STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155221	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00456676. This visit included a State Residential Licensure Survey. Complaint IN00456676 - No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, 25, and 28, 2025 Facility number: 000126 Provider number: 155221 AIM number: 100266400 Census Bed Type: SNF/NF: 68 Residential: 31 Total: 99 Census Payor Type: Medicare: 10 Medicaid: 28 Other: 30 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 6, 2025.	F 0000	Survey Disclaimer Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the community, its employees, its agents, or other individuals who draft or who may be discussed in this response and correction plan summary. This correction summary is submitted as the community's credible allegation of compliance. Westminster Village wishes to have this plan of correction (POC) stand as its allegation of compliance and respectfully request a desk review.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on record review and interview the facility failed to indicate the full code status of a resident	F 0578	The physician's order for Resident 271 was immediately corrected on 4/22/25 to reflect the resident's	05/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terra Holler	Health Facility Administrator	05/18/2025

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	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 4/17/25. 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		accurate Full Code status per the POST form signed on admission, and the care plan was updated accordingly. This alleged deficient practice has the potential to impact all residents; therefore, a full audit of all current residents' medical records has been conducted to verify that the code status in the physician orders, POST forms, and care plans align. Licensed nursing staff and admissions personnel will receive re-education by 5/18/25 on the facility's current policy regarding POST form review and accurate entry of code status into physician orders and care plans upon admission. The SSD or designee will audit 10% of new admissions weekly for 90 days to ensure that the POST form, physician orders, and care plans match. Findings will be reported monthly to the QAPI committee for ongoing review and further recommendations. Please see exhibit AAA, AA ,A,B,C All corrective actions will be completed by May 18, 2025.	

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	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). 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)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on interview and record review, the facility failed to ensure documentation of a resident's transfer included a progress note with pertinent information that the resident was being	F 0622	Resident 7's medical record has been updated to include a comprehensive nursing progress note detailing the clinical status,	05/18/2025

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	transferred to the hospital and the facility failed to ensure report was called to the emergency room for 1 of 1 resident reviewed for hospitalization (Resident 7). Findings include: During an interview, on 4/22/25 at 8:52 a.m., Resident 7 indicated she had been transferred to the hospital a couple of times in the last few months. Resident 7's record was reviewed on 4/23/25 at 8:59 a.m. The profile indicated the resident's diagnosis included, but were not limited to, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities causing significant impairment in daily life), heart failure (can occur if the heart cannot pump or fill adequately), and chronic obstructive pulmonary disease (COPD-term for lung and airway diseases that restrict your breathing). Resident 7's census information indicated she was transferred to the hospital on 1/27/25 and returned on 2/2/25 and she was transferred to the hospital on 2/5/25 and returned to the facility on 2/17/25. A quarterly Minimum Data Set (MDS) assessment, dated 3/26/25, indicated the resident was cognitively intact. A social service progress note, dated 1/27/25 at 10:06 a.m., indicated Resident 7's daughter requested during a care plan meeting that her mother be sent out to the emergency room due to decline in condition. The record lacked documentation that a nursing		and rationale for transfer on 1/27/25. A late entry was completed by nursing staff, and the hospital discharge checklist with documentation confirming notification to the receiving hospital. This alleged deficient practice has the potential to impact all residents. A retrospective audit of all resident hospital transfers from 1/1/25 to 4/28/25 will be conducted to ensure documentation includes physician orders, clinical assessment, vital signs, discharge checklist, and confirmation of report to receiving hospitals. All licensed nursing staff and nurse managers will receive mandatory in-service training on the existing “Facility-Initiated Transfer or Discharge” policy, with emphasis on proper documentation procedures, and reporting to receiving facilities. The DON or designee will re-educate staff on using the existing hospital transfer checklist as a required step in the process. The DON or designee will audit 10 resident hospital transfers weekly for 12 weeks to ensure required documentation (e.g., nursing progress notes, physician orders, discharge checklist, and ER notification) is complete. Audit	

