PRINTED: 12/02/2022

	T OF HEALTH AND H R MEDICARE & MEDI						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/07/2022	
	PROVIDER OR SUPPLII			2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3	(X5) COMPLETION DATE
E 0000							
Bldg		reparedness Survey was Indiana Department of Health in 2 CFR 483.73.	E 0	000			
	Survey Date: 11/0	07/22					
	Facility Number: Provider Number: AIM Number: 10	155191					
	Westminster Heal not in compliance Requirements for	y Preparedness survey, thcare Kentuckiana was found with Emergency Preparedness Medicare and Medicaid riders and Suppliers, 42 CFR					
	The facility has 94 the survey, the cer	4 certified beds. At the time of nsus was 60.					
	Quality Review co	ompleted on 11/16/22					
	The requirement a MET as evidenced	at 42 CFR, Subpart 483.73 is NOT d by:					
E 0015 SS=C Bldg	(1), 482.15(b)(1) 485.625(b)(1) Subsistence Nee §403.748(b)(1), §441.184(b)(1),	18.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1), eds for Staff and Patients §418.113(b)(6)(iii), §460.84(b)(1), §482.15(b)(1), 483.475(b)(1), §485.625(b)(1)					

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

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph

> TITLE (X6) DATE

Stephanie Wise Administrator 11/30/2022

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.

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		155191	B. WI	NG		11/07	/2022
NAME OF			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER .		2210 G	REENTREE N		
WESTM	INSTER VILLAGE	KENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(a) of this section	ı, risk assessment at					
		of this section, and the					
		lan at paragraph (c) of this					
	section. The poli	icies and procedures must					
	be reviewed and	updated every 2 years					
	[annually for LTC	facilities]. At a minimum,					
	the policies and p	procedures must address					
	the following:						
	(1) The provision	of subsistence needs for					
	1 ' '	s whether they evacuate or					
		nclude, but are not limited					
	to the following:						
	_	nedical and pharmaceutical					
	supplies						
	1	rces of energy to maintain					
	the following:	see of energy to mammam.					
		s to protect patient health					
		or the safe and sanitary					
	storage of provisi						
	(B) Emergency light						
	1 ' '	n, extinguishing, and alarm					
	systems.	i, oxungalorung, and alarm					
	(D) Sewage and	waste disposal					
	(-,	·  r					
	*[For Inpatient Ho	ospice at §418.113(b)(6)(iii):]					
	Policies and prod						
		are additional requirements					
		ated inpatient care facilities					
		s and procedures must					
	address the follow	-					
		of subsistence needs for					
		es and patients, whether					
		shelter in place, include, but					
	are not limited to						
		medical, and pharmaceutical					
		•					•

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supplies.

the following:

(B) Alternate sources of energy to maintain

(1) Temperatures to protect patient health

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED	
		155191	B. W	ING	_	11/07/2022	
NAME OF T	DROWNER OF GURRA TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	K		2210 G	REENTREE N		
WESTMI	NSTER VILLAGE F	KENTUCKIANA	_	CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG		r the cafe and capitary	-	TAG	DET CHERCIT	DATE	—
	storage of provision	r the safe and sanitary					
	(2) Emergency lig						
		extinguishing, and alarm					
	systems.	3,					
	(C) Sewage and v	waste disposal.					
	Based on record re-	view and interview, the facility	E 0	015	The filing of this plan of	12/08/2022	2
		ergency preparedness policies			correction does not constitu	ı	
	_	lude at a minimum, (1) The			that the alleged deficiency d	id	
	_	tence needs for staff and			in fact exist. This Plan of		
		they evacuate or shelter in			correction is filed as evidend	e	
	*	are not limited to the following:			of the facility's desire to		
		dical, and pharmaceutical nate sources of energy to			comply with the regulatory		
	**	peratures to protect resident			requirements and continue t provide quality care.	·	
	, ,	nd for the safe and sanitary			Please accept this plan of		
	_	ns; (B) Emergency lighting; (C)			correction as our credible		
		nguishing, and alarm systems;			allegation of compliance		
		d waste disposal in accordance			E015		
	with 42 CFR 483.7	3(b)(1). This deficient practice			Subsistence Needs for Staff a	nd	
	could affect all occ	upants.			Patients		
	Findings include:				I. Action taken for		
					those residents identified:		
		The Emergency Preparedness 2 between 9:30 a.m. and 1:50			No individual resident was		
		tenance Director and			identified. Policies and procedures		
	*	ent, the plan provided did not			addressing water, pharmaceu	tical	
		pharmaceutical supplies and			supplies were added to the	liodi	
	_	and waste disposal to protect			manual. Policies and procedu	res	
		d safety in an emergency.			were also added for sewage a		
		at the time of records review,			waste disposal in an emergen		
	the Administrator of	confirmed the plan provided did					
		nd pharmaceutical supplies			II. How other resider	nts	
		age and waste disposal to			are identified:		
	_	ealth and safety in an			All residents have the potentia	al to	
	emergency.				be affected.		
	This finding was re	eviewed with the Administrator			III. System in place:		
		Director during the exit			The facility updated the		

