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	04/28/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview the facility failed to indicate the full code status of a resident upon admission to the facility according to a POST (physician's order for scope of treatment) form for 1 of 24 records reviewed. (Resident 271) Findings include: On 4/22/25 at 9:45 a.m., the medical record of Resident 271 was reviewed. The medical record indicated the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, infection and inflammation and inflammatory reaction due to other internal joint prosthesis (a medical device, typically an artificial joint, designed to replace or improve the function of a damaged or diseased natural joint), methicillin susceptible staphylococcus aureus infection (a bacterial infection), and hypertension (high blood pressure). A Minimum Data Set (MDS) assessment, dated 4/24/25, indicated that the resident was cognitively intact. A physician order, dated 4/17/25, indicated that the resident chose to be a DNR (Do Not Resuscitate). The medical record lacked evidence of a POST (a form which designates the wishes of the resident regarding resuscitation measures). A care plan, dated 4/18/25, indicated that the resident had an Advanced Directive(s) and had documentation in the medical record related to DNR. On 4/22/25 at 10:46 a.m., during interview, the medical record nurse provided a document titled Indiana Physician Orders for Scope of Treatment POST dated 3/25/25 and verified the form was signed by the resident upon admission to the facility. She indicated the resident was to be a full code at admission and acknowledged the physician order at the time of admission was incorrectly entered as DNR. She provided a copy of an updated physician order dated 4/22/25 that indicated Full Code status. A physician order, dated 4/22/25 at 10:30 a.m., indicated the resident chose to be a Full Code (full resuscitation measures). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 2:20 p.m., during interview the Director of Nursing (DON) indicated when a resident was admitted they would obtain a POST form which indicated the directive of the resident. If the resident was unable to sign the form they would obtain a verbal directive from the responsible party. On 4/23/2025 at 9:28 a.m., the DON provided an undated document, titled, physician orders for scope of treatment (POST), and indicated it was the policy currently being used by the facility. The policy indicated, . IV. Definitions .POST is a physician order that is designed to be a portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings .Policy Statement .The POST form shall be maintained in the front of the resident's medical record 3.1-4(d)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 34525 Based on record review and interview, the facility failed to ensure the timely transmission of a discharge Minimum Data Set (MDS) assessment for 1 of 21 residents MDS assessments reviewed (Resident 56). Findings include: Resident 56's closed record was reviewed on 4/24/25 at 8:53 a.m. The record indicated the resident had been admitted to the facility, on 11/25/24, for diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of lung diseases that cause progressive airflow obstruction and breathing difficulties) and congestive heart failure (CHF-a condition where the heart muscle is weakened and cannot pump blood effectively enough to meet the body's needs). The resident had been discharged back to his home with Home Health Care (medical care provided to individuals in their own homes) on 1/4/25. An admission MDS assessment, dated 12/11/24, indicated the resident had no cognitive deficit, required extensive assistance with his activities of daily living (ADLs-fundamental self-care tasks necessary for daily living, such as eating, bathing, dressing, and moving around), and had a plan to discharge back to his home. A discharge MDS assessment, dated 1/4/25, indicated the resident had been discharged from the facility back to his home. The record lacked documentation that the MDS assessment had been transmitted in a timely manner. During an interview, on 4/24/25 at 11:58 a.m., the Administrator (ADM) indicated the MDS Coordinator was out of the building on a leave of absence. She had contacted her via telephone. The MDS Coordinator had told her that she was unsure about the difference in transmitting an assessment for a regular Medicare versus Managed Medicare (private insurance plans that work with Medicare to cover the same benefits as Original Medicare [Parts A and B] and may offer additional coverage) resident. At the same time, the ADM indicated the facility policy for the MDS transmission would be the RAI (Resident Assessment Instrument) manual. On 4/24/25 at 11:59 a.m., the ADM provided a document, dated October 2024, titled, CMS's (Center for Medicare and Medicaid Services) RAI Version 3.0 Manual, and indicated it was the policy currently being used by the facility. The policy indicated, .Discharge refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in the facility .Any of the following situations warrant a Discharge assessment .Resident is discharged from the facility to a private residence . Discharge Assessment-return not anticipated .Transmission Date No Later Than MDS Completion Date +14 calendar days

