	WIEDICAKE & WIEDIC		772)) 7	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL		
		155191	B. WI	NG		12/19	/2024	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
	NSTER VILLAGE P				GREENTREE N KSVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY 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)		DATE	
E 0000								
Bldg								
		paredness Survey was	E 00	000	January 13, 2025			
	_	ndiana Department of Health in						
	accordance with 42	2 CFR 483.73.			To: Indiana State Department	t of		
					Health (Life Safety)			
	Survey Date: 12/19	9/24			From: Westminster Village			
					Kentuckiana			
	Facility Number: (000100			RE: Request for desk review	for		
	Provider Number:	155191			event ID 5WXH21			
	AIM Number: 100	266130			Please accept this letter as ou	ır		
					formal request for a desk revie	∍w for		
	At this Emergency	Preparedness survey,			event ID 5WXH21 for annual I	ife		
	Westminster Villag	ge Kentuckiana was found in			safety survey at Westminster			
	substantial complia	nce with Emergency			Village Kentuckiana on 12/19/	24.		
	Preparedness Requ	irements for Medicare and			We have submitted our plan o	f		
	Medicaid Participa	ting Providers and Suppliers, 42			correction with a completion d	ate		
	CFR 483.73				of February 3, 2025.			
					Your assistance with this matt	er		
	The facility has 94	certified beds. At the time of			is greatly appreciated.			
	the survey, the cens				Respectfully,			
					Kathy Dearing, Administrator			
	Quality Review con	mpleted on 12/27/24			The filing of this plan of correct	tion		
		•			does not constitute that the			
					alleged deficiency did in fact			
					exist. This Plan of Correction	is		
					filed as evidence of the facilities			
					desire to comply with the			
					regulatory requirements and			
					continue to provide quality car	·e		
					Please accept this plan of	0.		
					correction as our credible			
					allegation of compliance.			
					anogation of compliance.			
E 0025	403.748(b)(7) 41	8.113(b)(5), 441.184(b)						
SS=C	Arrangement with							
Bldg	, arangomone with	Caron r domado						
	Based on record re-	view and interview, the facility	E 00)25	1 Action taken for those		02/03/2025	
		ergency preparedness policies		143	residents identified:		02/03/2023	
	lanea to ensure em	ergenes, preparedness ponetes			residents identified.			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNAT				<u> </u>	TITLE		(X6) DATE	

Kathy Dearing Administrator 01/13/2025

Any defiencystatement 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: 5WXH21 Facility ID: 000100 If continuation sheet Page 1 of 12

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

PRINTED: 01/13/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING		COMPL	ETED
		155191	B. WIN	G		12/19/	2024
		<u> </u>	' т	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			REENTREE N		
WESTMI	NSTER VILLAGE K	(ENTUCKIANA			SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	_	ude the development of			No individual resident was		
	_	other LTC facilities and other			identified. Transfer agreemen		
	_	e residents in the event of			between Westminster and three		
	limitations or cessation of operations to maintain				entities have been drafted to b	e in	
	the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This				place by completion date.		
					2 How other residents are		
	deficient practice co	ould affect all occupants.			identified:	140	
	Findings include:				All residents have the potentia	ι ιΟ	
	rmanigs include:				be affected.		
	Raced on review of	the Emergency Preparedness			3 Systems in place:Emergency Preparedness ma	nual	
		lures Plan and interview with			updated to include the signed	ııual	
		irector (MD) and Administrator					
		en 10:40 am and 1:45 p.m.,			transfer agreements. Staff ha		
		angements with other LTC			been educated on the requirer of transfer agreements and wh		
	_	providers to receive residents			they are located in the Emerge		
		tations or cessation of			Preparedness Manual.	FIICY	
		ilable for review but the			4 How the facility will moni	tor	
	-	everal years old, dating back to			and quality assurance program		
	-	interview during records			Administrator/Designee will au		
		strator stated she had been			the Emergency Preparedness	uit	
		transfer agreements.			manual for current letters of		
					transfer weekly for four weeks		
	This finding was ac	knowledged by the MD at the			then bi-weekly for four weeks.		
	_	nd again by the MD and			results of these audits and any		
	Administrator at the				necessary corrective actions v		
					be discussed during the month		
					QAPI meetings with additional	•	
					education or revision of the pla		
					made based on audit findings.		
					Monthly meeting will continue		
					minimum of four months then		
					be stopped after two consecut	ive	
					months with no findings or issu	ues	
					noted with the audits.		
K 0000							
D							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 000	00	January 13, 2025		