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	F OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191			ì í	ILDING	ONSTRUCTION 	(X3) DATE SURVEY  COMPLETED  11/07/2022	
	PROVIDER OR SUPPLIER			2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  conference.			ID PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for futur reference.  IV. How the facility will monitor and quality assurance program: The Administrator/Designee will responsible for auditing the Emergency Preparedness manu weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional			(X5) COMPLETION DATE
E 0023 SS=C Bldg	441.184(b)(5), 48. 483.73(b)(5), 484 485.68(b)(3), 485	6.54(b)(4), 418.113(b)(3), 2.15(b)(5), 483.475(b)(5), .102(b)(4), 485.625(b)(5), .727(b)(3), 485.920(b)(4), 1.12(b)(3), 494.62(b)(4) es for Medical			education or revision of the planade on the basis of the findin Monthly meetings will continue a minimum of six months then be stopped after two consecut months of finding no issues withe stand down meeting audits.  V. Date Complete: 12/8/22	an ngs. e for ı will tive ith	

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Documentation

§403.748(b)(5), §416.54(b)(4), §418.113(b) (3), §441.184(b)(5), §460.84(b)(6), §482.15(b)

(5), §483.73(b)(5), §483.475(b)(5),

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Facility ID: 000100

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED	
		155191	B. W	ING		11/07	/2022
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			REENTREE N		
WESTMI	WESTMINSTER VILLAGE KENTUCKIANA				SVILLE, IN 47129		
WEGTIVII		CENTOONIANA		OLAIN			_
(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
		§485.68(b)(3), §485.625(b)					
	. ,	3), §485.920(b)(4),					
	§486.360(b)(2), §	491.12(b)(3), §494.62(b)(4).					
	-, ,	procedures. The [facilities]					
	1	l implement emergency					
		icies and procedures, based					
		/ plan set forth in paragraph					
		risk assessment at					
		of this section, and the					
	-	an at paragraph (c) of this					
	I	cies and procedures must					
		updated at least every 2					
		r LTC facilities]. At a					
	1	cies and procedures must					
	address the follow	ving:]					
	[/E) or /2\ /4\ /6\]	A system of madical					
	, , , , , , , , , , , , , , , , , ,	A system of medical					
		at preserves patient					
	I	cts confidentiality of patient secures and maintains					
	availability of reco						
	avaliability of reco	nus.					
	*IFor RNHCls at 8	§403.748(b):] Policies and					
	procedures. (5) A	· · · · -					
	. , ,	at does the following:					
	(i) Preserves patie						
		dentiality of patient					
	information.						
		naintains the availability of					
	records.	namami and aramazini, c					
	*[For OPOs at §48	86.360(b):] Policies and					
		A system of medical					
		at preserves potential and					
	actual donor infor						
		potential and actual donor					
		secures and maintains the					
	availability of reco						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	<del></del>	COMPL	
		155191	B. Wl	NG		11/07/	2022
	PROVIDER OR SUPPLIEF			2210 G	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		view and interview, the facility	E 00	)23	The filing of this plan of		12/08/2022
		ergency preparedness policies			correction does not constitut		
	-	ude a system of medical			that the alleged deficiency di	d	
	documentation that	-			in fact exist. This Plan of		
	-	ts confidentiality of resident			correction is filed as evidence	e	
		cures and maintains the rds in accordance with 42 CFR			of the facility's desire to comply with the regulatory		
		deficient practice could affect all			requirements and continue to	,	
	occupants.	deficient practice could affect an			provide quality care.	ا ا	
	occupants.				E023		
	Findings include:				Policies and Procedures for		
	8				Medical Documentation		
	Based on review of	the Emergency Preparedness					
		2 between 9:30 a.m. and 1:50			I. Action taken for		
	p.m. with the Maint	tenance Director and			those residents identified:		
	Administrator prese	ent, policies and procedure that			No individual resident was		
	included a system of	of medical documentation that			identified.		
	preserves resident i	nformation, protects			Policies and procedures		
	confidentiality of re	esident information, and			addressing a system of medical	al	
	secures and maintai	ins the availability of records			documentation that preserves		
	was not available for	or review. Based on interview			resident information, protects		
		d review, the Administrator			confidentiality of resident		
		ity's Emergency Preparedness			information, and secures and		
		clude a system of medical			maintains the availability of		
	documentation that	-			records were added to the		
	-	ts confidentiality of resident			Emergency Preparedness ma	nual.	
		cures and maintains the			l		
	availability of recor	rds.			II. How other residen	its	
	This finding was	viewed with the Administrator			are identified:	l to	
	_				All residents have the potential be affected.	ii to	
	conference.	rirector during the exit			be allected.		
	conference.				III. System in place:		
					The facility updated the		
					Emergency Preparedness Mai	<sub>nual</sub>	
					and educated staff on contents		
					and where to locate the manua		
					both printed and on-line for fut	•	
					reference.		