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	progress note was completed of the resident's condition change. The record lacked documentation of any pertinent information on the resident such as: vital signs and clinical assessment. A physician order, dated 1/27/25 at 10:25 a.m., indicated they sent Resident 7 to emergency room to eval and treat. The record lacked documentation that the ambulance had arrived to transport the resident to the hospital. The record lacked documentation that the emergency room was notified of the resident's transfer from the facility. A social service progress note, dated 1/28/25 at 7:10 a.m., indicated the Social Service Director had spoken with Resident 7's daughter and she was currently admitted to the ICU (intensive care unit). A nursing progress note, dated 2/2/25 at 2:26 p.m., indicated Resident 7 had returned to the facility. During an interview, on 4/23/25 at 9:37 a.m., Registered Nurse (RN) 7 indicated when a resident was sent out to the hospital the nursing staff should complete a e-interact (interventions to reduce acute care transfers) transfer form, she indicated it was like a written report for the hospital, and call the emergency department to give them report on the resident's condition and reason for transfer. During an interview, on 4/23/25 at 10:08 a.m., Licensed Practical Nurse (LPN) 3 indicated the nursing staff was to complete an e-interact form when sending residents out to the hospital. The		findings will be reported and reviewed monthly during the facility's Quality Assurance and Performance Improvement (QAPI) meetings for a minimum of 90 days or until 90% compliance is achieved. Please see Exhibit AAA, AA, D, E All corrective actions will be completed by May 18, 2025.	

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	nurse was unable to provide documentation of an e-interact form being completed on 1/27/25. During an interview, on 4/23/25 at 11:01 a.m., the Director of Nursing (DON) indicated the nursing staff had a checklist they were to follow when sending out a resident to the hospital. She was aware that some documentation was not being completed as it should. The DON was unable to locate documentation regarding Resident 7's transfer to the hospital on 1/27/25. Review of the checklist provided by the DON on 4/23/25 at 11:40 a.m., indicated the nursing staff were to complete the following: Nursing progress notes detailing vital signs, change in condition, clinical assessment, any other pertinent information, and notification of MD. Complete e-interact transfer form Enter order to transfer to ER. Document contact name of resident and resident representative contacted of transfer. Document when resident left community, how left community, what documentation was sent with the resident, etc ... Person report called to at the hospital. On 4/26/25 at 11:26 a.m., the DON provided a document with a revised date of October 2022, titled, "Transfer or Discharge, Facility Initiated," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1.			

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	When a resident is transferred or discharged from the facility, the following information is documented in the medical record: ...c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition ...." 3.1-12(a)(6)(A)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments 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,	F 0640	The discharge MDS assessment for Resident 56 has been reviewed, accurately encoded, and transmitted to the CMS QIES ASAP system as of 4/25/2025 to ensure compliance with federal requirements. An audit of all MDS assessments completed for discharged residents between 11/1/2024 and 4/24/2025 will be conducted to verify that assessments were transmitted within the required 14-day timeframe. Licensed staff responsible for MDS completion and transmission, including all MDS Coordinators and backup designees, will be re-educated on CMS RAI Manual guidelines regarding transmission timelines, with an emphasis on distinguishing timelines for Medicare versus Managed	05/18/2025

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	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		Medicare residents. MDS or designee will audit a random sample of 10 MDS discharge assessments weekly for 12 weeks to ensure timely transmission, with findings reviewed monthly during the QAPI committee meetings and corrective actions taken as needed. Please see exhibit AAA, AA, F, G All corrective actions will be completed by May 18, 2025.	

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	Date No Later Than MDS Completion Date +14 calendar days...."			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments 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. 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	F 0641	To correct the alleged deficiency for the affected residents, the MDS assessments have been updated for Residents 11 and 15 to accurately reflect their dental status, ensuring the assessments are properly coded for missing/broken teeth and the loose denture issue. Any necessary follow-up with the dental practitioner will be arranged to ensure a thorough evaluation and appropriate intervention. An audit will be conducted on a 20% sample of current MDS assessments for residents with known dental issues or dentures, ensuring that each resident's dental status is accurately recorded. This will include reviewing the most recent MDS assessments for accuracy, focusing on coding for missing/broken teeth and the condition of dentures. DON or designee will provide targeted education to the MDS Coordinator, Registered Nurses (RNs), Certified Nursing Assistants (CNAs), and Social Services staff on the proper coding of dental status in the MDS	05/18/2025

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	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. 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		assessments, following the CMS RAI Version 3.0 Manual instructions. Staff will be retrained on how to observe and report any signs of broken or loosely fitting dentures, as well as document any dental issues, even if a resident cannot self-report. To monitor the corrective actions, DON or designee will conduct monthly audits for the next 90 days, reviewing a sample of 20% of MDS assessments for accuracy in documenting dental issues. The results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to ensure continued compliance and identify areas for improvement. Please see exhibit AAA, AA, L The corrective actions will be completed by May 18, 2025, to ensure all affected assessments are corrected, staff training is conducted, and the audit process is in place.	

