	MEDICARE & MEDIC	•			OMB NO. 0938-039	
STATEMEN'	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155221	B. WING	·	01/23/2023	
			CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.		DAVIS DR		
WESTMIN	NSTER VILLAGE H	IEALTH & REHAB		E HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/23/23 Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400 At this Emergency Preparedness survey, Westminster Village Health & Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 78 certified beds. At the time of the survey, the census was 54. Quality Review completed on 01/25/23 403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),		E 0000	Westminster Village Terre H wishes to have this submitted plan of correction (POC) stated as its allegation of complianted Preparation and/or execution this POC does not constitute admission to, nor agreement with either the existence of the scope and severity of an the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is prepared and/or executed to ensure continuity compliance with regulatory requirements.	ed nd nce. n of e or ny of	
E 0039 SS=F Bldg						

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

TITLE (X6) DATE

Shannon Williams Administrator 02/09/2023

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0T3P21 Facility ID: 000126 If continuation sheet Page 1 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155221	B. W	ING		01/23	/2023
	PROVIDER OR SUPPLIER			1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [f exercises to test the annually. The [fact following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the [fact natural or man-materization of the exempt from encommunity-based functional exercise actual event. (ii) Conduct an advery 2 years, oppor functional exercise actual event. (ii) Conduct an advery 2 years, oppor functional exercise (B) A second full-scommunity-based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem stamessages, or prepared to challenge an er (iii) Analyze the [famaintain documents)	facility] must conduct the emergency plan ility] must do all of the full-scale exercise that is every 2 years; or munity-based exercise is anduct a facility-based e every 2 years; or flity] experiences an actual ade emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least cosite the year the full-scale cise under paragraph (d)(2) s conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed					
	the [facility's] eme	rgency plan, as needed.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 2 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155221	B. W	ING		01/23	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	₹		1120 E	DAVIS DR		
WESTMI	NSTER VILLAGE H	HEALTH & REHAB		TERRE	HAUTE, IN 47802		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	*[For Hospices at	· · -					
	_ , ,	spices that provide care in e. The hospice must					
	1						
	conduct exercises to test the emergency plan at least annually. The hospice must do						
	the following:						
	(i) Participate in a full-scale exercise that is						
	community based every 2 years; or						
	(A) When a community based exercise is not						
	· '	ict an individual facility					
		exercise every 2 years; or					
	(B) If the hospice	experiences a natural or					
	man-made emergency that requires activation						
	of the emergency	plan, the hospital is					
	exempt from enga	aging in its next required full					
	scale community-	based exercise or individual					
	facility-based fund	ctional exercise following the					
	onset of the emer						
	1 ' '	dditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	, ,	scale exercise that is					
		or a facility based					
	functional exercise	•					
	(B) A mock disas						
		ercise or workshop that is and includes a group					
	discussion using a	• .					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	(3) Testina for hos	spices that provide inpatient					
	l ' '	hospice must conduct					
	1	he emergency plan twice					
		spice must do the following:					
	1 ' '	an annual full-scale exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet Page 3 of 20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	A (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/23/2023	
	PROVIDER OR SUPPLIEF			1120 E I	DDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)	ATE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, condu- facility-based functional exercise (B) If the hospice man-made emerging of the emergency exempt from enga- full-scale community-scale community-based functional exercise (ii) Conduct an activate may include, following: (A) A second full- community-based functional exercise (B) A mock disas (C) A tabletop ex- facilitator that inclusing a narrated, emergency scena- statements, direct questions designe emergency plan. (iii) Analyze the h- maintain documer exercises, and en- the hospice's emer	-based; or nunity-based exercise is not not an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ted messages, or prepared ed to challenge an espice's response to and entation of all drills, tabletop ergency events and revise ergency plan, as needed.					
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the	PRTF, Hospital, CAH] must s to test the emergency ar. The [PRTF, Hospital, of following:					
	that is community	an annual full-scale exercise -based; or nunity-based exercise is not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