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
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	<u></u>	COMPLETED	
		155191	B. W	ING		11/07/	/2022
WESTMI	PROVIDER OR SUPPLIEF	KENTUCKIANA		2210 G CLARK	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(X4) ID		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	ΙΤΕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
E 0024 SS=C Bldg	441.184(b)(6), 483.73(b)(6), 484.485.68(b)(4), 485.491.12(b)(4), 494.Policies/Procedure \$403.748(b)(6), \$441.184(b)(6), \$483.73(b)(6), \$4485.68(b)(4), \$4485.920(b)(5), \$485.920(b)(5), \$485.9	6.54(b)(5), 418.113(b)(4), 2.15(b)(6), 483.475(b)(6), .102(b)(5), 485.625(b)(6), .727(b)(4), 485.920(b)(5), .62(b)(5) es-Volunteers and Staffing 416.54(b)(5), §418.113(b)(4), 460.84(b)(7), §482.15(b)(6), 83.475(b)(6), §484.102(b)(5), 85.625(b)(6), §485.727(b)(4), 491.12(b)(4), §494.62(b)(5).			IV. How the facility wimonitor and quality assurant program: The Administrator/Designee wiresponsible for auditing the Emergency Preparedness may weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions with be discussed during the month QAPI meetings with additional education or revision of the plamade on the basis of the finding Monthly meetings will continue a minimum of six months then be stopped after two consecutions of finding no issues with the stand down meeting audits.  V. Date Complete: 12/8/22	ce vill be unual y will hly l an ngs. e for n will tive ith	

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preparedness policies and procedures, based on the emergency plan set forth in paragraph

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<del></del>	COMPL	ETED	
		155191	B. WIN	G		11/07/	2022	
NAME OF I	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP COD	•		
					REENTREE N			
WESTMI	NSTER VILLAGE K	(ENTUCKIANA		CLARK	SVILLE, IN 47129			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DETICIENC! )		DATE	
	` ,	risk assessment at of this section, and the						
		an at paragraph (c) of this						
	· ·	cies and procedures must						
	-	updated at least every 2						
		r LTC facilities]. At a						
		cies and procedures must						
	address the follow	•						
		(7) as noted above] The use						
		n emergency or other						
		g strategies, including the						
		for integration of State and						
	Federally designa							
		ddress surge needs during						
	an emergency.							
	*[For RNHCIs at §	§403.748(b):] Policies and						
	-	he use of volunteers in an						
		ther emergency staffing						
		ess surge needs during an						
	emergency.							
	*IFor Hooping of S	§418.113(b):] Policies and						
		he use of hospice						
	. ,	emergency and other						
		g strategies, including the						
		for integration of State and						
	Federally designa	-						
		ddress surge needs during						
	an emergency.							
		view and interview, the facility	E 002	24	The filing of this plan of		12/08/2022	
		ergency preparedness policies			correction does not constitu	te	- /	
	and procedures incl	ude the use of volunteers in			that the alleged deficiency d	id		
		her emergency staffing			in fact exist. This Plan of			
		g the process and role for			correction is filed as evidence	e		
	_	or Federally designated health			of the facility's desire to			
		o address surge needs during			comply with the regulatory			
		cordance with 42 CFR			requirements and continue t	0		
	483.73(b)(6). This	deficient practice could affect			provide quality care.			