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	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			

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	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)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan 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 11/22/24. 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	F 0656	Resident 20's care plan was updated to include a comprehensive, person-centered care plan specifically addressing their dementia diagnosis and related interventions. This updated care plan will outline dementia-related behaviors, triggers, and resident-specific interventions, such as structured routines, environmental modifications, and cognitive therapies to address agitation, hallucinations, and anxiety. MDS or designee will conduct a retrospective chart review of all residents who have a diagnosis of dementia or cognitive impairment, identifying those without an appropriate care plan addressing dementia-specific intervention. A sample of 20 resident records will be audited to ensure compliance with care planning requirements related to dementia care.	05/18/2025

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WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

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	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.		DON or designee will implement mandatory education for the interdisciplinary team (IDT), including nursing, social services, on the proper process for developing and implementing person-centered care plans for residents with dementia or cognitive impairment. The training will reinforce the importance of documenting dementia-specific care interventions as per the current clinical protocols. MDS or designee will perform weekly audits for the next 90 days to ensure that care plans for residents with dementia are comprehensive, including all required dementia-specific interventions. The results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee monthly for a 90 day minimum or until 90% compliance is achieved to assess compliance and effectiveness, with adjustments made as necessary. Please see exhibit AAA, AA, H, I Corrective actions will be completed no later than May 18, 2025.	

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	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			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI 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 4/22/25 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 3/31/25, indicated the resident had a severe cognitive impairment and an indwelling catheter.	F 0690	Resident 53, the facility will immediately ensure that antibiotics are administered as per the physician's order, with documentation confirming timely initiation. A review of all lab results will be conducted daily to ensure prompt communication with the physician for critical findings, with antibiotics initiated without delay. For Resident 25, the staff immediately corrected the positioning of the Foley catheter drainage bag to ensure it is kept off the floor, and staff will be re-educated on the importance of maintaining catheter hygiene. An audit will be conducted for all residents with indwelling catheters, reviewing their lab results, antibiotic orders, and catheter care documentation. The facility will also check for any	05/18/2025

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	A urinalysis (UA) culture and sensitivity (C&S) report indicated the urine specimen was collected on 4/10/25, and the results were reported to the facility on 4/13/25. The UA and C&S indicated two types of bacteria were isolated. Progress Notes, dated 4/13/25 to 4/17/25, lacked documentation the physician was notified of the UA and C&S results or an antibiotic was ordered prior to 4/17/25. A physician's order, dated 4/17/25, 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 4/17/25, indicated to administer ampicillin (antibiotic) 500 milligrams (mg) by mouth three times daily for seven days for UTI. A physician's order, dated 4/17/25, indicated to administer levofloxacin 500 mg by moth once daily for seven days for UTI. A Medication Administration Record (MAR), dated April 2025, lacked documentation the resident was treated for the UTI prior to 4/17/25. During an interview, on 4/22/25 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 4/17/25 but would look into it. During an interview, on 4/23/25 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		instances where catheter drainage bags were in contact with the floor by conducting an immediate review of 10-20% of residents with catheters. Staff will be re-educated on the facility's protocols for managing UTIs, including ensuring prompt physician notification for lab results and timely initiation of antibiotics. Additionally, staff will be retrained on proper catheter care, with emphasis on ensuring drainage bags and tubing are kept off the floor at all times. The DON or designee will conduct weekly audits for 90 days, reviewing 10-20% of residents with indwelling catheters to ensure proper antibiotic initiation, timely physician notifications, and adherence to catheter care policies. The results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for 90 day minimum and 90% compliance is achieved. Please see exhibit AA Corrective actions will be completed no later than 5/18/2025.	