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

Event ID:

5WXH21 Facility ID: 000100

If continuation sheet Page 2 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		01	COMPL	
		155191	B. WING	-		12/19/	/2024
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
	Licensure Survey w	as conducted by the Indiana					
	Department of Heal 483.90(a).	th in accordance with 42 CFR			To: Indiana State Department Health (Life Safety)	of	
	Survey Date: 12/19	0/24			From: Westminster Village Kentuckiana		
	Facility Number: 0	00100			RE: Request for desk review event ID 5WXH21	for	
	Provider Number: 155191				Please accept this letter as ou	r	
	AIM Number: 100	266130			formal request for a desk revie event ID 5WXH21 for annual I	w for	
	At this Life Safety (Code survey, Westminster			safety survey at Westminster		
	-	a was found not in compliance			Village Kentuckiana on 12/19/	24.	
	with Requirements	_			We have submitted our plan o		
	-	, 42 CFR Subpart 483.90(a),			correction with a completion d		
		re and the 2012 edition of the			of February 3, 2025.		
		ction Association (NFPA) 101,			Your assistance with this matt	er	
		SC) and 410 IAC 16.2. The			is greatly appreciated.		
		yed with Chapter 19, Existing			Respectfully,		
	Health Care Occupa	-			Kathy Dearing, Administrator The filing of this plan of correc	tion	
	This one story facil:	ity was determined to be of			does not constitute that the	uon	
		ruction and fully sprinkled.			alleged deficiency did in fact		
		re alarm system with smoke			exist. This Plan of Correction	is	
	,	ridors, spaces open to the			filed as evidence of the facilities		
		y-operated smoke detectors in			desire to comply with the	,,,	
		g rooms. The facility has a			regulatory requirements and		
		nad a census of 55 at the time			continue to provide quality car	e.	
	of this visit.				Please accept this plan of		
					correction as our credible		
	All areas where resi	idents have customary access			allegation of compliance.		
	were sprinkled and	all areas providing facility					
	services were sprinl	kled.					
	Quality Review cor	mpleted on 12/27/24					
K 0325	NFPA 101						
SS=E Bldg. 01		nd Rub Dispenser (ABHR)					
J. 5.		on and interview, the facility f over 20 alcohol-based hand	K 032	5	Action taken for those residents identified: No individ	ual	02/03/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/19/2024		
NAME OF I	PROVIDER OR SUPPLIEF	3	•		ADDRESS, CITY, STATE, ZIP COD REENTREE N	-	
WESTMI	NSTER VILLAGE K	KENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		were not installed over an		IAG	resident was identified. The		DATE
	-	PA 101, Section 19.3.2.6(8)			identified hand sanitizing		
	states dispensers sh	all not be installed in the			dispensers , were relocated o	ver	
	following locations	:			near rooms 118, 122 and 203	were	
		on source within a 1-inch			moved 4 feet in horizontal spa	acing	
	horizontal distance	from each side of the ignition			from an electric outlet.		
	source				2 How other residents are	ı	
		n ignition source within a			identified: All residents have	the	
		istance from the ignition source			potential to be affected.		
		tion source within a 1-inch			3 Systems in place: Audit		
		om the ignition source ice could affect 20 residents in			all hand sanitizing dispensers	was	
	two smoke compart				completed by Maintenance Director on 12/19/24. Two		
	two smoke compan	inent.			additional sanitizers were		
	Findings include:				identified, near room 103 and	105	
	i mamga maraas				each has been relocated at le		
	Based on observation	on and interview with the			feet horizontal spacing from		
	Maintenance Direct	tor (MD) and Administrator on			electric outlet. Staff have bee	n	