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JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	<del></del>	COMPL	ETED
		155191	B. WIN			11/07	
		155191	D. WIN	<u> </u>		11/07/	2022
NAME OF I	DOWNER OF CHIRD IEL			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		2210 GI	REENTREE N		
WESTMI	NSTER VILLAGE K	(ENTUCKIANA		CLARK	SVILLE, IN 47129		
	-				,		1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	all occupants.				E024		
					Policies/Procedures – Volunte	ore	
	Eindings in sluder					CIS	
	Findings include:				and Staffing		
	Based on review of	the Emergency Preparedness			I. Action taken for		
	Manual on 11/07/22	2 between 9:30 a.m. and 1:50			those residents identified:		
	p.m. with the Maint	tenance Director and			No individual resident was		
	Administrator prese	ent, the facility's plan did not			identified.		
	_	olunteers in an emergency.			Policies and procedures		
		at the time of review, the			addressing the use of voluntee	ore	
		irmed the plan provided did not			_		
					during an emergency were ad		
	address the use of v	rolunteers in an emergency.			to the Emergency Preparedne	SS	
					manual.		
	This finding was re	viewed with the Administrator					
	and Maintenance D	irector during the exit			II. How other residen	its	
	conference.				are identified:		
					All residents have the potentia	I to	
					be affected.		
					bo unoctou.		
					III. System in place:		
					- 7 1		
					The facility updated the		
					Emergency Preparedness Ma		
					and educated staff on contents	S	
					and where to locate the manua	al,	
					both printed and on-line for fut	ure	
					reference.		
					IV. How the facility wi	II	
					monitor and quality assurance		
						<i>.</i>	
					program:	:II I	
					The Administrator/Designee w	ılı be	
					responsible for auditing the		
					Emergency Preparedness ma	nual	
					weekly for four weeks, then		
					bi-weekly for four weeks. The		
					results of these audits and any	/	
					necessary corrective actions w		
					be discussed during the month		
					_	-	
	I		I		QAPI meetings with additional		ĺ

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Event ID:

Facility ID: 000100

education or revision of the plan

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PRINTED: 12/02/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPI			(X3) DATE S	
		155191	B. WING		11/07/		
	ROVIDER OR SUPPLIER			2210 GI	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE
					made on the basis of the findir Monthly meetings will continue a minimum of six months then be stopped after two consecut months of finding no issues wi the stand down meeting audits	e for will ive ith	
					V. Date Complete: 12/8/22		
E 0026 SS=C Bldg	(iv), 441.184(b)(8) (8), 483.73(b)(8), 4 (7), 494.62(b)(7) Roles Under a Wa §403.748(b)(8), §4 (C)(iv), §441.184(l §482.15(b)(8), §48 §485.625(b)(8), §4 [(b) Policies and p must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policies ereviewed and u years [annually for minimum, the policies and policies in the po	6.54(b)(6), 418.113(b)(6)(C) , 482.15(b)(8), 483.475(b) 485.625(b)(8), 485.920(b)  siver Declared by Secretary 416.54(b)(6), §418.113(b)(6) b)(8), §460.84(b)(9), 63.73(b)(8), §483.475(b)(8), 485.920(b)(7), §494.62(b)(7).  rocedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 r LTC facilities]. At a cies and procedures must ring:]  (7), or (9)] The role of the aiver declared by the rdance with section 1135 provision of care and dernate care site identified magement officials.					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/07/2022 155191 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE \*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act. in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility E 0026 The filing of this plan of 12/08/2022 failed to ensure emergency preparedness policies correction does not constitute and procedures include the role of the LTC facility that the alleged deficiency did under a waiver declared by the Secretary, in in fact exist. This Plan of accordance with section 1135 of the Act, in the correction is filed as evidence provision of care and treatment at an alternate of the facility's desire to care site identified by emergency management comply with the regulatory officials in accordance with 42 CFR 483.73(b)(8). requirements and continue to This deficient practice could affect all occupants. provide quality care. E026 Findings include: Roles Under a Waiver Declared by Secretary Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 Action taken for p.m. with the Administrator and Maintenance those residents identified: Director present, the plan did not address the role No individual resident was of the LTC facility under a waiver declared by the identified. Secretary. Based on interview at the time of Policies and procedures record review, the Administrator acknowledged addressing the role of the LTC the available plan did not address the role of the facility under a 1135 waiver LTC facility under a waiver declared by the declared by the Secretary were Secretary. added to the Emergency Preparedness manual. This finding was reviewed with the Administrator and Maintenance Director during the exit II. How other residents conference. are identified: All residents have the potential to be affected.

