STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155221	B. W	NG		03/20/	2025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			DAVIS DR		
WESTMI	NSTER VILLAGE H	IEAI TH & DEHAR			E HAUTE, IN 47802		
VVLSTIVII	NOTER VILLAGE I	ILALIII & NLIIAD		ILIXIXL	- 11AO1L, IN 47002		
(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
		ne Investigation of Complaints	F 00	000	Survey Disclaimer		
	IN00454240, IN004	452783, and IN00452733.			Preparation and/or execution	of	
					this plan does not constitute		
	Complaint IN00454	240 - Federal/state deficiencies			admission or agreement by th	e	
	related to the allega	tions are cited at F623, F626,			provider that a deficiency exis	ts.	
	and F740.				This response is also not to be	e	
					construed as an admission of	fault	
	Complaint IN00452	2783 - No deficiencies related to			by the community, its employe	es,	
	the allegations are c	eited.			its agents, or other individuals	who	
					draft or who may be discussed	d in	
	Complaint IN00452733 - No deficiencies related to				this response and correction p	lan	
	the allegations are c	eited.			summary. This correction		
					summary is submitted as the		
	Survey dates: March	h 20, 2025		community's credible allegation of		n of	
					compliance. Westminster Villa	ige	
	Facility number: 00	0126			wishes to have this plan of		
	Provider number: 1:	55221			correction (POC) stand as its		
	AIM number: 1002	66400			allegation of compliance and		
					respectfully request a desk re	view.	
	Census Bed Type:						
	SNF/NF: 63						
	Total: 63						
	Census Payor Type:	:					
	Medicare: 4						
	Medicaid: 32						
	Other: 27						
	Total: 63						
		reflect State Findings cited in					
	accordance with 410	0 IAC 16.2-3.1.					
	Quality review com	pleted on March 25, 2025.					
]	
F 0623	483.15(c)(3)-(6)(8						
SS=D	Notice Requireme						
Bldg. 00	Transfer/Discharg	e					