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38847 Based on observation, record review, and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were coded accurately regarding the residents' dental status for 2 of 21 MDS Assessments reviewed (Residents 11 and 15). Findings include: 1. On 4/21/25 at 11:27 a.m., Resident 11 was observed with broken and missing teeth. Resident 11's record was reviewed on 4/22/25 at 2:43 p.m. A significant change MDS Assessment, dated 3/6/25, lacked documentation the resident had obvious likely cavities or broken natural teeth. A care plan, initiated on 1/25/24, indicated the resident had the potential for oral and dental problems related to missing teeth and needed assistance with oral care. During an interview, on 4/23/25 at 9:23 a.m., Certified Nurse Aide (CNA) 6 indicated the resident was missing the two front middle teeth on the bottom of her mouth, and there were a couple of other teeth on either side of those that were broken down. 34525 2. During a lunch meal observation, on 4/21/25 at 12:19 p.m., Resident 15's upper dentures were observed to be very loose. The dentures fell off her gums whenever she opened her mouth. She was observed to push the dentures up with her spoon each time she placed the spoon in her mouth. Resident 15's record was reviewed on 4/22/25 at 1:10 p.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes (when the body doesn't make enough insulin [a hormone that helps regulate blood sugar levels] or doesn't use insulin well) and unspecified protein-calorie malnutrition (a deficiency in both protein and calories, leading to various health issues). A significant change Minimum Data Set (MDS) assessment, dated 11/12/24, indicated the resident had severe cognitive deficit and had no documented broken or loosely fitting full or partial dentures. A quarterly MDS assessment, dated 2/4/25, indicated the resident had severe cognitive deficit and had no documented broken or loosely fitting full or partial dentures. A care plan, dated 5/24/22, indicated the resident was at risk for altered dentition related to upper denture with no lower denture per her preference. Interventions included, but were not limited to, obtain dental consultation as ordered and as needed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/22/25 at 2:09 p.m., the Social Services Director (SSD) indicated she had spoken with the resident's son about her loose denture on multiple occasions and he did not want anything done. The facility dental practitioner had indicated that the resident's upper portion of her mouth was so deformed that she was not a candidate for upper dentures anymore.The resident's son insisted that she wear them. He said that he would make an appointment at a local dental office to get this situation looked at, but when she had contacted the company to check on the appointment, no appointment had been arranged for the resident. During an interview, on 4/22/25 at 3:01 p.m., the SSD indicated the resident's denture issue had been an ongoing problem for quite some time. The MDS Coordinator was out of the building on a leave of absence and there was a consultant filling in during her absence. During an interview, on 4/23/25 at 9:22 a.m., Registered Nurse (RN) 5 indicated the resident's loose upper plate often makes it hard to give her medications. She believed the resident's son was aware but had not seemed to be acting on it. During an interview, on 4/23/25 at 9:31 a.m., Certified Nursing Assistant (CNA) 6 indicated the resident's loose teeth often would make it very hard for her to eat. During an interview, on 4/23/25 at 9:39 a.m., the Director of Nursing (DON) indicated she was aware of the resident's upper denture being very loose and that the resident's son had been involved. She was unaware as to why the MDS had not been coded correctly. She believed the RAI (Resident Assessment Instrument) manual would be the policy for the facility. On 4/23/25 at 9:40 a.m., the DON provided a document dated October 2024, titled, CMS's (Center for Medicare and Medicaid Services) RAI Version 3.0 Manual, and indicated it was the policy currently being used by the facility. The policy indicated, .L0200: Dental (cont.) Steps for Assessment .3. If the resident has dentures or partials, examine for loose fit .If the resident is unable to self-report, then observe them while eating with dentures or partials .to determine if chewing problems .are present .Coding Instructions Check L0200A, broken or loosely fitting full or partial denture .Check L0200D, obvious or likely cavity or broken natural teeth 3.1-31(a) 3.1-31(c)(9) 3.1-31(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to ensure a care plan related