26

If continuation sheet Page 4 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155221	B. W	ING		01/23	/2023
NAME OF A	DDOVIDED OF GUIDN TEX			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	(1120 E	DAVIS DR		
	NSTER VILLAGE H	HEALTH & REHAB		TERRE	HAUTE, IN 47802		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	ıct an annual individual,					
	1	ctional exercise; or					
		Hospital, CAH] experiences					
	an actual natural or man-made emergency that requires activation of the emergency						
		is exempt from engaging in ull-scale community based					
	1	ity-based functional exercise					
		et of the emergency event.					
	_						
	(ii) Conduct an [additional] annual exercise or and that may include, but is not						
	limited to the following:						
	(A) A second full-scale exercise that is						
	community-based or individual, a						
	•	ctional exercise; or					
	1	ock disaster drill; or					
	, ,	e exercise or workshop that					
		tor and includes a group					
	discussion, using						
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er						
	1 ' '	he [facility's] response to					
		umentation of all drills,					
	•	s, and emergency events					
	and revise the [fac	cility's] emergency plan, as					
	needed.						
	*[For PACE at §40	60.84(d):]					
		PACE organization must					
	. ,	s to test the emergency					
	plan at least annu						
	organization must	do the following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community						
	(A) When a comm	nunity-based exercise is not					
		ıct an annual individual,					
	1	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet Page 5 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155221	B. W	ING		01/23/	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			DAVIS DR		
WESTMI	NSTER VILLAGE H	IFAI TH & RFHAB			HAUTE, IN 47802		
	T						<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		ergency that requires					
		mergency plan, the PACE					
	•	gaging in its next required					
	full-scale community based or individual,						
		facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every					
	` '						
		2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)					
	of this section is conducted that may include, but is not limited to the following:						
	(A) A second full-scale exercise that is community-based or individual, a facility						
	based functional exercise; or						
	(B) A mock disas	•					
	, ,	ercise or workshop that is					
		and includes a group					
	discussion, using						
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the F	PACE's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and en	nergency events and revise					
	the PACE's emero	gency plan, as needed.					
	*[For LTC Facilitie						
	· · ·	ty] must conduct exercises					
		ency plan at least twice per					
	_	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	_					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	•	ct an annual individual,					
	facility-based fund						
	. ,	ility] facility experiences an					
	actual natural of n	nan-made emergency that					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If co

If continuation sheet Page 6 of 20

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/23/2023	
	PROVIDER OR SUPPLIEF		1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	requires activation LTC facility is exe required a full-sca individual, facility-following the onse (ii) Conduct an act that may include, following: (A) A second full-community-based based functional et (B) A mock disas: (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem sta messages, or preper to challenge an er (iii) Analyze the [I response to and number all drills, tabletop events, and revise emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an activation of the events is exempt from endorse.	n of the emergency plan, the mpt from engaging its next le community-based or based functional exercise at of the emergency event. Iditional annual exercise but is not limited to the scale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed energency plan. TC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. 1483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 7 of 20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	î ´	JILDING	NSTRUCTION	(X3) DATE COMPI 01/23	LETED
	PROVIDER OR SUPPLIEI			1120 E	DDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL PLISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION
TAG	facility-based fundonset of the emer (ii) Conduct an ad that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the IC maintain documel exercises, and enthe ICF/IID's eme *[For HHAs at §44 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a distribution of the exempt from engage full-scale community-scale commun	ditional annual exercise but is not limited to the scale exercise that is I or an individual, ctional exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop inergency events, and revise rgency plan, as needed. 84.102] e HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is it; or community-based exercise conduct an annual chased functional exercise IA experiences an actual adde emergency plan, the HHA is aging in its next required inty-based or individual, ctional exercise following the		TAG	DEPICIENCYI		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 8 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155221	B. W	ING		01/23	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			DAVIS DR		
WESTMI	NSTER VILLAGE H	HEALTH & REHAB			HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is o	•					
	include, but is not limited to the following:						
	(A) A second full-scale exercise that is						
		community-based or an individual,					
		ctional exercise; or					
	, ,	isaster drill; or o exercise or workshop that					
		or and includes a group					
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
	_	emergency scenario, and a					
	set of problem sta	•					
	messages, or prepared questions designed						
	to challenge an er	· · · · · · · · · · · · · · · · · · ·					
	_	HA's response to and					
	, ,	ntation of all drills, tabletop					
		nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §4	86.360]					
	_	e OPO must conduct					
	, , , ,	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	_	cy scenario, and a set of					
	•	nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		nan-made emergency that					
	-	n of the emergency plan, the					
		om engaging in its next					
		xercise following the onset					
	of the emergency						
		PO's response to and					
		ntation of all tabletop					
	I exercises, and en	nergency events, and revise					1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 9 of 20