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Event ID:

8QNM21

Facility ID: 000100

The facility updated the

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System in place:

**Emergency Preparedness Manual** 

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING			(X3) DATE COMPL	LETED
		155191	B. W	ING		11/07	/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
E 0029 SS=F Bldg	403.748(c), 416.5 441.184(c), 482.1 484.102(c), 485.6 485.727(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),		TAG	and educated staff on content and where to locate the manual both printed and on-line for fut reference.  IV. How the facility wimonitor and quality assurant program: The Administrator/Designee was responsible for auditing the Emergency Preparedness maweekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions where discussed during the month QAPI meetings with additional education or revision of the plamade on the basis of the finding Monthly meetings will continue a minimum of six months then be stopped after two consecut months of finding no issues with estand down meeting audits.  V. Date Complete: 12/8/22	s al, ture  ill ce vill be nual y vill hly l an ngs. e for will tive	DATE

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

Event ID:

8QNM21 Facility ID: 000100

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	<del></del>	(X3) DATE SURVEY COMPLETED 11/07/2022	
	PROVIDER OR SUPPLIEI INSTER VILLAGE 1		2210 G	ADDRESS, CITY, STATE, ZIP COD SREENTREE N (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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	(c) The [facility] m an emergency prepared plan that complies local laws and must least every 2 ye facilities]. Based on record refailed to develop an preparedness commowith Federal, State, and updated at least 42 CFR 483.73(c). affect all occupants Findings include:  Based on review of Manual on 11/07/2 p.m. with the Adminited plan preparedness plan proparedness commowith Federal, State, interview at the time Administrator acknowledge a plan to defend the mergency prepared complies with Federal This finding was refailed.	Tthe Emergency Preparedness 2 between 9:30 a.m. and 1:50 nistrator and Maintenance e facility's emergency provided did not include a plan	E 0029	The filing of this plan of correction does not constitute that the alleged deficiency di in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  E029  Development of Communication Plan  I. Action taken for those residents identified:  No individual resident was identified.  The facility developed a plan for emergency communications at how it will be maintained and placed in the Emergency Preparedness manual.  II. How other resident are identified:  All residents have the potential be affected.  III. System in place:  The facility updated the Emergency Preparedness Manual and educated staff on contents.	e  or  or  nd  ts  I to	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/02/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155191		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2022				
	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 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		
E 0036 SS=F	403.748(d), 416.5 441.184(d), 482.1	4(d), 418.113(d), 5(d), 483.475(d), 483.73(d),		and where to locate the manuboth printed and on-line for fureference.  IV. How the facility we monitor and quality assurant program: The Administrator/Designee were propossible for auditing the Emergency Preparedness may weekly for four weeks, then bi-weekly for four weeks. The results of these audits and an necessary corrective actions be discussed during the mont QAPI meetings with additional education or revision of the plantage on the basis of the finding Monthly meetings will continual a minimum of six months there is stopped after two consecutions of finding no issues we the stand down meeting audition.	ial, ture  ill ce vill be anual  y will hly an ings. e for n will tive		
Bldg	§441.184(d), §460 §483.73(d), §483. §485.68(d), §485.	20(d), 486.360(d), (d)					