	12/19/24 between 1	:45 p.m. and 3:45 p.m.,			educated that hand sanitizers		
	alcohol-based hand	sanitizer dispensers were			must be located at least 4 fee	t	
		l directly above electrical			horizontal spacing from electr	ic	
		or near resident rooms 118,122			outlets, if one is noted too clos		
		interview at the time of			is to be reported immediately	to	
		D confirmed the alcohol-based			the Maintenance		
		ensers were installed on the			Director/Administrator for		
	•	electrical outlets in the corridor			immediate corrective action.	itor	
	by rooms 118,122 a	mu 203.			4 How the facility will mon and quality assurance program		
	This finding was ac	knowledged by the MD at the			Administrator/Designee will a		
	_	nd again by the MD and			hand sanitizers are located at		
	Administrator at the				least 4 feet horizontal spacing		
					from electric outlets weekly fo	-	
	3.1-19(b)				four weeks, then bi-weekly for		
					weeks. The results of these a	udits	
					and any necessary corrective		
					actions will be discussed durir		
					the monthly QAPI meetings w		
					additional education or revisio		
					the plan made based on audit		
					findings. Monthly meeting wil	I	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 12/19/2024	
	PROVIDER OR SUPPLIE		2210 0	ADDRESS, CITY, STATE, ZIP COD GREENTREE N KSVILLE, IN 47129		
(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 APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
				continue for a minimum of four months then will be stopped aff two consecutive months with no findings or issues noted with the audits.	0	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Installation				
	failed to maintain to accordance with N Installation of Spring edition, Section 6.2 or other devices us around a sprinkler listed for use around practice could affer residents. Findings include: Based on observation Maintenance Direct 12/19/24 between 12/19/24 between 13/10 for 6 Sprinkles protruding down for 5 inches creating specification which would allow above the ceiling. B) The Soiled Ut missing an escutch cover the hole around interview at the timestall to the section of	on and interview, the facility he ceiling construction in FPA 13, Standard for the nkler Systems. NFPA 13, 2010 2.7.1 states plates, escutcheons, ed to cover the annular space shall be metallic, or shall be ad a sprinkler. This deficient et staff and up to 4 staff and 25 on and interview with the eter (MD) and Administrator on 1:45 p.m. and 3:45 p.m.; er Heads in the dining area was om the ceiling approximately 4- pace around the sprinkler head a smoke to escape into the area iility Closet near RR# 111 was eon and did not completely and the sprinkler. Based on the of observation, the MD entioned area was missing the	K 0351	1 Action taken for those residents identified: No individe resident was identified. The two sprinkler heads one which was adjusted on 1/7/25 by Maintenance Technicians so the is no gap around it and the missing escutcheon has been replaced in w36 which is located near room 111. This was completed on 12/19/24 by Maintenance Technician. 2 How other residents are identified. All residents have the potential to be affected by this deficient practice. 3 Systems in place: Audit completed by Maintenance Director on 12/19/24 shows no other issues detected involving sprinkler head or missing escutcheons. Staff educated that no gaps can be present around sprinkler head all must have an escutched when one is missing or a gap.	nere	
	_	cknowledged by the MD at the and again by the MD and e exit conference.		exist, a work order is to be completed. 4 How the facility will monit	or	

