PRINTED: 10/04/2022
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. BUILDING	00	COMPLETED
		B. WING		09/02/2022
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP COD)
TWINE OF I	THE VIDEN ON SELL ELEK	2210 G	REENTREE N	
WESTM	NSTER HEALTH CARE CENTER	CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
F 0000				
Bldg. 00				
	This visit was for the Investigation of Nursing	F 0000		
	Home Complaint IN00384372 and a COVID 19			
	Infection Control survey. This visit included the			
	Investigation of Residential Complaint			
	IN00387203.			
	Commission INIO0294272 Substantiated No			
	Complaint IN00384372 - Substantiated. No			
	deficiencies related to the allegations are cited.			
	Complaint IN00387203 - Substantiated. State			
	deficiency related to the allegations is cited at			
	F0241.			
	F0241.			
	Survey dates: September 1 and 2, 2022			
	Survey dates. September 1 and 2, 2022			
	Facility number: 000100			
	Provider number: 155191			
	AIM number: 100266130			
	Census Bed Type:			
	SNF/NF: 61			
	Residential: 88			
	Total: 149			
	Census Payor Type:			1
	Medicare: 9			
	Medicaid: 40			1
	Other: 12			1
	Total: 61			
	Westminster Health Care Center was found to be			
	in compliance with 42 CFR Part 483 Subpart B and			1
	410 IAC 16.2-3.1 in regard to the Investigation of			1
	Nursing Home Complaint IN00384372.			1
	6 M. (000 10 / 2)			1
	Quality review completed on September 8, 2022.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 004S11 Facility ID: 000100 If continuation sheet Page 1 of 6

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191			JILTIPLE CO JILDING NG	00		COMPL 09/02/	ETED	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETION DATE
R 0000								
Bldg. 00	Complaint IN00387 Investigation of Nur	e Investigation of Residential 203. This visit included the rsing Home Complaint COVID 19 Infection Control	R 00	000				
	•	203 - Substantiated. State the allegations is cited at						
	-	372 - Substantiated. No to the allegations are cited.						
	Survey dates: Septe	ember 1 and 2, 2022						
	Facility number: 00	00100						
	Residential Census:	88						
	This State Residenti accordance with 410	al Finding is cited in IAC 16.2-5.						
	Quality review com	pleted on September 8, 2022.						
R 0241	410 IAC 16.2-5-4(Health Services - 0	, , ,						
Bldg. 00	(e) The administra provision of reside as ordered by the shall be supervise the premises or or (1) Medication sha licensed nursing p medication aides.	tion of medications and the ntial nursing care shall be resident's physician and d by a licensed nurse on a call as follows: Ill be administered by ersonnel or qualified						
	failed to ensure a res	and record review, the facility sident (Resident B) received ons for 1 of 3 residents	R 02	241	1. TEX This	PLAN OF CORRECTION T s plan of correction is prep		09/23/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. BUII	2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 00 COMPLE B. WING 99/02/2		LETED		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD	-	
WESTMINSTER HEALTH CARE CENTER					REENTREE N SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	3 RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	reviewed for medic	cation administration.			and executed because it is		
	Findings includes				required by the provisions of		
	Findings include:				and federal law. Westminster Health Care Center Assisted		
	The clinical record	for Resident B was reviewed			Living maintains that the alle		
		a.m. The diagnoses included,			deficiencies do not jeopardiz	-	
		d to, hypertension, depression,			health and safety of the resid		
	hyperlipidemia, and				nor are they of such charact		
	J1 1 7	3			as to limit its ability to render		
	The incident report	, dated 8/3/22 at 10:01 p.m.,			adequate care. This plan of		
	indicated Resident	B was given the wrong			correction shall operate as		
	medications, no inj	uries were noted, and facility			Westminster Health Care Co	enter	
	staff would be inser	rviced/educated medication			Assisted Living credible alleg	gation	
	administration.				of compliance. This plan of		
					correction is not meant to		
		ated 8/3/22 at 11:09 p.m.,			establish a standard of care,		
	indicated LPN (Licensed Practical Nurse) 4 had				contract, obligation or position		
	given Resident B her night time medications. The				Westminster Health Care Co		
	resident had taken the Melatonin (sleep aid) 10 mg				Assisted Living reserves all	-	
		oxyurea (antineoplastic) 500 mg,			to raise all possible contention	ons	
	·	ilator) 400 mg before Resident ications were not hers. The			and defenses in any civil or		
		was notified with a new order			criminal claim, action or proceeding.		
		lent's vital signs ever 2 hours			What corrective actions will	20	
		n every shift for 3 days.			accomplished for the resider		
					found to have been affected		
	During an interview	v on 9/1/22 at 4:10 p.m., LPN 4			deficient practice:	.,	
	indicated she had se	et up the medications for both			Resident #B was provided	the	
	Resident B and Res	sident C. She received a phone			correct medication starting	on	
	call and when she r	returned to the medication cart,			8/3/22 at 11:00pm. The res	ident	
		vrong cup of medications.			was monitored for any		
		en the Hydroxyurea, Trental			negative effects from the		
		n the resident reported that			provision of the incorrect		
	she did not think th	e medications were hers.			medication on 8/3/22 at		
	D	0/1/22 / 11.52			10:01pm.		
		v on 9/1/22 at 11:53 a.m., the			2. How other resident's h	•	
		rector indicated medication			the potential to be affected by	-	
	provided to the staf	cation had not yet been			same deficient practice will be identified and what corrective		
	provided to the star	1 1141565.			actions will be taken: All	-	
			1		actions will be taken. All		

