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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Village Health & Rehab	1120 E Davis Dr Terre Haute, IN 47802

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 0689 Level of Harm - 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 interview and record review, the facility failed to ensure a resident was mechanically transferred safely resulting in harm when a resident had a fall from the mechanical lift and had a left clavicle fracture and laceration to the back of the head for 1 of 3 residents reviewed for falls (Resident C). The deficient practice was corrected by 3/8/26 prior to the start of the survey and was therefore Past Noncompliance. Findings include:A Facility Reported Incident (FRI), dated 3/9/26 at 4:14 p.m., indicated Resident C had a fall during a mechanical lift transfer. Staff administered first aid and pain management and transferred the resident to the emergency room for further evaluation and treatment for a left clavicle fracture and laceration to the back of her head. Resident C's clinical record was reviewed on 3/12/26 at 10:10 a.m. Diagnoses on Resident C's profile included metabolic encephalopathy, history of stroke, muscle weakness, and respiratory failure.ˆ A 5-day scheduled Minimum Data Set (MDS) assessment, completed on 1/18/26, assessed the resident as being severely cognitively impaired. The resident was dependent on staff for transfers and did not walk. There was no documentation of falls in the six months prior to the assessment. ˆ A care plan, dated 10/13/23, indicated Resident C had an activities daily of living (ADL) self-care performance deficit related to cerebral infarction due to embolism of unspecified cerebral artery (stroke). Interventions included she required the assistance of one to two staff for bed mobility and maximum assistance of two staff with a mechanical lift for transfer. A nursing progress note, dated 3/7/26 at 7:20 p.m., entered by LPN 2, indicated the resident had a fall incident during a mechanical lift transfer. The resident was being transferred from the wheelchair to the bed using a mechanical lift, assisted by two Certified Nursing Assistants (CNAs). The resident had fallen to the ground hitting her left shoulder on the base of the mechanical lift and the back of her head. The resident showed signs of pain by grimacing, moaning, and crying. The ambulance was contacted immediately. An emergency room Discharge note, dated 3/7/26 at 7:29 p.m., indicated Resident C had arrived in the emergency department at 7:29 p.m. and was discharged back to the facility at 11:41 p.m. She was found to have a closed left clavicular fracture and a hematoma of the scalp with laceration requiring closure occurring from a fall. A written statement, dated 3/7/26, signed by CNA 3, indicated CNA 4 and her were putting Resident C to bed. She had hooked three straps on her and hooked the two bottom ones and one on the top of the lift. CNA 4 had hooked the other top strap. CNA 4 started to lift the resident and when she was in the air, CNA 3 pulled the wheelchair away. The strap came undone and CNA 4 tried to catch her. When the resident was on the ground, CNA 3 went and got the nurse. A written statement, dated 3/7/26, signed by CNA 4, indicated they had hooked up the resident to the mechanical lift. When she began to operate the lift, CNA 3 pulled the chair away from the lift and the resident fell. It happened very fast. The lift became unhooked from the left side, and the resident fell to the floor. Interviews with the two CNAs were attempted but unsuccessful during the survey. During an interview on 3/12/26 at 1:26 p.m., the Administrator indicated Resident C had slipped out of the mechanical lift sling onto the floor, striking her head and right shoulder on the base of the lift. During her investigation, it was determined that one of the straps probably had not fully engaged on the lift and had slipped from its position. This was the only explanation why one of the straps would come (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 0689 Level of Harm - Actual harm Residents Affected - Few	loose. On 3/13/26 at 10:25 a.m., the Administrator provided a Using a Mechanical Lifting Machine Policy, revised July 2017, and indicated the policy was the one currently being used by the facility. The policy indicated, .The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device.Steps in the Procedure.12. Attach sling straps to sling bar.a. Make sure the sling is securely attached to the clips and that is it properly balanced.c. Before resident is lifted, double check the security of the sling attachment. d. Examine all hooks, clips or fasteners. e. Check the stability of the straps. The deficient practice was corrected by 3/8/26 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included the following actions: The mechanical lift was inspected by the Administrator following the incident. The maintenance director and a manufacturer representative also inspected all mechanical lifts in the facility. All residents requiring extensive or total assistance with transfers, those requiring mechanical lifts and those utilizing reclining wheelchairs for mobility were identified and all care plans reviewed for consistency and clearly defined transfer assistance levels. All staff emergency in-service training for 100% of the licensed nurses and nurse aides regarding safe transfer techniques, care plan adherence and manufacturer specifications. Training included demonstrated practical competence. Ongoing auditing and tracking to be followed by the Interdisciplinary Team/QAPI Committee. This citation relates to Intake 2800134. ˆ 410 Indiana Administrative Code (IAC) 16.2-3.1-45(a)(2)