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Event ID:

5WXH21 Facility ID: 000100

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

PRINTED: 01/13/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155191		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(x3) DATE SURVEY COMPLETED 12/19/2024			
	PROVIDER OR SUPPLIER NSTER VILLAGE K		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(b)			and quality assurance program Administrator/Designee will au section of Healthcare building weekly to assure each has no gaps noted in sprinkler heads each sprinkler head has an escutcheon for four weeks, the bi-weekly for four weeks. The results of these audits and any necessary corrective actions who be discussed during the month QAPI meetings with additional education or revision of the plamade based on audit findings. Monthly meetings will continue a minimum of four months the will be stopped after two consecutive months with no findings or issues noted with the audits.	and en / vill anly an e for		
K 0353 SS=F Bldg. 01	Based on record rev failed to provide wr evidence the sprink been inspected and 4.6.12.1 requires an required for compli- maintained in accor requirements. Sprin maintained in accor for the Inspection, 7 Water-Based Fire P 4.3.1 requires recor- inspections, tests, an components and sha	Maintenance and Testing riew and interview, the facility itten documentation or other ler system components had tested for 1 of 4 quarters. LSC y device, equipment or system ance with this Code be dance with applicable NFPA akler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, ds shall be made for all and maintenance of the system all be made available to the isdiction upon request. 4.3.2	K 0353	Action taken for those residents identified: No individ resident was identified. Sprink inspection completed by Integration Fire Safety Services on 12/26/ How other residents are identified: All residents have to potential to be affected. Systems in place: Have sprinkler systems certified/inspected every 3 moscheduled by to be scheduled perform quarterly inspection of	kler rity 24. he nths and		

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

Event ID:

 $5WXH21 \quad \text{ Facility ID: } \quad 000100$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/19/2024		
	OF PROVIDER OR SUPPLIE			2210 GI	ADDRESS, CITY, STATE, ZIP COD REENTREE N		
WEST	MINSTER VILLAGE P	(ENTUCKIANA		CLARK	SVILLE, IN 47129		
(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 APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	requires that record performed (e.g., insthe organization that results, and the date waterflow alarm de quarterly to verify the damage. NFPA 25 waterflow alarm de to, water motor gor 5.3.3.2 requires var switch-type waterflow all residents, facility. Findings include: Based on review of inspection records a Maintenance Director 12/19/24 between 1 was no quarterly spreport available for most recent sprinkles over 6 months old. revealed that a springuarter of 2024 did at the time of record Director acknowled documentation avar system had been in quarter of 2024. This finding was according to the date of the da	s shall indicate the procedure spection, test, or maintenance), at performed the work, the e. NFPA 25, 5.2.5 requires that vices shall be inspected they are free of physical special, 5.3.3.1 requires the mechanical vices including, but not limited to the special			sprinkler system by Maintenard Director. Maintenance staff educated that vendor is expect months to perform and where file inspections. Sprinkler inspection completed by Integ Fire Safety Services on 12/26. 4 How the facility will moniand quality assurance program Administrator/Designee to aud Maintenance inspections weef for 4 weeks, then biweekly for weeks to ensure quarterly inspection of sprinkler system complete. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plamade based on audit findings. Monthly meeting will continue minimum of four months then be stopped after two consecution months with no findings or issunoted with the audits.	cted to rity /24. itor n. dit kly 4 is e	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 5WXH21 Facility ID: 000100 If continuation sheet Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155191	B. W	NG		12/19/	/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			REENTREE N		
WESTMII	NSTER VILLAGE K	ENTUCKIANA			SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01							
		on and interview, the facility	K 0	363	1 Action taken for those		02/03/2025
		f over 30 corridor doors had no			residents identified: No indivi		
	_	ing and latching into the door			resident was identified. The		
		sist the passage of smoke.			has been on order and will be		
	-	ice could affect 2 residents and			installed no later than 1/21/24		
	4 staff.				The latch for the break room of		
					was repaired on 12/19/24 by t	he	
	Findings include:				Maintenance Director.		
					2. How other residents are		
	· ·	ration and interview with the			identified: All residents have the	ne	
		for (MD) and Administrator on			potential to be affected.		
		:45 p.m. and 3:45 p.m., the			3. Systems in place: Audit of	all	
		sident Room 217 was missing			bedrooms to assure a door is		
		on interview at the time of the			present completed by		
		D agreed the corridor door			Maintenance Director on		
	_	e room would not have any			12/19/24. Education provided		
	_	ssage of smoke into the			staff that all resident rooms m		
		or fire event originated in the			have a door, when one is miss	-	
		ed that the room was going to			or damaged a work order is to	be	
		area open to the corridor			put in. Audit completed by		
		evert the hall into a memory			Maintenance Director on 12/1		
		now the room is going to be a			shows no issues with other do		
		esident room, as it has been in			latches. Education completed		
	•	re observed in the room			with staff that any door latch w		
		and track had been removed.			issues must have a work orde	r put	
	Room #217 is curre	ently not occupied by residents.			in to repair/replace it.		
					4. How the facility will mon		
	_	knowledged by the MD at the			and quality assurance prograr		
	_	nd again by the MD and			Administrator/Designee wil		
	Administrator at the	e exit conference.			audit resident rooms to assure		
	_,				each has a door weekly for for		
	· ·	ation and interview with the			weeks, then bi-weekly for four		
		tor (MD) and Administrator on			weeks. The results of these at	udits	
		:45 p.m. and 3:45 p.m., the			and any necessary corrective		
		ICF Break Room had a			actions will be discussed durir	-	
		s not installed properly and			the monthly QAPI meetings w		
	had a gan creating a	hale through the door. The	1		additional education or revision	n of	I