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

TITLE

(X6) DATE

Terra Holler Health Facility Administrator 04/07/2025

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155221	B. W	ING		03/20/2	025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
VA/EOTAIL	NOTED VIII I AGE I	IEALTH O DELIAD			DAVIS DR		
WESTMI	NSTER VILLAGE F	IEALTH & REHAB		TERRE	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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on interview	and record review, the facility	F 00	623	The facility will provide proper		04/09/2025
	failed to ensure a re	sident or his responsible party			written notice of transfer or		
		notice of transfer or			discharge to all affected reside	ents	
		was not permitted to return to			and their representatives in a		
	-	e Emergency Room (ER)			language and manner they		
		not meet criteria for hospital			understand. Copies of the noti	ices	
		3 residents reviewed for quality			will also be sent to the Office of		
	of care (Resident B)				the State Long-Term Care		
	or our (resident 2)	,-			Ombudsman, and the reason	for	
	Findings include:				discharge will be properly	101	
	i mamgs meraac.				documented in the resident's		
	During an interview	on 3/20/25 at 11:19 a m			medical record by the Social		
During an interview, on 3/20/25 at 11:19 a.m., Hospital Employee 8 indicated Resident B				Service Director or Designee.			
		, on 2/20/25, and the facility			dervice Birector or Besignee.		
	-	at had aggressive behaviors.			This alleged deficient practice	has	
	-	t have behaviors in the ER,			the potential to impact all	iias	
		edical reason to admit him to			residents. A facility-wide audit	will	
		attempted to send him back			be conducted on all resident	VVIII	
		Administrator refused to allow			transfer and discharge notices		
	-	facility and indicated they			issued in the past 90 days to)	
		m back until he had a			ensure compliance with federa		
	-	on. The resident had recently			and state requirements. (Exhib		
		nange at the facility, and the			F, G)	JIL	
		ought the behaviors might			[F, G)		
		e change. Hospital Employee			The facility will re-educate all		
		ry the hospital did not have			nursing, social services, and		
		evaluations available, and this			administration involved in residual	dent	
	situation was not an				transfers and discharges on th		
		nued to refuse to allow the			regulatory requirements for pro		
		the facility without a			notification, including content,		
		on. The resident was held in a			timing, and required recipients		
		n the ER for two days. The			Staff will be trained on the	·.	
		alized from 2/21/25 to 3/6/25					
	-	arged to a different skilled			importance of accurate	,	
		_			documentation in the resident'	I	
		(F). Hospital Employee 8 asked			medical record. (Exhibit A, C &		
	-	strator if the resident was			The Social Service Director or		
	•	ice of transfer or discharge but			designee will conduct weekly		
	had not received a d	iirect answer.			audits of 10% of all transfers a		
	D '1 (D)	1 2/00/07			discharges for the next 90 day		
	Resident B's record	was reviewed on 3/20/25 at			ensure compliance with notice	;	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155221	B. W	ING		03/20/	/2025
		<u>I</u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	₹			DAVIS DR		
WESTMI	NSTER VILLAGE H	ΙΕΔΙ ΤΗ & REHΔR			HAUTE, IN 47802		
VVESTIVII	ING I LIX VILLAGE F	ILALIII & NEIIAD		ILKKE	11701E, IN 4700Z		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	nformation indicated the			requirements. Findings will be		
resident was admitted to the facility on 1/10/25				reported to the Quality Assura			
	and discharged on 2/20/25.				and Performance Improvemer		
					(QAPI) committee monthly for		
	Diagnoses on the resident's profile included, but				review and until compliance is		
		unspecified encephalopathy			maintained for 3 consecutive		
		brain's function), unspecified			months.		
	· ·	mild cognitive impairment with					
	uncertain or unknow	wn etiology.			All corrective actions will be		
		D			completed by April 9, 2025.		
		mum Data Set (MDS)			l		
		2/6/25, indicated the resident			Westminster Village wishes to		
	_	itive impairment. The resident			have this plan of correction (P	OC)	
		and verbal behavioral			stand as its allegation of		
		towards others one to three			compliance and respectfully		
	-	ck period. The behaviors put			request a desk review.		
	_	nificant risk of physical illness					
		atly interfered with the					
	-	participation in activities or					
		The behaviors put others at a					
	-	hysical injury, significantly					
	_	vacy or activities of others, and					
		ted the care or living					
		ers. The resident rejected care					
		the look-back period. The dent on staff for toileting					
	•	lower body dressing, chair to					
		tub and shower transfers and					
		/maximal assistance with					
	_	The resident was always					
		el and bladder. The resident					
		chotic and antidepressant					
		the look-back period.					
	waring t	p					
	A Social Services P	Progress Note, dated 2/10/25 at					
		ed the resident was referred to					
		ic units, but both declined to					
	accept him for adm						
	To want						
	A Social Services P	Progress Note, dated 2/12/25 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIEF		1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	Non-Coverage (NO resident's wife and lacked documentati explained to or und whether or not she resident's plan was changing. A Social Services Pindicated the reside	l a Notice of Medicare MNC) was issued to the "agreed upon." The note on the appeal process was erstood by the resident's wife, wanted to appeal, or what the since his payment source was rogress Note, dated 2/17/25, nt's wife "gave consent to ral." The note lacked			
	documentation of w the resident was ref A Behavior Progres	where, or what type of facility, terred. ss Note, dated 2/20/25 at 8:45			
	with ADLs prior to CNAs tried to get h two staff members, assist with the trans (mechanical) lift to CNAs adjusted the one of the CNAs in was notified. The ne resident-specific int implemented to man	CNAs assisted the resident his dialysis appointment. The im up with the assistance of but the resident would not fer. The CNAs used a Hoyer get him out of bed. As the resident in the lift he kicked the abdomen. The physician ote lacked documentation of terventions developed or mage the resident's behaviors.			
	1:27 p.m., indicated and kick staff, kicker resident remained note lacked docume	rogress Note, dated 2/20/25 at the resident continued to hit ed staff in the stomach. The on-compliant with care. The entation of resident-specific oped or implemented to the behaviors.			
	3:06 p.m., indicated resident's wife, and	rogress Note, dated 2/20/25 at the SSD spoke with the she consented to sending the tue to "behavioral health." The			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155221	B. W	ING		03/20	/2025
		ı		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			DAVIS DR		
WESTMI	NSTER VILLAGE H	ΙΕΔΙ ΤΗ & REHΔR			HAUTE, IN 47802		
VVLO I IVII	THOTEIN VILLAGE I	ILALIII & IALIIAD		ILININE	. 11/101L, IIN 7/00Z		
(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 APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		entation of resident-specific					
		oped or implemented to					
	manage the residen	t's behaviors.					
	A.D. 31. 1	1.0/00/05 1.2.47					
	_	ated 2/20/25 at 3:47 p.m.,					
		nt was sent to the ER for a					
		on due to ongoing behaviors					
		ecoming a danger to others at					
		sident's wife was at the facility					
	and informed of the	e plan to transfer the resident.					
	The Progress Notes	lacked documentation the					
	_	a 30-day notice of transfer or					
	discharge.	a 50-day notice of transfer of					
	discharge.						
	An investigation tir	neline included a summary of					
	_	ith Resident B's discharge. The					
		on 2/20/25, the Administrator					
		pital director of case					
		ling the resident. The director					
		crator and requested to send					
	the resident back to	the facility approximately 30					
	minutes after the re	sident left the facility. The					
	resident was sent to	a higher level of care due to					
	altered mental statu	s, verbal, and physical					
	behaviors resulting	in a staff injury. The SSD and					
		attempted previously to find a					
	behavioral health u	nit to send the resident to, but					
		d accept him due to his clinical					
		spital case manager indicated					
	_	reason to keep the resident					
		y behaviors occurred while he					
		hospital did not have onsite					
		s. The case manager said a					
		on was completed, but the					
		ed to follow up with the ER					
		ager said they would follow up					
	1	2/21/25. The timeline did not					
		t or his representative was					
	issued a 30-day not	ice of transfer or discharge.					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	LTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED		
		155221	B. W	'ING		03/20/	/2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	8			DAVIS DR			
WESTMI	NSTER VILLAGE H	IEALTH & REHAB			HAUTE, IN 47802			
	Г		ı	ID			(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
IAG	REGULATORT OR	CESC IDENTIF TING INFORMATION		IAG			DATE	
	A note included in t	the investigation timeline,						
		cated the Administrator had a						
	l '	he case manager, and the case						
		no psychiatric evaluation had						
		is time. The resident had a						
	_	ager indicated the resident was						
		vay of the ER, and this was not						
		Administrator "continued to						
		of status and psych						
	_	ent and community safety."						
	The note lacked doo	cumentation the resident or his						
	representative was i	issued a 30-day notice of						
	transfer or discharge	e.						
		nagement note, dated 2/21/25						
		ted the writer received a phone						
		l case manager the night						
		t was in the ER. It was reported						
		nt to the ER for increased						
		facility refused to allow him to						
	· ·	The case manager reached						
	1	Administrator who indicated,						
	1	to meet his needs at this time						
		ychiatric evaluation" The						
		d they had tried different						
		o improvement. The case						
		n the ER provider who						
		nt had not had any aggressive arrival. The provider stated						
		ge him back to the facility, but						
	l	ept him back. The case						
	l -	ack out to the Administrator						
	_	to take the resident back						
	~	ic evaluation because he had						
		The ER provider ordered labs						
		valuation, and they planned to						
		arge him back to the facility.						
		<i>5</i>						
	A hospital case mar	nagement note, dated 2/21/25						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221		UILDING	instruction 00	(X3) DATE COMPL 03/20/	ETED
	PROVIDER OR SUPPLIEF		į	1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with the ER provided had a urinary tract if on antibiotics. Per the declined to see because was the resident's is. The case manager's Coordinator at the freesident had exhause was now Medicaid.	ted the case manager spoke er who indicated the resident infection (UTI) and was started the ER provider, psychiatry ause the primary impression issues were medication related. Spoke with the Admissions facility who indicated the sted his Medicare A days and pending.					
	indicated the reside rounds and after he	nt was discussed on morning exhibited aggressive staff. A GeriPsych transfer was					
	indicated the reside discharge. The faci indicated she would	nagement note, dated 2/25/25, nt was medically stable for lity's Admission's Coordinator d consult with management ent's potential re-admission.					
	at 10:37 a.m., indic [redacted GeriPsych because they did no available for the res the resident was sta ready to be dischar- case manager conta Coordinator who re	nagement note, dated 2/26/25 ated the resident's transfer to h unit's name] was declined at have a nephrologist sident. The physician advised ble psychiatrically and was ged back to the facility. The cted the Admission's quested clinical information so review his current behaviors.					
	at 2:12 p.m., indica Coordinator and Admanager. The Adm with the resident's v	nagement note, dated 2/26/25 ted the facility's Admission's dministrator called the case inistrator indicated they met wife, and she refused to sign a t. The Administrator reported					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155221	B. W	ING		03/20	/2025
				CTD PPT	ADDRESS CITY STATE ZID COR		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
VA/EOTAIL	NOTEDAWLAGEL	IEALTH O DELIAD			DAVIS DR		
WESTMI	NSTER VILLAGE H	HEALTH & REHAB		TERRE	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	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the resident's wife s	stated he was not coming back					
	to the facility and re	emoved his belongings. The					
	facility gave the res	sident's bed to someone else,					
	and they were no lo	onger able to accommodate the					
	resident.						
	_	nagement note, dated 2/26/25					
	_	ted the case manager called the					
		reported she did want the					
		the facility because he had					
		le. The case manager asked his					
		ved his belongings and say he					
was not returning, and she said she must not have							
		s agreeable to finding another					
	facility.						
		at the area are are					
		the investigation timeline,					
		cated the resident's wife refused					
	_	cleaned out his room, and					
		oming back to the facility. The ey were unable to comate his					
		nd his bed was occupied. The					
	-	entation the resident or his					
		issued a 30-day notice of					
	transfer or discharg	-					
	and the second of the second of	-					
	During an interview	v, on 3/20/25 at 1:31 p.m., the					
		eated the resident's behaviors					
		in severity, he was physically					
		ff, and kicked a staff member in					
		esident was sent to the ER for a					
		on due to the incident when					
		ember in the stomach. The					
	hospital attempted t	to send the resident back to					
	_	ites after he arrived, but the					
	-	them he needed a psychiatric					
		e returned. The Administrator					
		unable to provide care for the					
		pehaviors of being physically					
		refusals of care. The facility					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/20/2025	
	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 SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE COMPLETION
TAG	attempted to send h units, but they decli was clinically compresident was not iss or discharge. During an interview SSD indicated she is had behaviors of his refusal. The resident member. The resident member. The resident stay at the facility. Shad a history of behaviors of the facility, but they admission. The resident's behaviors She was not a danger to resident's behaviors She was not sure if representative were transfer or dischargh handled by the Admidel During an interview Registered Nurse (Fremembered the resident's of raising kicking. The behaviors of raising kicking. The behaviors of the ER. The very soon after held take him back becaut unable to care for his behaviors and refusion 13/20/25 at 3:10	im to multiple psychiatric ned to admit him because he olex and required dialysis. The ued a 30-day notice of transfer 7, on 3/20/25 at 2:55 p.m., the remembered Resident B, and he rating, kicking, yelling, and care to treat the resident aviors prior to admission to a started within 72 hours after dent's behaviors were not ner residents, and the resident himself or others. All of the were directed towards staff. The resident or his issued a 30-day notice of e, and the notices were usually ministrator. 7, on 3/20/25 at 3:05 p.m., RN) 4 indicated she ident. The resident exhibited this fist, grabbing, and fors were directed towards ongoing from the time of ked when the resident was hospital tried to send him back eft, but management refused to use they said the facility was im safely because of his	TAG	DEFICIENCY	DATE
	Discharge, Facility-	Initiated," last revised in indicated it was the policy			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2025	
NAME OF F	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP COD		
	NSTER VILLAGE H				DAVIS DR HAUTE, IN 47802		
(X4) ID		STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
		d by the facility. The policy					
	-	Statement: Once admitted to					
	-	ts have the right to remain in					
		y-initiated transfers and					
	-	ecessary, must meet specific					
	_	e resident/representative					
		entation, and documentation policyPolicy Interpretation					
		nNotice of Transfer or					
	-	ept as specified below, the					
	-	her representative are given a					
		ance written notice of an					
	• • •	or discharge from this facility.					
		representative are notified in					
	writing of the follo	wing information: a. The					
		the transfer or dischargeb.					
		of the transfer or discharge; c.					
		onto which the resident is					
		r discharged; d. An explanation					
	_	ht to appeal the transfer or					
	-	te, including: (1) the name,					
		telephone number of the entity					
		h appeal hearing requests; (2)					
		now to obtain an appeal form; assistance in completing and					
	` '	eal hearing request; (3) how to					
		mpleting and submitting the					
		nest; e. The Notice of Facility					
		cies; f. The name, address, and					
	-	of the Office of the State					
	-	mbudsmani. The name,					
	address, and teleph	one number of the state health					
		that has been designated to					
	* *	ransfers and discharge					
	notices"						
	This citation relates	s to Complaint IN00454240.					
	3.1-12(a)(7)						