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/23/2023	
	ROVIDER OR SUPPLIER		1120 E	ADDRESS, CITY, STATE, ZIP COD E DAVIS DR E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paper at least annually. It group discussion is narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and enter the RNHCl's emet Based on record reversalled to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community-based function is community-based function of the emergency ple from engaging its not community-based of the conset of the actual the onset of the actual the conset of the conset	CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION OPO's] emergency plan, as 3.748]: PRINHCI must conduct the emergency plan. The the following: Pr-based, tabletop exercise A tabletop exercise is a the de by a facilitator, using a therefore emergency the of problem statements, as, or prepared questions renge an emergency plan. NHCI's response to and thatation of all tabletop therefore events, and revise regency plan, as needed. Therefore emergency there is not an interview, the facility there is to test the emergency there year, including therefore exercise that the continuation of the emergency there is not an annual full-scale exercise that the continuation of the exercise is not an annual individual, tional exercise. Therefore exercise is not an annual individual, tional exercise. Therefore emergency the requires an actual natural therefore exercise is not an annual individual, tional exercise. Therefore exercise is not an annual individual, tional exercise. Therefore exercise is not an annual individual, the LTC facility is exempt the exercise for 1 year following that event.	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	a O2/10/2023 a O2/10/2023 a O2/10/2023 a O2/10/2023 a O2/10/2023 a O2/10/2023
	include, but is not li a. A second full-sca	itional exercise that may imited to the following: ale exercise that is or an individual, facility-based		Preparedness Exercises was developed by the Administrat Plant Operations Director and approved by QAPI committee	or,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CONS A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/23/2023	
ROVIDER OR SUPPLIEF NSTER VILLAGE H			1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
SUMMARY (EACH DEFICIENT REGULATORY OF functional exercise. b. A mock disaster of a control of the control of th	HEALTH & REHAB STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION drill; or se or workshop that is led by a ides a group discussion, using y relevant emergency scenario, in statements, directed red questions designed to				of ncy will es ally eted lits iew udits ch d as The	(X5) COMPLETION DATE
_	viewed with the Administrator nt Operations at the exit					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0T3P21

Facility ID: 000126

If continuation sheet Page 11 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/23/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE HAUTE, IN 47802			
(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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0000 Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/23 Facility Number: 0 Provider Number: 1002 At this Life Safety O Village Health & Ro compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L) Health Care Occupa This two story facili II (000) construction The facility has a findetection in the corr the corridor. The facility census of 54 at the to All areas where the access were sprinkle facility services were Quality Review con NFPA 101	200126 155221 266400 Code survey, Westminster ehab was found not in equirements for Participation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. The strip was determined to be Type in and was fully sprinklered. The alarm system with smoke ridors and in all areas open to cility has battery operated talled in all resident sleeping has a capacity of 78 and had a stime of this visit. The strip was determined to be Type in and was fully sprinklered. The strip was determined to be Type in and was fully sprinklered. The strip was determined to be Type in and was fully sprinklered. The strip was determined to be Type in and was fully sprinklered. The strip was determined to be Type in and was fully sprinklered. The strip was determined to be Type in and was fully sprinklered. The strip was determined to be Type in and was fully sprinklered.	K 0	000	Westminster Village Terre I- wishes to have this submitt plan of correction (POC) sta as its allegation of complian Preparation and/or execution this POC does not constitut admission to, nor agreement with either the existence of the scope and severity of any the cited deficiencies, or conclusions set forth in the statement of deficiencies. The plan is prepared and/or executed to ensure continu compliance with regulatory requirements.	ed and ace. on of te at or or my of	
SS=E	Hazardous Areas	- Enclosure					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet Page 12 of 20