<u> </u>		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		01	COMPL	
		155191	B. WING			12/19/	/2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		D	DECLINATION OF CORPORATION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)	·	DATE
	MD agrees the door	knob was loose and needed			the plan made based on audit		
	attention, was not for	unctioning properly and had			findings. Monthly meeting will		
	created a hole throu	gh the door.			continue for a minimum of four	ſ	
					months then will be stopped a	fter	
	This finding was acknowledged by the MD at the				two consecutive months with r	10	
	-	nd again by the MD and			findings or issues noted with the	те	
	Administrator at the	e exit conference.			audits. Administrator/Designe	е	
					will audit a ¼ section of		
	3.1-19(b)				Healthcare building weekly to		
					assure door latches work corre	-	
					for four weeks, then bi-weekly		
					four weeks. The results of the	₃e	
					audits and any necessary corrective actions will be		
					discussed during the monthly		
					QAPI meetings with additional		
					education or revision of the pla		
					made based on audit findings.		
					Monthly meeting will continue		
					minimum of four months then		
					be stopped after two consecut		
					months with no findings or issu		
					noted with the audits.		
			İ	İ			
K 0921	NFPA 101						
SS=F	Electrical Equipme	ent - Testing and					
Bldg. 01	Maintenanc						
		eview, observation, and	K 092	1	1 Action taken for those		02/03/2025
		ty failed to conduct the			residents identified: No indivi		
	•	ce and maintain complete			resident was identified. Policy		
		nspections for Patient Care			Procedure addressing patient		
		Equipment (PCREE). NFPA 99			related electrical appliances a	nd	
	· ·	ns 10.3 and 10.5 states the			equipment added to the	dor	
		esistance, leakage current, and for fixed and portable PCREE			Emergency Preparedness Bin 2 How other residents wer		
		uired in 10.3. Testing intervals			2 How other residents wer identified. All residents have t	-	
		policies and protocols. All			potential to be affected by this		
		ient care rooms is tested in			deficient practice.		
	•	.3.5.4 or 10.3.6 before being put			3 Staff trained on the Police	·V	
		er any repair or modification.			and Procedure regarding testing	-	
	into service and and	or any repair or invalineation.	I	l	and i roccounce regarding lesti	19 01	I