to dementia care and resident specific interventions were implemented for 1 of 2 residents reviewed for dementia care (Resident 20). Findings include: On 4/22/25 at 2:44 p.m., the medical record of Resident 20 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but were not limited to, unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), psychotic disturbance (when someone experiences a significant disconnection from reality), mood disturbance (a mental health condition where a person's emotional state is significantly and negatively affected), and anxiety (a feeling of fear, dread, and uneasiness). A care plan, dated 11/6/24, indicated that the resident had potential to demonstrate verbally abusive behaviors related to anxiety including false accusations, yelling, cursing at staff, refusal of care, hallucinations, and delusions. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc.; assess resident's coping skills and support system; and attempt one on one (1:1) care. A care plan, dated 12/6/23, indicated that the resident required additional services related to mental health diagnosis and/or intellectual disability. Interventions included rehabilitative services, supportive counseling from nursing facility staff, training in self-healthcare management, family involvement in care, and medication review. The care plan did not indicate the resident had dementia or Alzheimer's (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) nor a diagnosis of Bipolar (formerly called manic-depressive illness or manic depression a mental illness that causes unusual shifts in a person's mood). The medical record lacked evidence of a care plan related to dementia care or resident specific interventions to support a resident with dementia. A Minimum Data Set (MDS) assessment, dated 1/3/25, indicated that the resident was cognitively impaired. On 4/23/25 at 9:00 a.m., during interview the Social Services Director acknowledged the resident did not have a care plan related to dementia care with interventions. She indicated a care plan should have been implemented at the time of admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/2025 at 9:21 a.m., the Social Services Director provided a document, titled, Dementia - Clinical Protocol, dated November 2018, and indicated it was the policy currently being used by the facility. The policy indicated, .Treatment/Management 1. For the individual with confirmed dementia, the IDT (intradisciplinary team) will identify a resident - centered care plan to maximize remaining function and quality of life 3.1-37

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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** 38847 Based on record review, interview, and observation, the facility failed to ensure timely treatment for a urinary tract infection (UTI) (Resident 53) and to ensure Foley catheter (tube inserted into the bladder to drain urine) tubing and drainage bag were not in contact with the floor (Resident 25) for 2 of 2 residents reviewed for catheters. Findings include: 1. Resident 53's record was reviewed on [DATE] at 11:54 a.m. Diagnoses on the resident's profile included, but were not limited to UTI and extended spectrum beta lactamase (ESBL) (enzyme produced by some bacteria that makes them resistant to certain antibiotics). A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had a severe cognitive impairment and an indwelling catheter. A urinalysis (UA) culture and sensitivity (C&S) report indicated the urine specimen was collected on [DATE], and the results were reported to the facility on [DATE]. The UA and C&S indicated two types of bacteria were isolated. Progress Notes, dated [DATE] to [DATE], lacked documentation the physician was notified of the UA and C&S results or an antibiotic was ordered prior to [DATE]. A physician's order, dated [DATE], indicated the resident required contact isolation precautions due to ESBL in the urine. The resident was to remain in isolation for eight days. A physician's order, dated [DATE], indicated to administer ampicillin (antibiotic) 500 milligrams (mg) by mouth three times daily for seven days for UTI. A physician's order, dated [DATE], indicated to administer levofloxacin 500 mg by moth once daily for seven days for UTI. A Medication Administration Record (MAR), dated [DATE], lacked documentation the resident was treated for the UTI prior to [DATE]. During an interview, on [DATE] at 2:34 p.m., the Director of Nursing (DON) indicated the reported date on the UA and C&S lab report was the date the facility received the lab report. She was not sure why the resident was not treated with antibiotics until [DATE] but would look into it. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 9:19 a.m., Registered Nurse (RN) 5 indicated lab results were faxed to the facility when they were available. The Medical Records Nurse normally notified the physician of the results. If there was a critical result the nurse would have notified management, and management notified the physician. On weekends, there was an on call nurse who was notified of critical lab results, and the on call nurse notified the physician. The physician should have been notified of a UTI on the same day the results were received, and normally an antibiotic would have been ordered at that time. Once an antibiotic was ordered they would pull it from the emergency drug kit (EDK) and initiate it that day. A resident should not have waited four days after the results of a UA and C&S were received for an antibiotic to be started. During an interview, on [DATE] at 9:41 a.m., the DON she had looked into the resident's UTI and antibiotic initiation. The DON indicated the facility received the resident's UA and C&S results on [DATE]. The results were reviewed by the physician, and antibiotics were ordered, on [DATE]. She was not sure why it took two days for the physician to review the results. The medication was not available from the pharmacy until [DATE]. She did not think the medications were available in the emergency drug kit (EDK). Normally they would have called and requested the antibiotics be delivered from the back-up pharmacy stat (immediately). The called the pharmacy and requested the medications on [DATE], but the pharmacy said they were not available. The facility notified the physician the medications were not available and started the medications on [DATE]. The DON did not provide documentation to support these assertions, and she was not sure why it was not documented in the resident's medical record. On [DATE] at 10:25 a.m., the Medical Records Nurse provided an untitled document and indicated it was the list of medications available in the facility's EDK. The document indicated the kit expired on [DATE]. Ten tablets of levofloxacin 250 mg were included. The kit did not include ampicillin. During an interview, on [DATE] at 10:27 a.m., Pharmacist 8 indicated she worked for the facility's pharmacy. The pharmacy received orders for ampicillin and levofloxacin originally on [DATE] at 9:50 p.m. This was after their cut-off time for new orders of 8:00 p.m. If the facility ordered these medications as a basic order they would have entered the order the following morning, and the facility would have received it the evening of [DATE]. If an order was placed after the cut-off time, and the facility needed the medication prior to the next scheduled delivery, the facility needed to call the back-up call service. The back-up service would have called a local 24-hour pharmacy and arranged delivery of the medication. This was not completed for the resident's ampicillin and levofloxacin. On the original orders, the facility wrote a start time of [DATE] at 8:00 a. m., however the medications would not have been available at that time because they had not initiated an immediate delivery through the back-up service. The levofloxacin was available in the EDK. On [DATE] at 10:54 a.m., the DON provided a document titled, Pharmacy Services Overview, last revised in [DATE], and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Policy Interpretation and Implementation .3. Pharmacy services are available to residents 24 hours a day, seven days a week. 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner 35317 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On [DATE] at 9:03 a.m., Resident 25 was sitting up in his recliner and his Foley catheter (indwelling catheter, inserted into the bladder to drain urine) urinary drainage bag was in contact with the floor on the left side of his recliner. On [DATE] at 11:38 a.m., Resident 25 was asleep in his recliner and his catheter urinary drainage bag was in direct contact with the floor on the left side of his recliner. On [DATE] at 2:41 p.m., Resident 25 was sitting up in his recliner and his catheter urinary drainage bag was in direct contact with the floor on the left side of his recliner. On [DATE] at 8:40 a.m., Resident 25 was sitting up reading a book while in his recliner and his catheter urinary drainage bag and tubing were in direct contact with the floor on the left side of his recliner. On [DATE] at 9:59 a.m., Resident 25 was sitting in his recliner with his legs elevated and the catheter urinary drainage bag was in direct contact with the floor on the left side of his recliner. Resident 7's record was reviewed on [DATE] at 1:15 p.m. The profile indicated the resident's diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms (the prostate gland is growing and causing symptoms related to urination). A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact and had an indwelling urinary catheter. A physician order, dated [DATE], indicated to change Foley catheter every night shift starting on the 28th and ending on the 28th every month and as needed. A physician's order dated [DATE], indicated to provide catheter care- cleanse with soap and water every shift. A physician's order, dated [DATE], indicated Foley catheter size 16 Fr (French) (diameter of catheter tubing) 5cc (cubic centimeter) balloon every