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Event ID: 2SW211 Facility ID: 000126

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
		155221	B. WI	NG		03/20/	/2025
	ROVIDER 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			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0626	483.15(e)(1)(2)						
SS=D	Permitting Reside	nts to Return to Facility					
Bldg. 00							
		and record review, the facility	F 06	526	The facility will review and cor	rect	04/09/2025
	failed to ensure a re	sident was allowed to return to			any improper denials of reside	nt	
	the facility after an	Emergency Room (ER) visit			return following hospitalization	or	
		ce the hospital determined the			therapeutic leave. Any affected	d	
	resident did not mee	et the criteria for hospital			resident will be offered the firs	t	
	admission for 1 of 3	3 residents reviewed for quality			available semi-private bed and	t	
	of care (Resident B)).			notified of their right to return.		
					This alleged deficient practice	has	
	Findings include:				the potential to impact all		
					residents. A facility-wide audit	will	
	_	y, on 3/20/25 at 11:19 a.m.,			be conducted on all		
		8 indicated Resident B			hospitalizations and therapeut	ic	
	_	, on $2/20/25$, and the facility			leaves from the past 90 days t	0	
	_	t had aggressive behaviors.			identify residents who may hav	ve	
		t have behaviors in the ER,			been improperly denied		
		edical reason to admit him to			readmission (Exhibit F, G)		
		attempted to send him back			The admissions, social service	es,	
	-	Administrator refused to allow			and nursing staff will be		
		facility and indicated they			re-educated on the facility's		
	-	m back until he had a			existing policy regarding reside		
		on. The resident had recently			rights to return after hospitaliza		
		nange at the facility, and the			or therapeutic leave. Staff will	also	
		ought the behaviors might			receive training on proper		
		e change. Hospital Employee			documentation and		
		y the hospital did not have			communication of bed availab	ility.	
		evaluations available, and this			(Exhibit A, C &D)		
	situation was not an				The Director of Nursing or		
		nued to refuse to allow the			designee will audit 10% of all	-	
		the facility without a			hospitalizations and therapeut	IC	
		on. The resident was held in a			leaves weekly for 90 days to		
	_	n the ER for two days. The			ensure compliance with	J:1	
	_	alized from 2/21/25 to 3/6/25			readmission requirements. Au		
		arged to a different skilled			findings will be reviewed by the	E	
		F). During his hospital stay,			Quality Assurance and	۸ D.I.\	
		ne behaviors but was never			Performance Improvement (Q	API)	
		aggressive with the staff.			committee monthly for further	io	
	i nere was no psych	iatric facility willing to accept			oversight and until compliance	: IS	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2025		
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD E DAVIS DR	
WESTMI	NSTER VILLAGE H	IEALTH & REHAB		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
		was reviewed on 3/20/25 at formation indicated the		maintained for 3 consecutive months. All corrective actions will be completed by April 9, 2025 .	
	resident was admitted and discharged on 2	ed to the facility on 1/10/25 2/20/25.		Westminster Village wishes t have this plan of correction (I stand as its allegation of	
	were not limited to, (impairment in the l	unspecified encephalopathy brain's function), unspecified mild cognitive impairment with wn etiology.		compliance and respectfully request a desk review.	
	resident had a poter patterns related to reaccusations towards towards staff, refusabehaviors towards santicipate and meet the resident in a calservices consult as of	-			
	discontinued on 2/1	was dated 1/30/25 and 2/25. The order indicated grams (mg) by mouth once daily			
	11:21 a.m., indicate consent was receive The resident's verba care continued to or documentation of re	rogress Note, dated 1/31/25 at d a psychiatric services ad and sent to the provider. all behaviors and rejection of ecur. The note lacked esident-specific interventions mented to manage the			

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Event ID:

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		A. BUILDING 00 B. WING			COMPLETED 03/20/2025		
	PROVIDER OR SUPPLIEF			1120 E	DDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
IAG	An admission Minital assessment, dated 2 had moderate cognital exhibited physical asymptoms directed days of the look-barthe resident at a signor injury, significant resident's care and proceed interactions. Significant risk of printruded on the privisignificantly disruptenvironment of other four to six days of the resident was dependently disruptenvironment of other to six days of the resident was dependently disruptenvironment of other to six days of the resident was dependently disruptenvironment of the four to six days of the resident was dependently disruptently dis	mum Data Set (MDS) /6/25, indicated the resident tive impairment. The resident tive impairment. The resident towards others one to three ex period. The behaviors put inificant risk of physical illness ttly interfered with the participation in activities or The behaviors put others at a thysical injury, significantly facy or activities of others, and ted the care or living ters. The resident rejected care the look-back period. The dent on staff for toileting lower body dressing, chair to the and shower transfers and //maximal assistance with the resident was always the land bladder. The resident techotic and antidepressant the look-back period. Indicated the ted cognitive function/dementia the processes. Interventions were luded approach the resident in the recident with the tegivers about the resident's the resident/family/caregivers. The trident-specific interventions. Progress Note, dated 2/10/25 at the resident continued to be ally aggressive with staff, the with the resident's wife and to an acute psychiatric stay		IAG			DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	LETED
		155221	B. WIN	lG		03/20/	/2025
		1	- 	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R	l		DAVIS DR		
/V/ESTMI	NSTER VILLAGE H	HEALTH & DEHAR	l		HAUTE, IN 47802		
VVE 3 I IVII	NOTER VILLAGE F	IEALIT & NETAD		IERRE	11AU1E, IN 470U2		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	referral. The note la	acked documentation of					
	resident-specific in	terventions developed or					
	implemented to ma	nage the resident's behaviors.					
		Progress Note, dated 2/10/25 at					
	10:04 a.m., indicated the resident was referred to						
		ric units, but both declined to					
	accept him for admission.						
		27. 1. 10/20/27					
		Progress Note, dated 2/12/25 at					
	_	d a Notice of Medicare					
		OMNC) was issued to the					
		"agreed upon." The note					
		ion the appeal process was					
		lerstood by the resident's wife,					
		wanted to appeal, or what the					
	_	since his payment source was					
	changing.						
	A Davahioter Initial	l Consult, dated 2/12/25,					
		ent was seen for initial					
		tion management for conditions					
		order, mild cognitive deficit,					
	_	resident's symptoms were					
		n severity, ongoing, sponded to medication. The					
		sponded to medication. The gup on the side of his bed with					
	1	is knees. His wife reported she					
	_	m to stand up for awhile, but					
		ff reported the resident was					
		y care given or attempted by					
		edications periodically, and was					
	1	he resident was not a danger					
		s. The aggression was physical					
		s staff. Depakote (mood					
		s 125 mg by mouth twice daily					
		onic, symptomatic mood					
	disorder.	ome, symptomatic mood					
	uisoruer.						
	A Social Services P	Progress Note, dated 2/17/25,					
	1 Social Scivices F	10g1035 11010, dated 2/11/23,	I				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155221	B. W	NG		03/20/	/2025
				CED FEET	ADDRESS OF A STATE OF COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
VA/EOTA4	NOTED VIII AGE I	IEALTILO DELIAD			DAVIS DR		
WESTMI	NSTER VILLAGE I	HEALTH & REHAB		TERRE	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
	indicated the reside	ent's wife "gave consent to					
	writer to send refer	ral." The note lacked					
	documentation of v	where, or what type of facility,					
	the resident was ref	ferred.					
		ed on 2/20/25, indicated the					
	resident had an alteration in neurological status, encephalopathy. Interventions were generalized						
		ss with resident and family any					
		l issues regarding diagnosis or					
	_	edications as ordered and					
		side effects and effectiveness,					
		nsure adequate fluid intake to					
		n, obtain and monitor					
	_	as ordered and report results					
		in management as needed and					
	_	comfort measures, and					
		T) and occupational therapy					
	1 1	treat as indicated. The care plan					
	lacked resident-spe	cific interventions.					
		37					
	_	ss Note, dated 2/20/25 at 8:45					
	· ·	CNAs assisted the resident					
	_	his dialysis appointment. The					
	_	nim up with the assistance of					
		but the resident would not					
		sfer. The CNAs used a Hoyer					
		get him out of bed. As the					
		resident in the lift he kicked					
		the abdomen. The physician					
		ote lacked documentation of					
	_	terventions developed or					
	implemented to ma	nage the resident's behaviors.					
	A Social Samilara	Progress Note dated 2/20/25 at					
		Progress Note, dated 2/20/25 at d the resident continued to hit					
	_						
	·	ed staff in the stomach. The					
		non-compliant with care. The					
		entation of resident-specific					
	interventions devel	oped or implemented to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155221	B. WI	NG	_	03/20	/2025
NAME OF B	DROLUDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				DAVIS DR		
WESTMI	NSTER VILLAGE H	HEALTH & REHAB		TERRE	HAUTE, IN 47802		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	manage the resident	rs benaviors.					
	A Social Services P	rogress Note, dated 2/20/25 at					
	3:06 p.m., indicated the SSD spoke with the						
	_	she consented to sending the					
		lue to "behavioral health." The					
		entation of resident-specific					
		oped or implemented to					
	manage the resident						
	A Progress Note, da	ated 2/20/25 at 3:47 p.m.,					
	indicated the reside	nt was sent to the ER for a					
	psychiatric evaluati	on due to ongoing behaviors					
	and the resident "be	ecoming a danger to others at					
	the facility." The re	sident's wife was at the facility					
	and informed of the	plan to transfer the resident.					
	TI D M	1 1 1 1 4 4 4					
	_	lacked documentation the					
	behaviors were dire	er to himself or others as his					
	behaviors were dire	cted towards start.					
	An investigation tin	neline included a summary of					
	the actions taken wi	ith Resident B's discharge. The					
	timeline indicated,	on 2/20/25, the Administrator					
	spoke with the hosp	oital director of case					
	management regard	ling the resident. The director					
		rator and requested to send					
	the resident back to	the facility approximately 30					
		sident left the facility. The					
		a higher level of care due to					
		s, verbal, and physical					
		in a staff injury. The SSD and					
		attempted previously to find a					
		nit to send the resident to, but					
		l accept him due to his clinical					
		spital case manager indicated					
		reason to keep the resident					
	1	y behaviors occurred while he					
		hospital did not have onsite					
	psychiatric services	. The case manager said a					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/20/2025	
WESTMI	ROVIDER OR SUPPLIER	IEALTH & REHAB	1120 E TERRE	ADDRESS, CITY, STATE, ZIP COD DAVIS DR E HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF psychiatric evaluati Administrator want staff. The case man with the facility on A note included in	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION on was completed, but the ed to follow up with the ER ager said they would follow up 2/21/25. the investigation timeline, eated the Administrator had a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE	
	manager indicated a been provided at the UTI. The case manain a bed in the hally good for him. The A request stabilization evaluation for resident	ne case manager, and the case no psychiatric evaluation had is time. The resident had a ager indicated the resident was vay of the ER, and this was not Administrator "continued to a of status and psych ent and community safety."				
	at 8:52 a.m., indicate call from the on call before. The resident the resident was ser aggression, and the return to the facility out to the facility's "They were unable and would like a ps	ragement note, dated 2/21/25 red the writer received a phone I case manager the night t was in the ER. It was reported at to the ER for increased facility refused to allow him to r. The case manager reached Administrator who indicated, to meet his needs at this time sychiatric evaluation" The				
	medications with no manager spoke with indicated the reside behaviors since his she tried to discharg they would not accommanager reached bat who again refused to without a psychiatric "been aggressive."	d they had tried different of improvement. The case in the ER provider who inthe had not had any aggressive arrival. The provider stated ge him back to the facility, but the per him back. The case ack out to the Administrator to take the resident back are evaluation because he had. The ER provider ordered labs raluation, and they planned to arge him back to the facility.				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 20/2025
	PROVIDER OR SUPPLIEF		1120 E	ADDRESS, CITY, STATE, ZIF DAVIS DR E HAUTE, IN 47802	P COD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	at 3:14 p.m., indicar with the ER provide had a urinary tract i on antibiotics. Per the declined to see because the resident's is. The case manager's Coordinator at the foresident had exhause was now Medicaid. A hospital case manimidicated the reside rounds and after he behaviors towards simitiated. A hospital case manimidicated the reside discharge. The facil indicated she would regarding the reside discharge at 10:37 a.m., indicated GeriPsycl because they did not available for the resident was staready to be discharge case manager contate Coordinator who remanagement could. A hospital case manager contate the resident was staready to be discharged case manager contate Coordinator who remanagement could. A hospital case manager contate the resident was staready to be discharged case manager. The Admanager. The Admanager. The Admanager. The Admanager.	ted the case manager spoke er who indicated the resident infection (UTI) and was started the ER provider, psychiatry ause the primary impression issues were medication related. Pook with the Admissions facility who indicated the ted his Medicare A days and pending. Inagement note, dated 2/24/25, and was discussed on morning exhibited aggressive staff. A GeriPsych transfer was inagement note, dated 2/25/25, and was medically stable for dity's Admission's Coordinator of consult with management ent's potential re-admission. Inagement note, dated 2/26/25 and the resident's transfer to in unit's name] was declined at have a nephrologist stident. The physician advised ble psychiatrically and was god back to the facility. The ceted the Admission's quested clinical information so review his current behaviors. Inagement note, dated 2/26/25 and the facility's Admission's decent the Admission's quested clinical information so review his current behaviors.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		A. BUILDING B. WING	00 00	COMPLETED 03/20/2025		
	ROVIDER OR SUPPLIER		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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	bed hold agreement the resident's wife s to the facility and refacility gave the result and they were no loresident. A hospital case man at 2:22 p.m., indicatoresident's wife who resident to return to been there for awhill wife why she remove was not returning, a understood. She was facility. A note included in the dated 2/26/25, indicatoresident was not returning, a understood of the was facility. During an interview of indicated the dialysis schedule, and buring an interview of indicated she removed indicated she removed the was not resident in the was admitted the was admitted the was not residents. The resident rever a kicked "at people" to behaviors were not residents. The residents. The residents. The residents and the was admitted the	LISC IDENTIFYING INFORMATION The Administrator reported tated he was not coming back smoved his belongings. The ident's bed to someone else, inger able to accommodate the largement note, dated 2/26/25 and the case manager called the reported she did want the the facility because he had see. The case manager asked his level his belongings and say he and she said she must not have as agreeable to finding another. The investigation timeline, atted the resident's wife refused eleaned out his room, and soming back to the facility. The level were unable to comate his had his bed was occupied. The company of the property of the proper	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	COMPLETION DATE
	throughout his stay. During an interview Administrator indicates	y, on 3/20/25 at 1:31 p.m., the ated the resident's behaviors in severity, he was physically				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey Pleted 20/2025
WESTMI	PROVIDER OR SUPPLIER		1120 E	ADDRESS, CITY, STATE, ZIP (DAVIS DR HAUTE, IN 47802	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the stomach. The repsychiatric evaluation he kicked a staff me hospital attempted to the facility 30 minus. Administrator told to evaluation before hindicated they were resident due to his be abusive to staff and attempted to send hounits, but they declive was clinically computing an interview SSD indicated shere had behaviors of him refusal. The resident member. The resident stay at the facility. Shad a history of behaviors of him recipied towards of the facility, but they admission. The resident was not a danger to resident's behaviors. During an interview Registered Nurse (Fremembered the resident's behaviors of raising kicking. The behaviors of raising kicking. The behaviors of the ER. The very soon after hele take him back became to the ER. The very soon after hele take him back became to the ER. The very soon after hele take him back became to the ER. The very soon after hele take him back became to the ER. The very soon after hele take him back became to the ER. The very soon after hele take him back became to the ER. The very soon after hele take him back became to the ER.	ident. The resident exhibited this fist, grabbing, and sors were directed towards ongoing from the time of ked when the resident was hospital tried to send him back eft, but management refused to use they said the facility was im safely because of his				