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/23/2023
	ROVIDER OR SUPPLIER NSTER VILLAGE H		1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802	
(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 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Maintend. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 gall f. Combustible Stotover 50 square feg. Laboratories (if Hazard - see K322)	are protected by a fire our fire resistance rating rated doors) or an nguishing system in 1.7.1 or 19.3.5.9. When the dic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4. f-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A Fired Heater Rooms are than 100 square feet) france, and Paint Shops froms f			
	failed to ensure 1 of Activities Closet wa by smoke resistant p shall be self-closing accordance with LS	on and interview, the facility I hazardous areas such as as separated from other spaces partitions and doors. Doors to or automatic closing in C 7.2.1.8. This deficient t 10 residents and staff in the	K 0321	Element #1 Activity Closet self-closing doc located in the activity room wa repaired by maintenance on 1/23/23. Element #2 All residents have the potentia	s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 13 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/23/2023 155221 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1120 E DAVIS DR TERRE HAUTE, IN 47802 WESTMINSTER VILLAGE HEALTH & REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE vicinity of the Activities Closet in the Activities being affected by the alleged room. deficient practice. All combustible storage rooms/spaces self-closing Findings include: were inspected by Director of Maintenance or designee for Based on observation with the Director of Plant functioning self-closure latching on Operations during a tour of the facility from 1:28 2/9/23 and were repaired as p.m. to 2:45 p.m. on 01/23/23, the door to the applicable. Self-closing doors will Activities Closet located in the Activities room be placed on a preventative that is open to the corridor was equipped with a maintenance inspection monthly. self-closing device but the door failed to fully close and latch into the door frame when tested Element #3 three separate times. When swinging to Maintenance Preventative Plan for self-close, the door appeared to be rubbing on the inspection of self-closing doors frame, preventing it from latching. Based on was reviewed and updated as interview at the time of observation, the Director applicable. Director of Plant of Plant Operations agreed the door to the Operations provided education of aforementioned hazardous area failed to self-close the Preventative Maintenance Plan and latch into the door frame. for combustible storage rooms/spaces self-closing doors This finding was reviewed with the Administrator to the maintenance and and Director of Plant Operations at the exit housekeeping employees on conference. 1/24/23. All employees were educated on how to put in a work 3.1-19(b) order for self-closing doors that do not close and latch. Element #4 Plant Operations Director will randomly inspect 5 combustible storage rooms/spaces doors for functioning self-closures to ensure door latches weekly times 4 weeks then monthly times 6 months. Additional audits will be completed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 14 of 20

PRINTED: 03/24/2023 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED
		155221	B. WING		01/23/2023
		1	<u> </u>		***************************************
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
				DAVIS DR	
WESTMI	NSTER VILLAGE H	IEALTH & REHAB	TERRI	E HAUTE, IN 47802	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1110	REGUERTORT	CESC IDEIVIII TIIVO IIVI ORGANITION	mo	time consistent substantial	BITE
				time consistent substantial	4
				compliance has been achieved	
				determined by the committee.	ine
				Administrator and Plant	
				Operations Director will be	
				responsible for sustained	
				compliance.	
				Element #5	
				The facility will be in and rema	in in
				compliance by 2/10/23.	
K 0712	NFPA 101				
SS=F	Fire Drills				
Bldg. 01	Fire Drills				
	Fire drills include t	the transmission of a fire			
	alarm signal and s	simulation of emergency fire			
	conditions. Fire dr	ills are held at expected			
	and unexpected ti	mes under varying			
	conditions, at leas	st quarterly on each shift.			
	The staff is familia	ar with procedures and is			
	aware that drills a	re part of established			
	routine. Where dr	rills are conducted between			
	9:00 PM and 6:00	AM, a coded			
		ay be used instead of			
	audible alarms.				
	19.7.1.4 through 1	19.7.1.7			
		view and interview, the facility	K 0712	Element #1	02/10/2023
		parterly fire drills for 3 of 4	1 0/12	Fire Drills are planned to be he	
		1.6 requires drills to be		on 1st shift 7am-3pm on 3/6/2	
	*	on each shift under varied		2nd shift 3pm-11pm on 4/3/23	
)-31 1135 temporary waiver		3rd shift 11pm-7am on 2/13/23	
		nysical fire drill, a documented		Administrator educated Plant	<i>'</i> .
		program related to the current		Operations Director on the Fire	
	_			I .	e
	_	nsiders current facility		Drill policy and procedure on	
	_	table. The training will instruct		1/23/23.	
		ng existing, new or temporary		Element #2	
		current duties, life safety		All residents, staff and visitors	
	_	fire protection devices in their		have the potential to be affected	
	assigned area. This	deficient practice affects all		by the alleged deficient practic	ce.