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE (A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 12/19/2024
	PROVIDER OR SUPPLIEI NSTER VILLAGE 1		2210	r address, city, state, zip coe GREENTREE N KSVILLE, IN 47129)
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	TION (X5) PLID BE COMPLETION COMPLETION DATE
	appliances demonsing 99 as a complete system instructions, and promanufacturer inclusions. 3.1.1 and are confused for a program for electerical equipment manuals are readily and condensed operappliance are legible equipment tests, reproduced for a percompliance in accomposition policy. Personnel reproduced for a percompliance in accomposition practice affects all formalist for a percompliance in accomposition produced for a percompliance in accomposition produced for a percompliance in accomposition produced. Findings include: Based on records reproduced for the PCRF facility, as required to documentation was testing of the PCRF facility, as required 99, Health Care Faduring the building provided electric beat Administrator state nebulizers, oxygen monitors, and other was present and in Both the Administration facility was not awarequired to be tester.	eview and interview with the tor (MD) and Administrator on 0:40 am and 1:45 p.m., no available for review for the EE in use throughout the by section 10.5.6.2 of NFPA cilities Code. Observation tour revealed that the facility eds for all residents. The d that PCREE such as concentrators, vital signs relectrical medical equipment use at the facility. ator and MD stated that the are that the PCREE was		patient related electrical appliances and equipment where to locate in book. Maintenance staff trained testing of in house medic equipment. Electrical test obtained equipment suppoutside vendors who sup TCM. System in place to documentation when need Innovative pharmacy or ovendors. Facility owned equipment tested by West Maintenance staff and documentation filed. 4 How the facility will and quality assurance produced and procedured addressing patient relate electrical appliances and equipment are present in Emergency Preparedness weekly for four weeks, the bi-weekly for four weeks, the bi-weekly for four weeks. results of these audits an necessary corrective active discussed during the location or revision of the made based on audit find Monthly meetings with addiceducation or revision of the stopped after two commonths with no findings on noted with the audits.	d on cal sting blied by uply it; or assure eded from other stminster monitor ogram. will audit re d d any ons will monthly tional the plan dings. tinue for a then will secutive

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155191	B. W	NG		12/19/	/2024	
				CTREET	ADDRESS SITY STATE ZID COD			
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD			
MECTM		CENTUCKIANIA			REENTREE N SVILLE, IN 47129			
WESTIMI	NSTER VILLAGE K	RENTUCKIANA		CLARK	SVILLE, IN 47 129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Administrator at the	e exit conference.						
	3.1-19(b)							
K 9999								
Bldg. 01								
	State Findings		K 9	999			02/03/2025	
					1 Action taken for those			
	3.1-19 ENVIRONM	MENT AND PHYSICAL			residents identified: No indivi	dual		
	STANDARDS				resident was identified. Track	s for		
					privacy curtain replaced on			
	` ′	ty must be designed,			12/27/24 by Maintenance Tecl	h.		
	constructed, equipped, and maintained to protect				Privacy curtains in place on			
	· · · · · · · · · · · · · · · · · · ·	y of residents, personnel, and			12/31/24 completed by			
	the public.				Housekeeping staff.			
		in private rooms, each bed			2 How other residents are			
	_	uspended cubicle curtains or			identified: All residents have t	he		
	_	of or flame-retardant material,			potential to be affected by this			
		d the bed to provide total			deficient practice.			
		ombination with adjacent walls			3 Systems in place: Audit			
	and curtains.				completed by Maintenance			
					Director on 12/19/24 showed r	10		
	This State Rule has	not been met as evidenced by:			other areas missing privacy			
					curtain tracks or curtain(s).			
		on and interview, the facility			Education provided to staff that			
		ivacy curtains in 2 of over 10			areas must have privacy curta	ins		
		oms containing at least 2			and tracks for them, when a			
		cient practice could affect 4			curtain or track is missing a wo	ork		
	residents.				order is to be completed.			
					4 How the facility will moni			
	Findings include:				and quality assurance program			
		11.			Administrator/Designee will au			
		on and interview with the			resident rooms weekly to assu			
		tor (MD) and Administrator on			each has privacy curtain track			
		:45 p.m. and 3:45 p.m., resident			and curtain(s) for four weeks,	then		
		and 218 each with two beds			bi-weekly for four weeks. The			
	_	cy were not equipped with			results of these audits and any			
		track for privacy curtains.			necessary corrective actions v			
	Based on interview	at the time of the	1		be discussed during the month	าไV	1	

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		01	(X3) DATE SURVEY COMPLETED 12/19/2024		
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE KENTUCKIANA			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION observations, the MD stated the curtains, and track had been removed anticipating using the two rooms as common areas open to the corridor but plans changed and they will once again be used as double occupancy rooms. The aforementioned rooms are currently not occupied. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference.				QAPI meetings with additional education or revision of the pla made based on audit findings. Monthly meeting will continue minimum of four months then be stopped after two consecut months with no findings or issunoted with the audits.	an for a will tive	

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