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	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 4/23/25 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 4/13/25. The results were reviewed by the physician, and antibiotics were ordered, on 4/15/25. 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 4/17/25. 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 4/15/25, but the pharmacy said they were not available. The facility notified the physician the medications were not available and started the medications on 4/17/25. 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 4/23/25 at 10:25 a.m., the Medical Records Nurse provided an untitled document and			

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indicated it was the list of medications available in the facility's EDK. The document indicated the kit expired on 2/7/25. Ten tablets of levofloxacin 250 mg were included. The kit did not include ampicillin.

During an interview, on 4/23/25 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 4/16/25 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 4/17/25. 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 4/17/25 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 4/23/25 at 10:54 a.m., the DON provided a document titled, " Pharmacy Services Overview," last revised in April 2018, 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

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	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...."2. On 4/22/25 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 4/23/25 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 4/23/25 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 4/24/25 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 4/24/25 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 4/22/25 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).			

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	A quarterly Minimum Data Set (MDS) assessment, dated 4/8/25, indicated the resident was cognitively intact and had an indwelling urinary catheter. A physician order, dated 10/8/24, 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 10/9/24, indicated to provide catheter care- cleanse with soap and water every shift. A physician's order, dated 10/30/24, indicated Foley catheter size 16 Fr (French) (diameter of catheter tubing) 5cc (cubic centimeter) balloon every shift. During an interview, on 4/24/25 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 4/24/25 at 11:36 a.m., the DON provided a document, with a revised date of August 2022, 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 ...." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to address a significant weight discrepancy for 1 of 4 residents reviewed for nutrition	F 0692	Licensed staff will notify the physician of the weight discrepancies for Resident 25,	05/18/2025

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	(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 4/8/25. 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		document all significant weight changes, and ensure a re-weigh is performed when there is a weight discrepancy of 3 pounds or more. IDT will also ensure a follow-up assessment for any nutritional needs, and adjustments to the diet plan will be made as required. DON or designee will conduct an audit of the past 30 days of weight records for all residents to identify any significant weight fluctuations that were not reported to the physician or properly documented, using a sample size of 10-20% of the resident population. DON or designee will provide additional education to nursing staff on the importance of reporting significant weight fluctuations immediately to the physician and ensuring that re-weighing occurs as per policy. Nursing staff will also be reminded of the importance of following the facility's "Weighing and Measuring the Resident" policy. The DON or designee will conduct weekly audits of weight records for a sample of 10-20% of residents over the next 90 days to ensure compliance with the updated processes. Results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee at the end of each month. Please see exhibit AAA, AA, J	

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	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. 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 corrective actions will be completed by 5/18/2025, ensuring all required audits, education, and monitoring are fully implemented and reviewed	

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	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			

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	standards of practice...." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning 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	F 0695	Audit was conducted and replaced all expired or updated respiratory equipment, including oxygen tubing, nebulizers, and related devices, for Resident 2. We will also ensure that all respiratory equipment is properly stored in designated bags and dated per manufacturer guidelines and facility protocols. An audit will be conducted on all residents receiving respiratory care, including oxygen therapy and nebulizer treatments. A sample size of 20% of residents will be reviewed for compliance with proper storage and dating of respiratory equipment assigned to the infection preventionist or designee. All clinical staff, including licensed nurses, will receive education on the proper storage, dating, and maintenance of respiratory equipment, adhering strictly to the facility's existing policies and the manufacturer's guidelines. Infection Preventionist or designee will conduct weekly equipment audits for 90 days, reviewing	05/18/2025

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	155221	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.		10-20% of residents receiving respiratory care to ensure proper storage and dating of. The results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee for continuous improvement. Please see exhibit AAA, AA, K Corrective actions will be completed by 5/18/2025.	