FORM CMS-2567(02-99) Previous Versions Obsolete

residents, staff, and visitors.

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Fire Drills are planned to held on

Page 15 of 20

PRINTED: 03/24/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMI	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155221	B. WIN	NG		01/23/	/2023
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH & REHAB			1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR E HAUTE, IN 47802			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE	DATE
	Findings include: Based on record revolutions on 01/22 p.m., complete doctorills or complete diraining could not be a) fire drills conductorills conductories, second or third by fire drills conductories, or Septemble third shifts. c) fire drills conductories conducted with staff the waiver period, It is a 3rd shifts' with training occurred. The provided indicated orientation hours. For it is over, and or orientation training the time of this survey. This finding was differenced in the conducted with staff they are researched in the conducted orientation hours. For it is over, and or orientation training the time of this survey.	view with the Director of Plant 3/23 from 10:00 a.m. to 1:28 amentation of the following fire ocumentation of orientation be provided: sted in the first quarter March) of 2022/2023 on the d shifts. Sted in the third quarter (July, per) of 2022 on the second and sted in the fourth quarter ext, December) 2022 on the iffs. Sented orientation trainings in lieu of a fire drill during nowever, the documents stated the thotimes of when the last at time range of several sased on interview at the time stated fire drills since the there were no further fire drilling documents for review as of view.			1st shift 7am-3pm on 3/6/23, 2 shift 3pm-11pm on 4/3/23 and shift 11pm-7am on 2/13/23. Administrator educated Plant Operations Director on the Fir Drill policy and procedure on 1/23/23. Element #3 The Fire Drill Policy and Procedure was reviewed by the Administrator and Plant Operations Director and meet professional standards. The furill schedule was reviewed an updated which includes the datand shift time frames of the fir drills. All Staff were educated the Fire Drill Policy and Procedure 1/23/23 with on-going education. Element #4 Plant Operations Director with audit Fire Drills on all shifts monthly with the Administrator compliance. Additional audit will be completed based upon level of compliance. Results of audits will be brought to QAPI review and revision as needed audits will be reviewed by Quadesurance Committee until suttime consistent substantial compliance has been achieved determined by the committee. Administrator and Director of Nursing will be responsible for sustained compliance. Element #5 The facility will be in and remained to the process of	ene sire and ate do not dits the of all for dity ach das The	

compliance by 2/10/23.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(x3) date survey Completed 01/23/2023
	PROVIDER OR SUPPLIER		1120 E	ADDRESS, CITY, STATE, ZIP COD E DAVIS DR E HAUTE, IN 47802	
(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 CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0781 SS=E Bldg. 01	prohibited in all he except, unless use employee areas we do not exceed 212 degrees Celsius). 18.7.8, 19.7.8 Based on observation interview; the facility portable space heater and enforce the spar practice could affect the lounge by the soft in the properties of the lounge by the soft in the Director of at 2:30 p.m., a portation of the floor in the Schoplugged into a wall manufacture documn 1500 W on the base maximum temperation records review a Policy dated 10/14/space heaters is proposed in the protable space in the pro	eaters eating devices shall be eath care occupancies, ed in nonsleeping staff and where the heating elements 2 degrees Fahrenheit (100 on, records review, and ty failure to ensure 1 of 1 ers was not used in the facility ce heater policy. This deficient t up to 8 residents and staff in cheduler office. on during a tour of the facility Plant Operations on 01/23/23 able space heater was sitting on eduler/Medical Supplies office outlet. The space heater's mentation indicated 120 V and e, but did not state the ure achieved by the unit. Based t 2:50 p.m., the Space Heater 20 stated 'The use of portable hibited in all areas of the stminster Village Terre Haute. The state is discovered, it shall be eater is discovered, it shall be eater is discovered, it shall be eater was in the health center, the eater and stated space	K 0781	K 781 Portable Space Heaters Element #1 The space Heater located in the Scheduler/Medical Supply office was removed immediately from room during survey. The Schereceived education on the Spatheater Policy from the Administrator on 1/23/23. Element #2 All residents have the potential be affected by the alleged defining practice. All offices were inspected for space heaters. In additional space heaters were observed. Element #3 The Space Heater Policy was reviewed and met professional standard of practice of "the use portable space heaters is prohibited in all areas of the He Center". All staff received education from the Administration maintenance, and Environment Service Director on the Space Heater policy on 1/23/23. Element #4 The Plant Operations Director Designee will conduct inspections.	ne ce no duler ce la

