STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155221	A. Building B. Wing	07/01/2026

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 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 that a physician was notified of STAT (immediate) lab results and a resident's change in condition related to low platelet count and increased confusion for 1 of 5 residents reviewed for hospitalization (Resident B). Findings include:During an interview on 6/25/26 at 9:22 a.m., Resident B indicated he had been sent out to the hospital a couple of times in the month of May 2026. During an interview on 6/29/26 at 3:53 p.m., Resident B indicated he could not recall how he was feeling the days prior to being sent out to the hospital, I was completely out of it. During a confidential phone interview on 6/29/26 at 4:18 p.m., Resident B's family member indicated they had visited the resident at the long-term care facility on the night of 5/9/26. They were concerned about the resident because he was seeing things that weren't there and talking out of his head. The family member indicated they had spoken to Resident B earlier in the week on the phone and the resident didn't sound right at that time. The resident was known to be highly intelligent and alert and he was not acting like himself. The family member approached the nurse's station to express their concerns to the nurse on duty and the nurse indicated she was an agency nurse and would not know what the resident's base line was. The family member requested the most recent lab results and the agency nurse indicated she did not have access to the labs, and they would have to wait until Monday when someone else could help them. The family member indicated she had to insist on the nurse calling the doctor and getting an order to send Resident B out to the hospital to be evaluated. During a confidential phone interview on 6/30/26 at 8:18 a.m., Resident B's family member indicated she was visiting with the resident on 5/8/26 and the resident could not complete a crossword puzzle (which was usually a simple task for him). She indicated the resident was hallucinating (seeing things that weren't there). She indicated the facility did not notify her of his lab values or his blood pressure running low. She was dissatisfied that she had to hear from a family member that the resident was going out to the hospital for evaluation instead of it coming from the nurse on duty. During an interview on 6/30/26 at 11:08 a.m., Certified Nurse's Aide (CNA) 11 indicated she had noticed Resident B was more confused than usual, but she could not remember if it started the day he was sent out to the hospital or before. Resident B's record was reviewed on 6/29/26 at 11:49 a.m. The profile indicated the resident's diagnoses included, but were not limited to, urinary tract infection (bacterial infection in any part of your urinary system), hypothermia (dangerously low core temperature), toxic encephalopathy (a neurological disorder caused by brain dysfunction from exposure to harmful substances), and chronic kidney disease, stage 4 (an advanced phase characterized by severe loss of kidney function). A care plan, dated 1/23/25, indicated the resident had hypertension (elevated blood pressure) and atrial fibrillation (irregular heartbeat). Interventions included, but were not limited to, monitor blood pressure, notify the physician of any abnormal readings. A care plan, dated 4/11/25, indicated the resident was on anticoagulant (blood thinner) therapy related to atrial fibrillation. Interventions included, but were not limited to, labs as ordered, report abnormal lab results to the doctor, notify doctor of sudden changes in mental status and significant or sudden changes in vital signs. A 5-day Medicare Minimum Data Set (MDS) assessment, dated 6/7/26, indicated the resident was cognitively intact and was dependent on staff for assistance with showers and toileting. Review of Nurse Practitioner progress note, dated (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/6/26 at 2:47 p.m., indicated she had seen Resident B. He had been having decreased blood pressures and was not feeling well. Review of routine laboratory order, dated 5/6/26, indicated to obtain CBC (complete blood count), CMP (complete metabolic panel), and Mag (magnesium) one time only for 1 day. Review of laboratory report, with a collection date of 5/6/26 at 7:14 a.m. and received date of 5/6/26 at 12:56 p.m., indicated a critical level of platelets (tiny, colorless cell fragments in your blood that form clots and stop bleeding) of (34), normal range 150-450. There were several other labs that were out of range on the report as well. The record lacked documentation of when the lab called the facility with the critical platelet lab value. Review of nursing progress note, dated 5/7/26 at 1:35 p.m., indicated the Medical Director was notified of Resident B's low platelet levels and new orders received to have a STAT CBC drawn and send copies of labs to nephrologist (doctor that specializes in kidney diseases) and refer to hematologist (doctor specializes in blood disorders). The record lacked documentation that labs were sent to the nephrologist and lacked documentation of a referral being sent to