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	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 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			

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	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)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaint IN00456676. Complaint IN00456676 - No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, 25, and 28, 2025 Facility number: 000126 Residential Census: 31 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Survey Disclaimer Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the community, its employees, its agents, or other individuals who draft or who may be discussed in this response and correction plan summary. This correction summary is submitted as the community's credible allegation of compliance. Westminster Village wishes to have this plan of correction (POC) stand as its allegation of compliance and	

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	Quality review completed on May 6, 2025.		respectfully request a desk review.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on observation, record review, and interview, the facility failed to ensure proper administration of inhaled medication during the medication administration pass for 1 of 5 residents observed (Resident 123). Findings include: During a medication administration observation, on 4/28/25 at 8:25 a.m., Licensed Practical Nurse (LPN) 23 was administering a Symbicort (medication used for asthma and chronic obstructive pulmonary disease) inhaler (small handheld devices that allow you to breathe through your mouth, directly to your lungs) to Resident 123. The resident did not rinse and spit after the use of the inhaler. The nurse proceeded to hand the resident his oral medications and he swallowed the pills along with the water. Resident 123's record was reviewed on 4/28/25 at 10:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, emphysema (a condition that causes shortness of breath), pulmonary fibrosis (a chronic lung disease that occurs when lung tissue around the air sacs becomes damaged and scarred, making it harder to breathe), and chronic obstructive pulmonary disease (COPD- a chronic lung disease that causes airflow limitation and breathing related symptoms). A physician order, dated 4/22/25, indicated to administer Symbicort inhalation aerosol 80 mcg	R 0296	The Assisted Living Director or designee will immediately ensure that Resident 123 is instructed to rinse and spit after the administration of the Symbicort inhaler, as per manufacturer guidelines. The Licensed Practical Nurse (LPN) involved in this incident will provide a documented reassessment to ensure the resident's understanding. The Assisted Living Director or designee will conduct a review of all residents receiving inhaled steroid medications, specifically focusing on those prescribed Symbicort or other similar inhalers, to ensure that the rinse-and-spit instruction is being followed appropriately for each resident. A sample audit of 20% of residents receiving these medications will be completed. The Director of Assisted Living or designee will implement education and training for licensed nursing staff on proper inhaler administration, specifically the need to follow manufacturer guidelines for rinsing and spitting after using inhaled steroid medications. This will be reinforced during staff meetings	05/18/2025

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	(micrograms) two puffs, inhale orally every morning and at bedtime related to emphysema. During an interview, on 4/28/25 at 10:25 a.m., the Assisted Living (AL) Supervisor indicated the pharmacy would send the facility instructions if a resident was to rinse and spit after use of an inhaler and she would add it to the order. She was not aware if a resident was to rinse and spit after using the Symbicort inhaler, she would have to check the manufacturer guidelines. During a phone interview, on 4/28/25 at 10:36 a.m., the pharmacist from the facility pharmacy indicated they did not always send instructions to the facility on inhaler use because the pharmacist assumed the nursing staff would be aware of making sure a resident rinsed and spit after the use of a steroidal (are designed to act like hormones to reduce inflammation) inhaler. The pharmacist indicated that the Symbicort did contain a steroid, and the resident should rinse and spit after use and not swallow. On 4/24/25 at 1:28 p.m., the Director of Nursing provided a document with a revised date of April 2019, titled, "Administering Medications," and indicated it was the policy currently being used by the facility. The policy indicated, " ...31. Each nurses' station has a current Physicians Desk Reference (PDR) and/or other medication reference as well as a copy of the surveyor guidance for F755-761 (Pharmacy Services) available. Manufacturer's instructions or user's manuals related to any medication administration devices are kept with the devices or at the nurses' station ...." On 4/28/25 at 11:37 a.m., the AL Supervisor provided the manufacturer guidelines document		and included in routine medication competency assessments. The Assisted Living Director or designee will conduct weekly audits of medication administration for all residents using inhalers to ensure that the rinse-and-spit procedure is being consistently followed. These audits will be reported to and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee for 90 day minimum or until compliance is achieved. Please see exhibit AAA, AA, A All corrective actions, including staff education, resident assessments, and audits, will be completed by May 18, 2025.	