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet Page 17 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 3/2023
	PROVIDER OR SUPPLIER NSTER VILLAGE H		1120 E	ADDRESS, CITY, STATE, ZIP E DAVIS DR E HAUTE, IN 47802	COD	
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0920	conference. 3.1-19(b)	nt Operations during the exit		of 5 offices monthly ti months then quarterly Additional audits will I based upon the level compliance. Results will be brought to QAI and revision as neede will be reviewed by Q Assurance Committee time consistent substrompliance has been determined by the conformation of the Compliance of the Compliance of the Compliance. Element #5 The facility will be in a compliance by	y thereafter. be completed of of all audits PI for review ed. The audits ruality e until such antial a achieved as mmittee. The ant vill be ined	
SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care r	ent - Power Cords and ent - Power Strips and electrical equipment eles that have been elified personnel and meet eles that have been eles that				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMP			
		155221	B. W	ING		01/23	/2023
NAME OF F	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
			1120 E DAVIS DR				
WESTMINSTER VILLAGE HEALTH & REHAB				TERRE HAUTE, IN 47802			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		precautions. Extension					
		d as a substitute for fixed re. Extension cords used					
		moved immediately upon					
		purpose for which it was					
	1	ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	,	(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	$ _{K0}$	920	K920 Electrical		02/10/2023
		f 1 power cord daisy chains		-	Equipment-Power Cords and	I	
	were not used as an	nd as a substitute for fixed			Extension Cords		
	wiring. NFPA-70/2	011, 400.8 state unless			Element #1		
		ed in 400.7 flexible cords and			The "daisy chain power cord	l"	
		used for (1) as a substitute for			were immediately removed		
	fixed wiring. Article 400.8 (1) prohibits daisy				from the Scheduler/Medical		
		first extension cord (or power			Supply office. The Schedule	r	
		as a substitute for the fixed			received education on the		
	_	e. This deficient practice could			Power Strip Policy from the		
	affect 1 or 2 staff.				Administrator on 1/23/23.		
	F' 1' ' 1 1				Element #2		
	Findings include:				All residents have the potentia		
	Dagad on absorpation	on dyning a facility taxayyith			be affected by the alleged def		
		on during a facility tour with on the Operations on 01/23/23			practice of use of "daisy chain power cord use". Plant		
		and 2:45 p.m., in the			Operations Director and desig	nee	
		Supplies office a power strip			completed an inspection of all		
		nd supplied power to another			areas in the Health Center for		
	1	nputer equipment. Based on			"daily chain power cord use",		
		e of observation, the Director			other daisy chain power cords		
	of Plant Operations	agreed that power strips were			were found to be in use.		
	daisy chained toget	her and would make sure it is			Element #3		
	corrected.				The Power Cord Use Policy w		
					reviewed and met professiona		
	I -	viewed with the Administrator			standard of practice. All staff		
		nt Operations at the exit			received education from the		
	conference.				maintenance director on the		
	21.10(1)				Power Cord Strip Policy on		
	3.1-19(b)				2/10/23.		
					Element #4		
l	Ī		1		The Plant Operations Director	or	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0T3P21

Facility ID: 000126

If continuation sheet Page 19 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 01/23 /	ETED	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE HAUTE, IN 47802				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
				Designee will conduct inspection of 5 random rooms for daisy of power cord use monthly times months then quarterly thereaft Additional audits will be complibased upon the level of compliance. Results of all auditional audits of all auditional audits will be compliance. Results of all auditional audits of all auditional audits of all auditional audits of all auditional auditional audits of all auditional	hain 6 6 der. leted dits riew audits ch d as The		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0T3P21 Facility ID: 000126 If continuation sheet Page 20 of 20