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	ENT OF DEFICIENCIES  N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTII A. BUILDI B. WING		STRUCTION	(X3) DATE : COMPL 11/07/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Hospice at §418.1 PACE at §460.84 HHAs at §484.102 CAHs at §486.629 485.727, CMHCs §486.360, and RH Training and testin develop and main preparedness trai that is based on the in paragraph (a) consists as the section, policies and (b) of this section, plan at paragraph training and testin reviewed and upd  *[For LTC facilities and testing. The and maintain and testing. The and maintain and testing and testing the emergency plan of this section, ris (a)(1) of this section at paragraph (b) communication plan section. The train must be reviewed annually.  *[For ICF/IIDs at § testing. The ICF/III maintain and testing programs and testing programs and testing programs this section, risk at (a)(1) of this section.	3403.748, ASCs at §416.54, 113, PRTFs at §441.184, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under at §485.920, OPOs at HC/FHQs at §491.12:] (d) Ing. The [facility] must tain an emergency ning and testing program and testing program and the communication (c) of this section. The g program must be lated at least every 2 years.  Sat §483.73(d):] (d) Training LTC facility must develop emergency preparedness g program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this sing and testing program and updated at least every 2 years.  S483.475(d):] Training and ID must develop and gency preparedness training and that is based on the set forth in paragraph (a) of insessment at paragraph (b) of this sing and testing program and updated at least						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155191	B. W	ING		11/07/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			REENTREE N		
WESTMI	NSTER VILLAGE F	(ENTUCKIANA			SVILLE, IN 47129		
		CENT CONTINUE		OL7 II II I			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		an at paragraph (c) of this					
	section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).  *[For ESRD Facilities at §494.62(d):]						
	_	- , , -					
	Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at						
		of this section, policies and					
		agraph (b) of this section,					
		cation plan at paragraph (c)					
		ne training, testing and					
		m must be evaluated and					
	updated at every	2 years.					
	Based on record rev	view and interview, the facility	E 0	036	The filing of this plan of		12/08/2022
	failed to develop ar	nd maintain an emergency			correction does not constitute		
		ng and testing program that			that the alleged deficiency di	d	
		apdated at least annually in			in fact exist. This Plan of		
		CFR 483.73(d). This deficient			correction is filed as evidence	e	
	practice could affect	et all occupants.			of the facility's desire to		
					comply with the regulatory		
	Findings include:				requirements and continue to	0	
	<u> </u>				provide quality care.		
		The Emergency Preparedness			E036		
		2 between 9:30 a.m. and 1:50			EP Training and Testing		
	_	inistrator and Maintenance			l		
	•	ere was no documentation			I. Action taken for		
		he facility had an emergency			those residents identified:		
		ng and testing program			No individual resident was		
	available. Based on interview at the time of record review, the Administrator confirmed there is no training and testing program available within the Emergency Preparedness Manual.				identified.		
					Policies and procedures	.f	
					addressing the development of		
	Emergency Prepare	caness ivianuai.			annual emergency preparedne		
	I		1		training and testing was place	u IN	ı

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2022			
	PROVIDER OR SUPPLIEI NSTER VILLAGE 1		STREET ADDRESS, CITY, STATE, ZIP COD  2210 GREENTREE N  CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Expression with the Administrator	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  the Emergancy Propagations	5.112			
	_	viewed with the Administrator birector during the exit		the Emergency Preparedness manual.  II. How other reside are identified: All residents have the potention be affected.  III. System in place: The facility updated the Emergency Preparedness Mand educated staff on contention and where to locate the manual both printed and on-line for for reference.  IV. How the facility with monitor and quality assurant program: The Administrator/Designee responsible for auditing the Emergency Preparedness mandedly for four weeks, then bi-weekly for four weeks. The results of these audits and are necessary corrective actions be discussed during the mon QAPI meetings with additional education or revision of the period made on the basis of the find Monthly meetings will continual a minimum of six months the be stopped after two consecutions of finding no issues with the stand down meeting audit v. Date Complete: 12/8/22	anual ts ual, uture  vill nce will be anual en y will thly al lan ings. ue for n will utive vith			