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

PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		A. BUILDING <u>00</u> COMP				survey eted (2025		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE HAUTE, IN 47802				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IAIE	DATE	
	provided a documer Discharge, Facility-October 2022, and is currently being used indicated, "Policy the facility, resident the facility. Facility discharges, when no criteria, and require notification and orion as specified in this pand Implementation permitted to remain transferred or discharge is necessary and the resident's not facilityc. the safet is endangered due to status of the resident or Discharge: 1. 'Far discharge' means a tresident objects to, or resident's verbal or in alignment with the care and preference Discharge (Emergence are sent emergently scenarios are considerations are considerations.	p.m., the Administrator at titled, "Transfer or Initiated," last revised in indicated it was the policy of by the facility. The policy Statement: Once admitted to as have the right to remain in initiated transfers and excessary, must meet specific resident/representative entation, and documentation policyPolicy Interpretation in the facility, and not be arged unless: a. the transfer or arry for the resident's welfare eads cannot be met in this yof individuals in the facility of the clinical or behavioral atFacility-Initiated Transfer cellity initiated transfer or transfer or discharge which the for did not originate through a written request, and/or is not the resident's stated goals for sNotice of Transfer or int) 1. When residents who to an acute care setting, these dered facility-initiated harges, because the resident's expected. 2. Residents who are an acute care setting, such as a feed to return to the facility"						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155221	B. W	ING		03/20	/2025
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
WESTMI	NSTER VILLAGE H	HEALTH & REHAB			DAVIS DR E HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DO AND THE REAL PROPERTY OF THE PROPERTY OF TH		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
F 0740	483.40						
SS=D	Behavioral Health	Services					
Bldg. 00							
	Based on interview	and record review, the facility	F 0'	740	The facility will assess all affect	cted	04/09/2025
		sident-centered behavior			residents to ensure they are		
	management care plan was developed and				receiving appropriate behavior	ral	
		identified and attempted			health services in accordance		
		pisodes prior to the resident			their care plan. Identified gaps		
		the Emergency Room (ER) for			services will be addressed thro		
	_	residents reviewed for quality			referrals to behavioral health	J	
	of care (Resident B)				professionals and updates to	care	
	Ì Ì				plans. Medication Administrati		
	Findings include:				Records for all residents will b		
					modified to prompt indications		
	During an interview	y, on 3/20/25 at 11:19 a.m.,			behaviors exhibited and effica		
	_	8 indicated Resident B			Residents with behavioral hea	•	
		, on 2/20/25, and the facility			needs will be tracked and tren	ded	
	reported the residen	t had aggressive behaviors.			weekly in Residents at risk		
	The resident did not	t have behaviors in the ER,			meeting ongoing.		
	and there was no me	edical reason to admit him to			This alleged deficient practice	has	
	the hospital, so they	attempted to send him back			the potential to impact all		
		Administrator refused to allow			residents. A facility-wide audit	will	
	him to return to the	facility and indicated they			be conducted on all residents	with	
	would not accept hi	m back until he had a			documented behavioral health	1	
	psychiatric evaluation	on. The resident had recently			needs to ensure they are rece	iving	
	had a medication ch	nange, and the hospital			the necessary services outline	ed in	
	provider thought the	e behaviors might have been			their care plans.		
	due to the change. T	Гhe Hospital Employee			Nursing, social services, and		
	notified the facility	the hospital did not have			direct care staff will be		
	24-hour psychiatric	evaluations available, and this			re-educated on the importance	e of	
	situation was not an	emergency. The resident was			assessing and addressing		
	hospitalized from 2	/21/25 to 3/6/25 when he was			residents' behavioral health ne	eds.	
	T	erent skilled nursing facility			Training will focus on recogniz	ring	
	(SNF). During his h	nospital stay, the resident had			signs of mental health concerr	ns,	
	some behaviors but	was never actually physically			proper documentation of		
	aggressive with the	staff.			interventions, efficacy, and tim	nely	
					referrals to behavioral health		
		was reviewed on 3/20/25 at			providers. (Exhibit A, B, D, E)	The	
	1:09 p.m. Census in	formation indicated the			Social Service Director or		
	resident was admitte	ed to the facility on 1/10/25			designee will audit 10% of res	ident	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155221	B. W	ING		03/20/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			DAVIS DR		
WESTMI	NSTER VILLAGE H	IEALTH & REHAB			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 CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	and discharged on 2				care plans weekly for 90 days	to	
	8				ensure behavioral health serv		
	Diagnoses on the re	esident's profile included, but			are properly assessed,		
	-	unspecified encephalopathy			documented, and implemente	d.	
	(impairment in the	brain's function), unspecified			Audit results will be reviewed		
	mood disorder, and mild cognitive impairment with				the Quality Assurance and		
	uncertain or unknow	wn etiology.			Performance Improvement (Q	API)	
					committee monthly for further		
	-	ated 1/10/25, indicated the			oversight and until compliance	e is	
		ed to the facility and was			maintained for 3 consecutive		
	agitated and rude up	pon admission.			months.		
					All corrective actions will be		
		ated 1/11/25, indicated when			completed by April 9 , 2025 .		
	-	to the resident he stated,			Westminster Village wishes to		
		to molest me." The incident			have this plan of correction (P	OC)	
	-	Administrator and Director of			stand as its allegation of		
		aff was instructed to provide			compliance and respectfully		
	-	ote lacked documentation of			request a desk review.		
		pted at the time of the					
	behavior.						
	A Behavior Progres	ss Note, dated 1/11/25,					
		nt stated staff was trying to					
		activities of daily living (ADL)					
		ter spoke with the resident, the					
		he staff was not inappropriate					
		d not like peri care (cleaning the					
		a) being provided. The					
		ed related to his physical					
		to his incontinence, and the					
	resident agreed. The	e note lacked documentation					
	of the resident's lev	el of understanding of the					
	education consideri	ng his cognitive impairment or					
	interventions for the	e staff to attempt when the					
	resident exhibited b	ehaviors.					
	A 1 * *** *	.1 1/11/05 : 1:- (1:1					
	_	ed on 1/11/25, indicated the					
	•	ntial for impaired behavioral					
	-	estlessness, agitation, false					
	accusations towards	s staff, physical behaviors					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155221			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIEF		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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
IAU	towards staff, refusibehaviors towards santicipate and meet the resident in a cal services consult as resident's wife, reap and care in pairs. The resident-specific into the A care plan, initiate resident received are were generalized are resident, family, and benefits, and side ethal "specify: anti-depregive antidepressant physician and moni effectiveness, and in physician as needed symptoms of depressident received are were generalized are sident-specific into the antidepressant in lacked resident-specific into the antidepressant in lacked resident-specific into the antidepressant in lacked resident-specific into the sident received are were generalized are medication as order movements scale (A medication-related six months and as in services consult as a resident-specific into the sident was combathe was leaving for a waste from the bloc function). The resident was combathe was leaving for a waste from the bloc function). The resident meeting the resident was combathe was leaving for a waste from the bloc function). The resident was consult as a combathe was leaving for a waste from the bloc function). The resident was combathe was leaving for a waste from the bloc function). The resident was combathe was leaving for a waste from the bloc function). The resident was combathe was leaving for a waste from the bloc function).	al of care, and verbal taff. Interventions indicated the resident's needs, approach m manner, behavioral health ordered, offer to call the approach in 10 to 15 minutes, the care plan lacked the expression of the antidepressant. Interventions and included educate the discaregivers about risks, and the antidepressant of the expression o	TAG TAG			DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/20/2025	
	ROVIDER OR SUPPLIEF			1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR HAUTE, IN 47802		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ent remained "care in pairs,"					
		lucated to provide a slow easy					
		lacked documentation of atterventions developed or					
		efficacy of interventions					
	provided.	0111000 01 111101 (011110110					
	1						
	A Progress Note, da	ated 1/14/25 at 11:11 p.m.,					
		ied Nurse Aide (CNA) reported					
		dent refused care earlier in the					
		e was in the wrong room.					
	* *	oroached the resident, the e thought he was moving					
		not. The nurse explained to					
		in the correct room, and staff					
		bed when he was ready. The					
		ble. When the CNAs					
	_	er time, the resident refused					
	and became irritate	d with staff. The nurse advised					
	_	ne resident more time as he					
	_	n ready for bed yet. During					
		ght shift CNA reported the					
	_	on the side of the bed as wheelchair and refused to					
		ove it. The resident was					
		with the CNA. The nurse					
		's room to find the resident					
	clinging to the whe	elchair while sitting on the side					
		As stated they had not					
		, and the resident confirmed he					
	_	The nurse requested					
	_	the resident's wheelchair to					
	_	, and the resident angrily everbally aggressive with					