shift. During an interview, on [DATE] at 10:34 a.m., the Director of Nursing (DON) indicated the catheter drainage bag and tubing should not be in contact with the floor. On [DATE] at 11:36 a.m., the DON provided a document, with a revised date of [DATE], titled, Catheter Care, Urinary, and indicated it was the current policy being used by the facility. The policy indicated, . Infection Control .2. Be sure the catheter tubing and drainage bag are kept off the floor 3XXX,d+[DATE](a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on record review and interview, the facility failed to address a significant weight discrepancy for 1 of 4 residents reviewed for nutrition (Resident 25). Findings include: Resident 25's record was reviewed on 4/22/25 at 1:15 p.m. The profile indicated the resident's diagnoses included, but were not limited to, heart failure (the heart is unable to pump enough blood to meet the body's needs), unspecified fracture of the left femur (indicates a broken left thigh bone, but the specific fracture isn't detailed), and vascular parkinsonism (caused by vascular damage, specifically small strokes or cerebrovascular disease, in the brain regions controlling movement). A quarterly Minimum Data Set (MDS) assessment, dated 4/8/25, indicated the resident was cognitively intact and required a one person assist with bed mobility and transfers. A physician order, dated 10/4/24, indicated daily weights every dayshift. Notify doctor of 3 lb (pound) weight gain or more overnight or 5 lb weight gain in one week. A physician order, dated 10/4/24, indicated the resident was to have a regular diet, regular texture, with regular thin liquid consistency. Review of the resident's weights indicated he weighed 168 pounds on most recent MDS assessment dated [DATE]. Subsequent weights included, but were not limited to the following: a. On 2/2/25 at 5:29 p.m., the resident had a documented weight of 158 pounds and on 2/3/25 at 1:30 p.m., the resident had a documented weight of 162 pounds, indicating a weight gain of 4 pounds in less than 24 hours. The record lacked documentation of the physician being notified of the weight gain. b. On 2/8/25 at 5:50 p.m., the resident had a documented weight of 166.4 pounds and on 2/9/24 at 3:05 p.m. , the resident had a documented weight of 170 pounds, indicating a weight gain of 3.6 pounds in less than 24 hours. The record lacked documentation of the physician being notified of the weight gain. c. On 3/2/25 at 5:57 p.m., the resident had a documented weight of 166.7 pounds and on 3/3/25 at 12:45 p.m. , the resident had a documented weight of 171.5 pounds, indicating a weight gain of 4.8 pounds in less than 24 hours. The record lacked documentation of the physician being notified of the weight gain. d. On 3/14/25 at 11:01 a.m., the resident had a documented weight of 168.8 pounds on 3/15/25 at 2:29 p.m., the resident had a documented weight of 172.6 pounds, indicating a weight gain of 3.8 pounds overnight. The record lacked documentation of the physician being notified of the weight gain. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 3/16/25 at 4:06 p.m., the resident had a documented weight of 170.4 pounds on 3/17/25 at 5:17 p.m., the resident had a documented weight of 174.9 pounds, indicating a weight gain on 4.5 pounds overnight. The record lacked documentation of the physician being notified of the weight gain. f. On 4/21/25 at 10:36 a.m., the resident had a documented weight of 160.4 pounds on 4/22/25 at 9:44 a.m., the resident had a documented weight of 172 pounds, indicating a weight gain of 12 pounds overnight. The record lacked documentation of the physician being notified of the weight gain. During an interview, on 4/23/25 at 2:59 p.m., Registered Nurse (RN) 7 indicated Resident 25 had been weighed already today and his weight was 171.8 pounds. During an interview, on 4/23/25 at 3:18 p.m., Registered Nurse (RN) 12 indicated the residents were usually weighed by nursing staff. If the staff noted a big difference in a resident's weight, they would re-weigh the resident during that same shift and or notify the doctor. During an interview, on 4/24/25 at 10:40 a.m., the Director of Nursing (DON) indicated she had been watching for weight discrepancies, but she had gotten busy with other tasks and had not been double checking them recently. She indicated the facility was going to hire a nursing supervisor and part of that person's tasks would be to monitor weights. The DON indicated staff should be notifying the physician as the orders indicate and residents should be re-weighed if there were any weight discrepancies. On 4/24/25 at 10:46 a.m., the DON provided a document with a revised date of March 2011, titled, Weighing and Measuring the Resident, and indicated it was the policy currently being used by the facility. The policy indicated, .The purpose of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition .6. Be sure that the weight scale is calibrated (balanced to zero) .1. Report significant weight loss/weight gain to the nurse supervisor .4. Report other information in accordance with facility policy and professional standards of practice 3.1-46(a)(1)