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	OF CORRECTION	IDENTIFICATION NUMBER 155191	A. BUILDING B. WING	00 00	COMPLETED 09/02/2022
	PROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129	
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	indicated Resident I medications. On 9/1/22 at 4:52 p. Director provided a titled "Administerin It included, but was StatementMedicat safemanner, and a must be administere ordersMedications resident may not be resident"	dated 8/3/22 at 10:01 p.m., B received the wrong m., the Assisted Living current copy of the document g Medications" dated 12/2012. not limited to, "Policy ions shall be administered in a s prescribedMedications d in accordance with s ordered for a particular administered to another s to Complaint IN00387203		residents that have an order a medication could be affected. Nursing staffs that administer medication or observe the resident taking a medication were re- inservice on the policies and procedur titled "Administering Medication". Nursing staffs that administer medication observe the resident taking a medication will be in-service on these requirements in new hire orientation and annually. An audit was completed to check the medication administration/observation practice by all nursing staff administer medication. If the is a need for further re-training this education was provided 3. What measures will be prin place or systemic change who be made to ensure that the deficient practice does not reconstructed on the policies and procedures title "Administering Medication". Nursing staffs that administer medication or observe the resident taking the medication". Nursing staffs that administer medication or observe the resident taking the medication will be in-serviced on these requirements in new hire orientation and annually. Ar audit was completed to check the medication administration/observation	che ed ees r che d w // chat ere ng, . out vill cur: er on d er on

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	OF CORRECTION	IDENTIFICATION NUMBER 155191	A. BUILDING B. WING	00	COMPLETED 09/02/2022
	ROVIDER OR SUPPLIE		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129	
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				practice by all nursing staff administer medication. If the is a need for further re-training this education was provided. The Nursing Manager or designee will check the in-service sign-in sheets related to these requirements to ensure compliance. In addition, the Nursing Manager or designee will audit the medication administration practices of six nursing staff members who administer/observe medicated monthly to ensure compliant. These audits will occur for a year. Any staff member four not to be in compliance will re-educated and counseled anecessary with the progress disciplinary process. 4. How the corrective action will be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put in place: audit findings will be review by the Quality Assurance Performance Improvement Committee (QAPI). These findings will be completed monthly and submitted to Quality and sub	ere ing, i. ated er f ion ce. ind be as sive ons e r, The ed API nic his chis chis

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/02/2022	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
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					and in serviced before returning to work.		

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