		rised the resident moving the					
		ave been safer, but the					
		ain. The resident threatened to					
	_	led his fist. The nurse advised					
	the resident this wa	s not appropriate behavior and					
	requested he not do	this. The resident falsely					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/20/2025	
	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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	accused the staff of resident. The nurse incorrect and staff v bed. The resident st myself for years, I con urse stood back que continued to assist I was able to bring his the bed using the becalmer after he adjugiven the call light, staff needed to be p safety, and the resident considering his cog were educated on he to perform his own intervention to alleve A Progress Note, daresident refused to a incontinence briefs, resident's wife were attempted to provid kept threatening to re-attempted later through the resident refused to a concurred and the resident refused to a concurred and the resident refused to a strength of the resident refused to provide the provide the provided interventions provided interventions provided interventions provided interventions of the resident refused to a strength of the provided interventions provided interventions provided interventions provided interventions and the resident specific problem. A Physician's Order discontinued on 2/1 quetiapine 25 milligations and Wound the writer spoke with refusals, and the resident resid	threatening to hit the advised the resident this was was trying to assist him into ated, "I've been doing this don't need help now." The need help now." The need help now." The need help now in the resident of the resident was legs into bed and adjusted and remote. The resident was need himself in bed and was the resident was "reminded" resent for all transfers due to dent expressed understanding. Examinders and education intive impairment or the CNAs ow to safely allow the resident ADLs safely if this was an existed 1/16/25, indicated the allow the staff to change his. The Administrator and the exint the room when the staff to the thit staff. The care was to be a proughout the evening and the documentation of ded when the behavior			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIEF NSTER VILLAGE H		1120 E	ADDRESS, CITY, STATE, ZIP COD DAVIS DR E HAUTE, IN 47802	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE COMPLETION
PREFIX TAG	stage two pressure to loss) to his buttock, enough time for the adequately and refur A Social Services P 11:21 a.m., indicate consent was received. The resident's verbacare continued to odocumentation of redeveloped or implementations or be wream (IDT) was not documentation of redeveloped or implementation or redeveloped or impl	LISC IDENTIFYING INFORMATION alcer (partial-thickness skin The resident would not allow nurse to assess the area sed a dressing. rogress Note, dated 1/31/25 at d a psychiatric services ed and sent to the provider. al behaviors and rejection of ceur. The note lacked esident-specific interventions mented to manage the . ated 1/31/25 at 12:12 p.m., at refused to take his reighed. The interdisciplinary ified. The note lacked esident-specific interventions mented to manage the	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	BE COMPLETION
	_	cumentation of erventions developed or nage the resident's behaviors.			
	indicated the reside CNA, and another reare. The resident hresident stated, "F-resident had an area cared for, but the resident resident had an area cared for, but the residence in the care of the c	ated 2/2/25 at 9:07 a.m., and refused to let the nurse, and tried to bite staff. The you," to the nurse. The a on his buttocks that needed sident refused to let the staff lacked documentation of			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	LETED
		155221	B. W	ING		03/20/	/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			DAVIS DR		
WESTMI	NSTER VILLAGE H	IEALTH & REHAB			HAUTE, IN 47802		
	T		ı	1	- , · · · · · · -		I
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION terventions developed or		TAG	BETOLEKOT		DATE
	_	nage the resident's behaviors.					
	implemented to mai	hage the resident's behaviors.					
	A Progress Note, da	ated 2/2/25 at 12:33 p.m.,					
	_	nt's wife came in to visit the					
		rse asked the resident's wife					
		hen staff attempted to provide					
		The resident's wife was happy					
		ged the resident to allow staff					
		ence care. The resident agreed					
	and allowed the car						
		•					
	A Therapy Progress	s Note, dated 2/3/25, indicated					
	the therapy staff me	ember entered the room with					
	the resident's wife a	and spoke with the resident					
	about sitting up on	the edge of the bed. The					
	therapy staff members	er placed a hand under the					
	resident's left foot to	o support the resident's legs					
	and moving to the e	edge of the bed. The resident					
	yelled at the therapy	y staff member and his wife,					
		can do it myself." The resident					
		ontroller and then pushed all of					
		ident's wife took the bed					
		uraged the resident to sit on					
		The resident asked the					
		er to to assist, and the resident					
	_	to sit on the edge of the bed.					
		d to scoot towards the edge					
		bed was lowered. The therapy					
	_	d the resident's rolling walker in					
		t, and the resident stated, "I					
		ant the chair," and pushed the					
		s wife. The therapy staff					
	_	e wheelchair, placed it					
		e bed, and asked the resident					
	_	fer to the wheelchair. The					
		herapy staff member a "f					
		nit the therapy staff member					
		er. The resident then placed the					
	wheelchair directly	in front of where he was sitting					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	l í	JILDING	onstruction 00	(X3) DATE : COMPL 03/20/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	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 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
	provided education resident's wife under threatened to hit the mouth and stated, "and began mimicking member said. The resident staff member his wife take him he her again. The resident staff member and her verbiage. The note resident-specific into implemented to many the Administrator on 3/20/25 at 2:30 principated it was the intervention binder. Offer to call wife, reand care in pairs. The resident-specific into the Anadmission Minited Anadmission Minited Anadmission Minited Anadmission Minited Symptoms directed days of the look-barther resident at a signor injury, significant resident's care and province the privilegal significant risk of printruded on the privilegal significantly disruple environment of other significantly disruple environment of other sidnited in the significantly disruple environment of other sidnited in the sidnited significantly disruple environment of other sidnited in the sidnited sidnited in the sidnited sidnited in the privilegal sidnited in the sidnited sidnited in the privilegal sidnited in the sidnited						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155221	B. W	ING		03/20/	/2025
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			DAVIS DR		
WESTMI	NSTER VILLAGE H	JENI TH & DEHAR			HAUTE, IN 47802		
VVLSTIVII		ILALIII & INLIIAD		ILIXIXL	117012, 111 47 002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	dent on staff for toileting					
		lower body dressing, chair to					
		tub and shower transfers and					
	_	/maximal assistance with					
		The resident was always					
		el and bladder. The resident					
		chotic and antidepressant					
	medication during t	the look-back period.					
	A care plan, initiate	ed on 2/7/25, indicated the					
	*	ed cognitive function/dementia					
	•	t processes. Interventions were					
		luded approach the resident in					
	~	ner, communicate with the					
		egivers about the resident's					
		scuss concerns about					
	_	process, and community					
	_	resident/family/caregivers. The					
	_	sident-specific interventions.					
		•					
	_	ss Note, dated 2/7/25 at 6:05					
	a.m., indicated the	CNAs were in the resident's					
	room to provide car	re, and during the linen change					
	the resident grabbed	d the CNA's forearm with both					
		her. The CNAs finished					
		e resident and left the room.					
	The note lacked do						
	resident-specific in	terventions developed or					
	implemented to ma	nage the resident's behaviors.					
	A Behavior Progres	ss Note, dated 2/7/25 at 1:41					
		resident was overheard					
		herapy made several attempts,					
		npted to provide assistance.					
		d. The writer assisted the					
		lent's wife with the resident's					
		dent grabbed one of the CNA's					
		efused to let go. The resident					
		as hurting the CNA, and the					
		knew how far to go before he					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 03/20/	ETED
	ROVIDER OR SUPPLIER			1120 E [DDRESS, 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	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	caused pain. The nuresident, and he releated the resident-specific intimplemented to man A Social Services P 8:14 a.m., indicated verbally and physic Social Services sposshe was agreeable to referral. The note la resident-specific intimplemented to man A Social Services P 10:04 a.m., indicated two acute psychiatr accept him for admix A Progress Note, daindicated the resident medications and can attempted to provide resident refused. Thout of here. I don't we Management, physis spouse were notified documentation of redeveloped or implementation of redeveloped or indicated refuse medications. documentation of redeveloped or indicated refuse medications.	rise was able to redirect the cased the CNA's hand and arm. Examentation of the reventions developed or mage the resident's behaviors. Trogress Note, dated 2/10/25 at the resident continued to be ally aggressive with staff. When with the resident's wife and to an acute psychiatric stay acked documentation of the reventions developed or mage the resident's behaviors. Trogress Note, dated 2/10/25 at the resident was referred to the ic units, but both declined to its sistent. The CNA and nurse the care three times, but the the resident often stated, "Get want anything from you." Cian, and the resident's decreased. The note lacked assident-specific interventions mented to manage the resident continued to The note lacked assident-specific interventions mented to manage the manage th					
	A Progress Note, da	ated 2/10/25 at 5:29 p.m.,					