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	04/28/2025

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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48226 Based on observations, record review, and interviews, the facility failed to ensure proper storage of respiratory equipment for 1 of 1 residents reviewed for respiratory care (Resident 2). Findings include: On 4/21/25 at 10:35 a.m., during an initial observation of Resident 2. Observed oxygen concentrator (a medical device that separates nitrogen from the surrounding air, providing a higher concentration of oxygen for breathing) in the resident's room. There was not a date on the oxygen tubing. The tubing was unbagged and draped over the oxygen concentrator. On 4/21/25 at 2:57 p.m., observed Resident 2 in her room sitting in recliner. Oxygen (O2) was being administered through an oxygen concentrator. Observed the equipment storage bag on the portable oxygen tank (a small, easily transportable container filled with compressed oxygen) dated 4/7/25. On 4/21/25 at 2:57 p.m., in Resident 2's room observed nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) equipment (consist of a main nebulization unit, a reservoir for holding the liquid for nebulization, and a mouthpiece through which drug aerosol is inhaled) on the bedside table, the nebulizer administration device and tubing was not dated and was not in a storage bag. On 4/22/25 at 11:00 a.m., the medical record of Resident 2 reviewed. Diagnosis included but were not limited to chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), chronic respiratory failure (a long-term condition where the respiratory system is unable to effectively exchange oxygen and carbon dioxide), and pulmonary fibrosis (a condition where the lungs develop scar tissue (fibrosis), making them stiff and difficult to breathe). A physician order, dated 3/31/25, indicated to administer oxygen (O2) at 6 liters per minute by way of nasal cannula (a thin flexible tube device to provide supplemental oxygen therapy to people who have lower oxygen levels). May titrate (adjust) to keep O2 sats (the percentage of hemoglobin in your blood that is carrying oxygen) greater than 90% every shift, to relieve hypoxia (a condition in which the body's tissues do not receive enough oxygen). Notify Medical Doctor if O2 Sat less than 90% for COPD. A physician order, dated 3/31/25, indicated to change O2 tubing and humidifier bottle every night shift every Monday. A physician order, dated 3/21/25, indicated to administer ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg (milligrams) / 3 ml (milliliter) (Ipratropium-Albuterol), 1 vial inhale orally four times a day related to chronic obstructive pulmonary disease. A care plan, dated 4/9/25, indicated that the resident had oxygen therapy related to pulmonary hypertension and COPD. Interventions included, but were not limited to, oxygen as ordered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set (MDS) assessment, dated 4/1/25, indicated that the resident was cognitively intact and was administered oxygen during the 7 day look back period. On 4/22/25 at 2:00 p.m., observed the Resident 2 resting in her room. O2 was being administered by nasal cannula through oxygen concentrator. Observed tape with date of 2/21/25 attached to tubing. Observed the O2 tubing inside of bag, attached to portable O2 tank, dated 4/7/25. No date observed on tubing. A nebulizer administration set was inside of a bag dated 4/7/24. No date noted on the tubing. On 4/23/25 at 11:00 a.m., observed the nebulizer administration equipment unbagged and laying on the overbed table in Resident 2's room. On 4/25/25 at 8:20 a.m., observed the Resident 2 sleeping in recliner. Nebulizer equipment lying on the overbed table unbagged the medication administration chamber noted to have clear liquid in the chamber. On 4/25/25 at 10:01 a.m., during interview Licensed Practical Nurse (LPN) 20 indicated she would stay with the resident when providing nebulizer treatment. Once administered she would clean the administration set and once dry, would place the equipment in a dated bag. On 4/25/25 at 10:03 a.m., during interview LPN 21indicated she would stay with the resident while administering nebulizer treatment. She would then clean the administration set and allow the equipment to air dry. Once dry, she would place the administration set in the dated bag. On 4/24/2025 at 3:24 p.m., the Director of Nursing provided an undated document titled, Oxygen tubing storage and management policy, and indicated it was the policy currently being used by the facility. The policy indicated, .6.4 .6.4.1. Replace tubing on resident equipment per manufacturer IFC and facility schedule (minimum every 30 days). 6.4.2. Document tubing changes and place in plastic bag, include date 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)