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	with a revised date of December 2017, titled, "Symbicort,". The manufacturer guidelines indicated, " ...2.1 Administration Information ...After inhalation, the patient should rinse the mouth with water, without swallowing ...."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure a medication was labeled properly for 1 of 1 medication storage rooms reviewed for medication storage. Findings include: On 4/28/25 at 9:43 a.m., the medication storage room contained an opened multi-use vial of Aplisol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution and had no open date on the vial. The vial was not contained inside a box but on the shelf in the medication refrigerator. During an interview, on 4/28/25 at 9:45 a.m., Licensed Practical Nurse (LPN) 23 indicated she was not aware of how long the Aplisol had been in the refrigerator or when it was opened, she indicated the vial would need to be discarded. She indicated the Aplisol vial was good for 30 days once opened. During an interview, on 4/28/25 at 10:25 a.m., the Assisting Living Supervisor indicated she was not aware of the Aplisol vial in the refrigerator and that she must have missed it, she was not aware of when it was opened. On 4/28/25 at 10:43 a.m., the Administrator provided a document with a revised date of	R 0301	The opened multi-dose vial of Aplisol will be immediately discarded, as it was not labeled with the required open date. The resident affected will be reassessed to ensure that no harm occurred due to the lack of proper labeling or expired medication. An audit of all medications in the medication storage rooms and refrigerators will be conducted, focusing on multi-dose vials to ensure that each one is properly labeled with the required open dates and other necessary information. The audit will cover 100% of the medications in these areas. All licensed nursing staff will undergo re-education on the existing policy regarding medication labeling and storage, emphasizing the importance of properly labeling multi-dose vials with open dates and checking for compliance. The Assisted Living Director will conduct weekly audits of the	05/18/2025

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	February 2023, titled, "Medication Labeling and Storage," and indicated it was the policy currently being used by the facility. The policy indicated, " ...5. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer dare for the open vial ...8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items ...."		medication storage areas for 90 days, reviewing 20% of all multi-dose vials to ensure they are correctly labeled with open dates and required information. Audit results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance and identify any ongoing issues. Please see exhibit AAA, AA, A Corrective actions will be fully implemented by May 18, 2025.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on Record review and interview the facility failed to ensure a preadmission Tuberculin test was completed prior to admission to the facility for 1 of 5 residents reviewed for Tuberculin testing. (Resident 125). Findings include: On 4/28/25 at 10:30 a.m., the medical record of Resident 125 was reviewed. The resident was admitted to the facility on 10/24/24. Admission diagnoses included but was not limited to 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) and hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. Also called underactive thyroid).	R 0410	Resident 125 received a tuberculin skin test immediately. The test will be documented in the resident's medical record, along with the required information (date given, date read, administered by). An audit of the medical records for all residents admitted between 10/24/24 and the present will be conducted to ensure all required tuberculin skin tests and chest x-rays are completed and documented correctly. Staff will be educated on the facility's tuberculosis screening policy, with an emphasis on performing pre-admission and admission tuberculin testing, as	05/18/2025

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	A physician order, dated 12/31/24, indicated to administer Aplisol Solution 5 unit/0.1ml (milliliter) (Tuberculin PPD) (a substance used in a skin test to help diagnose tuberculosis (TB) infection), inject 0.1 ml intradermally (under the skin) one time only related to encounter for screening for respiratory tuberculosis. The medical record lacked evidence of administration of a TB skin test upon admission to the facility on 10/24/24 and lacked evidence of a chest x-ray within 6 months of admission. The record indicated the tuberculin test was administered on 12/32/24. On 4/28/25 at 11:00 a.m., during interview LPN 25 indicated, the residents are administered a tuberculin skin test prior to admission or on the day of admission to the facility and a second step tuberculin test is also administered to the resident within the specified time period. On 4/28/2025 at 1:00 p.m., the Director of Nursing provided an undated document, titled, "Tuberculosis (TB) screening and Testing," and indicated it was the policy currently being used by the facility. The policy indicated, "...1. Initial screening ...all prospecive residents must provide documentation of a tuberculosis screening within 60 days prior to/upon admission ...Acceptable forms of documentation include: A negative Mantoux (PPD) skin test ...A negative Interferon - Gamma Release Assay (IGRA) blood test ...A chest x-ray ...3. At the time of admission, assessment must be completed by facility staff to rule out signs and symptoms of communicable disease ...."		well as documenting results accurately. Additionally, the admissions team will review all pre-admission documentation for tuberculosis testing prior to resident admission to ensure compliance. Audits will be conducted monthly for the next 90 days on new residents admitted, verifying that tuberculin tests are administered, results documented, and chest x-rays completed as necessary. The results of the audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) committee. Please see exhibit AAA, AA, B The corrective actions will be completed by 5/18/2025.	