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE HEALTH & REHAB INTERPRET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE HAUTE, IN 47802 INTERPRET MATTER OF LANGE HEALTH & REHAB INTERPRET MAUTE, IN 47802 INTERPRET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE MAUTE, IN 47802 INTERPRET MAUTE, IN 47802 INTERPRET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE MAUTE, IN 47802 INTERPRET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE MAUTE, IN 47802 INTERPRET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE MAUTE, IN 47802 INTERPRET ADDRESS, CITY, STATE, ZIP COD 1120 E DAVIS DR TERRE MAUTE, IN 47802 IN 47802 IN 47802 IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804 E PROVIDER FLAN OF CORRECTION STATEMENT, IN 47802 IN 47804		IENT OF DEFICIENCIES AN OF CORRECTION			(X3) DATE SURVEY COMPLETED 03/20/2025			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE COMPLETION DATE COM					1120 E	DAVIS DR		
medication and care. The resident became verbally and physically abusive with staff. Redirection was attempted without success. Management and the resident's family were notified. The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Progress Note, dated 2/11/25, indicated the resident refused breakfast and morning medication. The CNA attempted twice and the nurse attempted twice. The resident laughed at the nurse and did not stop laughing the entire time the nurse provided care to the resident's roommate. The DON and Unit Manager were aware of the "abnormal behavior." The note lacked documentation of resident-specific interventions developed or implemented to manage the resident's behaviors. A Behavior Note, dated 2/12/25 at 12:31 p.m., indicated the resident made wound care after three attempts. The resident's wife was notified and reported the resident was being extremely mean. When the resident was being extremely mean. When the resident asked his wife to open the blinds, and she went over to the blinds he told her she was not a nurse. The nurse opened the blinds for the resident and redirected the behavior. The note lacked documentation of resident-specific interventions developed or implemented to manage the	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
A Psychiatry Initial Consult, dated 2/12/25, indicated the resident was seen for initial psychiatric medication management for conditions including mood disorder, mild cognitive deficit, and insomnia. The resident's symptoms were chronic, moderate in severity, ongoing,		indicated the reside medication and car and physically abus attempted without resident's family we documentation of r developed or imple resident's behaviors. A Progress Note, do resident refused brownedication. The Cranurse attempted two the nurse and did not time the nurse provommate. The DC aware of the "abnoot lacked documentation interventions developed manage the resident wound care after the wife was notified a being extremely make the blinds he told how nurse opened the brownedicated the resident to the blinds he told how no penedicated the behand ocumentation of resident's behaviors. A Psychiatry Initial indicated the resident psychiatric medication of dispayments. The	ent continued to refuse e. The resident became verbally sive with staff. Redirection was success. Management and the ere notified. The note lacked esident-specific interventions emented to manage the s. ated 2/11/25, indicated the eakfast and morning NA attempted twice and the ice. The resident laughed at ot stop laughing the entire rided care to the resident's N and Unit Manager were rmal behavior." The note ion of resident-specific oped or implemented to tt's behaviors. dated 2/12/25 at 12:31 p.m., ent refused medication and aree attempts. The resident was ean. When the resident was ean. When the resident asked e blinds, and she went over to er she was not a nurse. The linds for the resident and vior. The note lacked esident-specific interventions emented to manage the s. I Consult, dated 2/12/25, ent was seen for initial tion management for conditions forder, mild cognitive deficit, resident's symptoms were					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 20/2025
	PROVIDER OR SUPPLIER		1120 E	ADDRESS, CITY, STATE, ZIP DAVIS DR HAUTE, IN 47802	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	resident was sitting his sweatpants at hi was trying to get his he refused. The staf aggressive with any anyone, refused me verbally abusive. To himself or others and verbal, towards stabilizer) sprinkles was started for chrodisorder. A Social Services P 3:31 p.m. indicated provided saw the refor mood disorder. A Progress Note, daindicated the reside by the psychiatric in resident's Seroquel discontinued, Departiagnosis was added A February 2025 M. Record (MAR), incidated 2/13/25. The monitoring, target betwards staff. If preintervention, and outshift. A February 2025 M. Order, dated 2/13/2 monitoring, target behaviors/aggression	d. dedication Administration luded a Physician's Order, order indicated behavior behavior false accusations sent, document behavior type, atcome in progress note, every delay in the condensation of the con				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155221		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/20/2025	
	PROVIDER OR SUPPLIER NSTER VILLAGE H		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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	Order, dated 2/13/2 monitoring, target be personal care, show present, document be and outcome in production of the personal care, show present, document be and outcome in production of the personal care, show present, document be and outcome in production of the personal care and outcome in production of the personal care and to take his because and Powen outified. The note large ident-specific into implemented to man and a Social Services Personal care and wanted to eat. A Behavior Note, do resident refused more identified man and his resident's wife was witnessed the refused more lacked document interventions development of the personal care and pe	rogress Note, dated 2/17/25, nt's wife "gave consent to ral." The note lacked where, or what type of facility,			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	l í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 03/20/	ETED
	PROVIDER OR SUPPLIER		•	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 LISC 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
	A care plan, initiate resident had an alte encephalopathy. Int and included discuss concerns, fears, and treatments, give me monitor/document smonitor intake to enprevent dehydration lab/diagnostic work to the physician, paprovide alternative physical therapy (P' (OT) evaluate and the lacked resident-special members, assist with the trans (mechanical) lift to CNAs adjusted the one of the CNAs in was notified. The mesident-specific intimplemented to mathematical mathematical members and kick staff, kicker resident remained in note lacked docume interventions developments.	d on 2/20/25, indicated the ration in neurological status, erventions were generalized s with resident and family any issues regarding diagnosis or dications as ordered and side effects and effectiveness, usure adequate fluid intake to a, obtain and monitor as ordered and report results in management as needed and comfort measures, and T) and occupational therapy reat as indicated. The care plan cific interventions. Is Note, dated 2/20/25 at 8:45 CNAs assisted the resident his dialysis appointment. The im up with the assistance of but the resident would not fer. The CNAs used a Hoyer get him out of bed. As the resident in the lift he kicked the abdomen. The physician of lacked documentation of the erventions developed or mage the resident's behaviors. Trogress Note, dated 2/20/25 at the resident continued to hit led staff in the stomach. The on-compliant with care. The entation of resident-specific oped or implemented to					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155221	B. WING	-	03/20/2025
			CTREET	ADDRESS CITY STATE ZID COD	
NAME OF P	ROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD	
VA/ECTAIL	NSTER VILLAGE H	ICALTILO DELIAD		EDAVIS DR	
MESTIMI	NSTER VILLAGE F	IEALTH & REHAB	IERRI	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	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	resident to the ER d	lue to "behavioral health." The			
note lacked documentation of resident-specific					
interventions developed or implemented to					
	manage the resident	t's behaviors.			
	-	ated 2/20/25 at 3:47 p.m.,			
	indicated the reside	nt was sent to the ER for a			
		on due to ongoing behaviors			
	and the resident "be	ecoming a danger to others at			
	the facility." The re	sident's wife was at the facility			
	and informed of the	plan to transfer the resident.			
The Progress Notes lacked documentation the					
	-	er to himself or others as his			
	behaviors were dire	ected towards staff.			
	_	v, on 3/20/25 at 12:14 p.m., CNA			
		embered Resident B and had			
	-	n when he resided in the			
		nt had verbal behaviors such as			
		'Don't touch me or I'll hit you."			
		actually hit her. The resident			
		but had not made contact. The			
		directed towards other			
		ent had behaviors from the			
		ed to the facility, and the			
	-	viors was up and down			
	throughout his stay.	•			
	During an interview	v, on 3/20/25 at 1:31 p.m., the			
	-	eated the resident's behaviors			
		in severity, he was physically			
		ff, and kicked a staff member in			
		esident was sent to the ER for a			
		on due to the incident when			
		ember in the stomach. The			
		o send him to multiple			
		at they declined to admit him			
		iically complex and required			
		nearry complex and required			
	dialysis.				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155221			03/20/	03/20/2025	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIEF	₹			DAVIS DR		
\\/EQTMI	NSTER VILLAGE H	JEALTH & DEHAR			HAUTE, IN 47802		
VVLOTIVII	NOTER VILLAGE I	ILALIII & INLIIAD		ILIXIXL	117012, 111 47 002		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	MI IST DE DRECEDED DV EI II I DREETV (EACH CORRECTIVE ACTION SE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	v, on 3/20/25 at 2:33 p.m., the					
	Administrator indicated there was an intervention						
		ntions for each resident at the					
	nurse's station. The staff should have used it to						
		erventions would have assisted					
	with the resident's b	behaviors.					
	~	v, on 3/20/25 at 2:55 p.m., the					
		remembered Resident B, and he					
		tting, kicking, yelling, and care					
		nt "caused harm" to a staff					
		ent had behaviors his entire					
		She was not sure if the resident					
	had a history of behaviors prior to admission to						
	the facility, but they started within 72 hours after						
	admission. At times, the resident's wife was able						
	to help calm him down, but sometimes that made it						
	worse. They reapproached the resident in 10 or 15						
	_	ed care in pairs. She indicated					
		ere not effective but did not					
		ecific interventions were					
	^	eted. She was not sure if the					
		hat interventions were utilized					
		en the resident had behaviors.					
		viors were not directed					
		ents, and the resident was not					
		or others. All of the resident's					
		ected towards staff. The					
		included in the intervention					
	binder at the nurse's	s station.					
	Daning a ' ('						
		v, on 3/20/25 at 3:00 p.m., CNA					
		membered the resident, and he					
		ying nonsensical statements,					
		The behaviors were directed					
		he resident bit her before. She					
	was not sure where to find interventions to						
	_	esidents had behaviors or what					
	interventions were	in place for Resident B.					l