the hematologist. During an interview on 6/29/26 at 1:35 p.m., Licensed Practical Nurse (LPN) 5 indicated she was unable to find documentation that she had sent the copies of Resident B's lab to the nephrologist. She could not recall if she had faxed the doctor or not. She was in the process of sending the referral to the hematologist before he was sent out to the hospital but did not get completed. Review of vital signs, dated 5/7/26 at 8:21 a.m., indicated Resident B's blood pressure was 91/61. The record lacked documentation of any physician notification of low blood pressure. Review of STAT lab with a collection date of 5/7/26 at 4:54 p.m. and received by lab at 6:27 p.m., indicated Resident B had a low platelet count of 32. The resident also had other lab values that were out of the normal range. The record lacked documentation of the facility notifying the physician of the STAT lab values. Review of vital signs, dated 5/7/26 at 10:15 p.m., indicated Resident B's blood pressure was 102/53. The record lacked documentation of any physician notification of low blood pressure. Review of vital signs dated 5/8/26 at 10:07 a.m., indicated Resident B's blood pressure was 96/40. The record lacked documentation of any physician notification of low blood pressure. During an interview on 6/30/26 at 10:00 a.m., the Director of Nursing (DON) indicated that staff would sometimes have to call the lab for results. The DON was unable to find any documentation of when the facility obtained the results or a physician notification of the STAT lab results. During an interview on 6/30/26 at 11:30 a.m., a laboratory technician (from the hospital where the STAT lab was completed) indicated that when a STAT lab was processed at their facility it should be resulted within 1-2 hours. She indicated a facility was welcome to call them at any time to check on the results and they could relay the information to them when it's available. According to the hospital records Resident B's lab report was sent to the ordering physician on 5/8/26 at 7:02 a.m. The lab tech indicated there was no connection and the first fax didn't go through. The second fax was sent to the fax machine at the nurse's station at the long-term care facility on 5/8/26 at 1:21 p.m. and their records indicated it went through. Review of nursing progress note, dated 5/9/26 at 10:22 p.m., indicated Resident B had family visiting him and the family member complained that the resident did not seem like himself. The family member indicated the resident was hallucinating and was not making sense. Vital signs were obtained and blood pressure was 107/60 with a temperature of 94.4 degrees Fahrenheit. Obtained orders from on call physician to send resident to hospital of choice for evaluation. Resident B left the facility at 10:12 p.m. via ambulance. Review of hospital discharge summary, with an admission date of 5/9/26, indicated Resident B was seen in the emergency room from the long-term care facility due to altered mental status and hallucinations present for 3 days. The resident had an oral temperature of 91.2 degrees Fahrenheit and was hypotensive (low blood pressure) and a platelet count of 32. The resident was not being followed by a hematologist and had no known prior episodes of low platelet per history of family member. The resident was admitted to the hospital until the discharge date of 5/14/26. The resident was admitted to the hospital with the diagnoses including, but not limited to, thrombocytopenia (abnormally low platelet in the blood), hypothermia (low core body temperature), acute metabolic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encephalopathy (disruption of brain function caused by illness, organ failure, or chemical imbalances), and sepsis (the body's extreme, life threatening response to an infection). During an interview on 6/30/26 at 11:59 a.m., the DON indicated they had a nurse that was given re-education on documentation and making sure it was completed timely and as ordered by physician. Education was completed prior to the annual survey indicating the facility was aware of an issue with documentation. On 6/3026 at 11:42 a.m., the DON provided a document with a revised date of 2/21, titled, Change in a Resident's Condition or Status, and indicated it was the current policy being used by the facility. The policy indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's attending physician or physician on call when there has been a(an).d. significant change in the resident's physical/emotional/mental condition.g. need to transfer the resident to a hospital/treatment center. On 6/30/26 at 11:59 a.m., the DON provided a document with a revised date of 4/07, titled, Test Results, and indicated it was the current policy being used by the facility. The policy indicated .The resident's attending physician will be notified of the results of diagnostic tests.1. Results of laboratory, radiological, and diagnostic tests shall be reported in writing to the resident's attending physician or the facility.2. Should the test results be provided to the facility, the attending physician shall be promptly notified of results. This citation relates to Intake 3018299. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(b)