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PRINTED: 12/02/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES   AND PLAN OF CORRECTION   DESTITICATION NUMBER   155191   SUMMARY STATEMENT OF DEFICIENCIE   IN WING   SUMMARY STATEMENT OF DEFICIENCIE   IN WING   SUMMARY STATEMENT OF DEFICIENCY   IN WING   SUMMARY STATEMENT OF DEFICIENCY   IN WING   SUMMARY STATEMENT OF DEFICIENCY   IN WING   IN WING	CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	MB NO. 0938-039
155191   B. WING	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	E SURVEY
STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N   CLARKSVILLE, IN 47129	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMP	LETED
2210 GREENTREE N   CLARKSVILLE, IN 47129			155191	B. W	ING		11/07	7/2022
PREFIX				<u> </u>	2210 GI	REENTREE N		
RREFIX   CRACI DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI ANI OF CORRECTIO	ON I	(X5)
### TAG	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
SS=F Bldg. — 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 485.68(d)(1), 481.12(d)(1) EP Training Program §403.748(d)(1), §446.54(d)(1), §448.113(d)(1), §448.113(d)(1), §448.114(d)(1), §485.475(d)(1), §485.727(d) (1), §485.625(d)(1), §485.625(d)(1), §485.727(d) (1), §485.920(d)(1), §485.625(d)(1), §485.727(d) (1), §485.920(d)(1), §485.360(d)(1), §485.727(d) (1), §485.727(d) (1), §485.727(d) (1), §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	PRIATE	DATE
and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.  *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E 0037 SS=F	403.748(d)(1), 41 441.184(d)(1), 48 483.73(d)(1), 484 485.68(d)(1), 485 486.360(d)(1), 49 EP Training Progression of the second	6.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1), .102(d)(1), 485.625(d)(1), .727(d)(1), 485.920(d)(1), 1.12(d)(1) ram 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 83.475(d)(1), §484.102(d)(1), 11, §486.360(d)(1), 11, §486.360(d)(1), 12, "Organizations" under at §486.360, RHC/FQHCs ram. The [facility] must do 13: 14 emergency preparedness 15 edures to all new and 16 viduals providing services 17 ent emergency preparedness 18 edures to all new and 19 ears. 19 ency preparedness training 19 ears. 19 ears. 19 ency preparedness policies 19 er significantly updated, the 19 duct training on the 19 eard procedures. 19 §418.113(d):] (1) Training.					

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(i) Initial training in emergency preparedness policies and procedures to all new and

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<u></u>	COMPLETED		
		155191	B. WIN	G		11/07/	2022	
		_	<del>-                                    </del>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	₹			REENTREE N			
WESTMI	NSTER VILLAGE H	KENTUCKIANA		CLARKS	SVILLE, IN 47129			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup> DEFICIENCY)	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCIT		DATE	
		employees, and individuals sunder arrangement,						
		eir expected roles.						
	(ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years.							
	, ,	eview and rehearse its						
		redness plan with hospice						
		ding nonemployee staff),						
	· ·	nasis placed on carrying out						
	and others.	ecessary to protect patients						
	(v) Maintain documentation of all emergency							
	preparedness training.							
		ncy preparedness policies						
	and procedures a	re significantly updated, the						
	hospice must con	duct training on the						
	updated policies a	and						
	procedures.							
	*[For PRTFs at § <sup>∠</sup>	141.184(d):] (1) Training						
	program. The PR	TF must do all of the						
	following:							
	``	n emergency preparedness						
		edures to all new and						
	-	viduals providing services						
	_	nt, and volunteers,						
		eir expected roles. ning, provide emergency						
	, ,	ning, provide emergency ning every 2 years.						
		staff knowledge of						
	emergency proce	<u> </u>						
	• • •	mentation of all emergency						
	preparedness trai	9 -						
	(v) If the emergency preparedness policies							
	and procedures a	re significantly updated, the						
		uct training on the updated						
	policies and proce	edures.						
			I					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPLETED		
		155191	B. WI	NG		11/07	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	CR.			REENTREE N			
WESTM	INSTER VILLAGE	KENTUCKIANA			SVILLE, IN 47129			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	*[For PACE at §4	160.84(d):] (1) The PACE						
	organization mus	t do all of the following:						
	(i) Initial training i	n emergency preparedness						
	policies and proc	edures to all new and						
	existing staff, indi	ividuals providing on-site						
	services under ar	rrangement, contractors,						
	participants, and	volunteers, consistent with						
	their expected ro	les.						
	(ii) Provide emerç	gency preparedness training						
	at least every 2 y	ears.						
	(iii) Demonstrate staff knowledge of emergency procedures, including informing							
	participants of wh	nat to do, where to go, and						
		in case of an emergency.						
		umentation of all training.						
	(v) If the emerge	ency preparedness policies						
	and procedures a	are significantly updated, the						
	PACE must cond	luct training on the updated						
	policies and proc	edures.						
	*[For LTC Facilities	es at §483.73(d):] (1)						
	Training Program	n. The LTC facility must do all						
	of the following:							
	(i) Initial training i	n emergency preparedness						
	policies and proc	edures to all new and						
	existing staff, indi	ividuals providing services						
	under arrangeme	ent, and volunteers,						
	consistent with th	neir expected role.						
	(ii) Provide emerg	gency preparedness training						
	at least annually.							
	(iii) Maintain docu	umentation of all emergency						
	preparedness tra	ining.						
	(iv) Demonstrate	staff knowledge of						
	emergency proce	edures.						
	*[For CORFs at 8	§485.68(d):](1) Training. The						
	CORF must do a							
		training in emergency						