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

PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-039

	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 03/20/2025	
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	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 APPROPRI DEFICIENCY)	ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE	
	Registered Nurse (I remembered the residents will received to attain or practicable physica well-being in accor assessment and plan and Implementation the comprehensive based on input fron caregivers, review observations: a. the cognition, mood an usual method of conhunger, thirst, and of the resident's typica fatigue, fear, anxiet triggers; and d. the coping with stress, depressionManag team will evaluate behavior of raising well-being with stress, depressionManag team will evaluate by the resident's typica fatigue, fear, anxiet triggers; and d. the coping with stress, depressionManag team will evaluate by the stating the resident's typica fatigue, fear, anxiet triggers; and d. the coping with stress, depressionManag team will evaluate by the stating the stating the resident's typica fatigue, fear, anxiet triggers; and d. the coping with stress, depressionManag team will evaluate by the stating the st	sident. The resident exhibited is his fist, grabbing, and iors were directed towards a ongoing from the time of ed a slow approach and used termine what interventions in the resident had behaviors. Wention binder at the nurse's not helpful and they seemed to interventions. p.m., the Administrator document titled, "Behavioral ention and Monitoring," and policy currently being used policy indicated, "Policy acility will provide and we behavioral health services as maintain the highest l, mental and psychosocial dance with the comprehensive in of carePolicy Interpretation inAssessment, staff will evaluate, in the resident, family, and of medical record and general resident's usual patterns of document is usual patterns of document in the physical discomforts; c. all or past responses to stress, y, frustration and other resident's previous pattern of					

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

PRINTED: 04/11/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155221	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/20/2025		
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	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR			ì	DEFICIENCY)	DATE	
	distress and potentia	al safety risk to the resident,					
	and develop a plan	and develop a plan of care accordingly. Safety					
	strategies will be in	plemented immediately if					
	necessary to protect						
	harm2. The care p						
	from the compreher						
	Interventions will b						
	overall care environ						
	functional and psyc						
	understand, prevent						
	distress or loss of al						
	approaches will be						
	assessment of physi						
		ns and their underlying causes,					
	•	situational and environmental					
		avior. The care plan will					
	include, as a minim						
		ventions for the behavioral					
		l symptoms; c. the rationale					
		s and approachese. how the					
		or effectiveness of the					
	interventions"						
	This citation relates	to Complaint IN00454240.					
	3.1-43(a)(1)						

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