saying my catheter came out. The catheter was inserted without difficulty with clear yellow urine return by the nursing staff. A physician's order, dated 1/15/26, indicated the resident would have a urinary leg bag placed on her lower extremity every morning. A physician's order, dated 1/15/26, indicated the resident would have the urinary collection bag placed back on at bedtime. The current policy, titled The Catheter Care, (continued on next page)		

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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 01/20/2026
NAME OF PROVIDER OR SUPPLIER Westminster Village Kentuckiana		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 Greentree N Clarksville, IN 47129	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Urinary was provided by the DON on 1/15/25 at 11:15 a.m. The policy indicated, Purpose: The purpose of this procedure is to prevent catheter associated urinary tract infections.Maintaining Unobstructed Urine Flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Infection Control: 2.b Be sure the catheter tubing and drainage bag are kept off the floor. 3.1-41(a)(1)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, record review, and interview, the facility failed to ensure residents were provided with the adaptive equipment necessary to maintain independence while eating or drinking for 1 of 1 resident who utilized adaptive feeding equipment reviewed. (Resident 9) Findings include: During a dining room observation, on 1/13/26 at 12:50 p.m., the tray card for Resident 9 indicated he was to have a two handled cup for liquids. No two handled cup was present and he was drinking from plastic cups with no handles for his tea and water. An interview with the Staff Coordinator, on 1/13/26 at 1:00 p.m., she indicated as far as she knew, the resident did not require any specific adaptive devices at meal times. During a second observation of the dining room on 1/16/26 at 12:45 p.m., Resident 9 was observed drinking his shake, water and tea from a regular plastic cup. No two handled cups were in sight. The record for Resident 9 was reviewed on 1/16/2026 at 1:39 p.m., The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, transient cerebral ischemic attack, generalized muscle weakness, essential tremor, and dysphagia, oropharyngeal phase. The Quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident had moderate cognitive impairment; required supervision and assistance for eating after tray set up; and impairment of bilateral upper extremities in functional Range of Motion (ROM). A care plan, dated 10/16/25, indicated the resident had a nutritional problem or potential problem related to mechanically altered and therapeutic diet, was underweight, received hospice care, and had a diagnosis of dysphagia. The goal was for the resident to consume food and fluids of choice. The interventions included, but were not limited to, two handled cup at all times. A physician's order, dated 7/3/24 with a revision date of 12/8/25, indicated the resident was to receive a regular diet with mechanical soft texture, with regular or thin liquids consistency. He was supposed to have a two handled cup for liquids. An interview, dated 1/16/26 at 1:30 p.m., with Dietary aides 11 and 12 indicated, they indicated they were responsible for making sure the residents had whatever adaptive equipment they required when the tray was set up. The adaptive cups and silverware were available right on the tray below on the cart. When asked if they knew if Resident 9 required any adaptive equipment for his meals and beverages, they indicated they were not aware of him needing anything. When they were shown the resident's tray card where it indicated the resident required a two handled cup for all liquids, they indicated they would make sure he got it from now on. During an interview with RN 13 and CNA 8, on 1/20/26 at 10:53 a.m., they indicated the resident had issues with his hands. He needed the two handled cup because of the way he grabbed things. He used it at breakfast and lunch. He had a tendency to spill things if he did not use the cup. Review of the facility's current policy on Adaptive Equipment, included, but was not limited to, Adaptive (Assistive) Eating Devices: Policy: The facility will provide special eating equipment, utensils, and assistance as appropriate to assure that each individual can use the adaptive (assistive) device when consuming meals and snacks. Procedure: 1. Individuals will be evaluated on admission, and periodically to assess the need for adaptive (assistive) devices. Referrals for needed equipment may come from speech therapy, occupational therapy, nursing, the physician or designee, the registered dietitian nutritionist (RDN) and/or designee. 2. Individuals will be referred to the therapy department as needed to evaluation for adaptive (assistive) devices. 3. A written order must be obtained for adaptive (assistive) devices. 4. Adaptive (assistive) devices should be noted on each individual's meal identification (ID) card/ticket and in the person centered care plan and/or in the medical record. 5. The food and nutrition services department will be responsible for ensuring that each individual receives the appropriate feeding devices as ordered for each meal. Adaptive (assistive) devices will be cleansed and sanitized, then stored in the kitchen and provided for each meal and/or snack as appropriate. 3.1-21(h)		