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preparedness policies and procedures to all new and existing staff, individuals providing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING COMPLI  B. WING 11/07/2					
	PROVIDER OR SUPPLIEF		•	2210 GF	DDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF	LD BE	(X5) COMPLETION
TAG	services under art consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docu (iv) Demonstrate semergency procedus be oriented a responsibilities regemergency plan workday. The train instruction in the lessystems and signal equipment.  (v) If the emergement and procedures a CORF must condupolicies and procedures.  *[For CAHs at §48 program. The CAI following:	rangement, and volunteers, eir expected roles. lency preparedness training ears. mentation of the training. staff knowledge of dures. All new personnel and assigned specific garding the CORF's within 2 weeks of their first ning program must include ocation and use of alarm als and firefighting ency preparedness policies re significantly updated, the luct training on the updated edures.  35.625(d):] (1) Training H must do all of the		TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
	policies and proce reporting and extirprotection, and who f patients, person prevention, and control and disaster author existing staff, indivender arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docu (iv) Demonstrate semergency proceed (v) If the emerge and procedures a	nere necessary, evacuation nnel, and guests, fire coperation with firefighting prities, to all new and viduals providing services nt, and volunteers, eir expected roles. eency preparedness training ears. mentation of the training.					

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191  NAME OF PROVIDER OR SUPPLIER  WESTMINSTER VILLAGE KENTUCKIANA		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2022	
		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	The CMHC must emergency prepared procedures to all individuals provide arrangement, and their expected roldocumentation of must demonstrate emergency procedures training and volunteers, corroles; (ii) Provide etraining at least and documentation of a training; (iv) Demonstraining; (iv) Demonstraining in the Emergency procedures to all not individuals providing and volunteers, corroles; (ii) Provide etraining at least and documentation of a training; (iv) Demonstraining; (iv) Demonstraini	g485.920(d):] (1) Training. provide initial training in predness policies and new and existing staff, ing services under d volunteers, consistent with es, and maintain it the training. The CMHC e staff knowledge of dures. Thereafter, the ide emergency ining at least every 2 years. view and interview, the facility mual training for the edness Program (EPP). The do all of the following: (i) Initial ney preparedness policies and ew and existing staff, ng services under arrangement, nsistent with their expected emergency preparedness nually; (iii) Maintain all emergency preparedness onstrate staff knowledge of ares in accordance with 42 CFR is deficient practice could affect	E 0037	The filing of this plan of correction does not constitut that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  E037 EP Training Program  I. Action taken for those residents identified: No individual resident was identified. Policies and procedures addressing the documentation annual Emergency Preparedness Manual training and staff demonstrating knowledge of the Emergency Preparedness Manual to the manual.	of ess	

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knowledge of the Emergency Preparedness

Manual was available for review. Based on an

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II.

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are identified:

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How other residents

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPLETED	
		155191	B. W	ing		11/07/2022	
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
WESTMI	NSTER VILLAGE K	(FNTUCKIANA		2210 GREENTREE N CLARKSVILLE, IN 47129			
	1		<u> </u>		I	1 ~~	
(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	(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		e of record review, the			All residents have the potentia		
	Administrator confi				be affected.		
	documentation of a						
	Preparedness Manu	al training and no how staff could demonstrate			III. System in place:		
		mergency Preparedness			The facility updated the Emergency Preparedness Ma	nual	
	Manual was available for review.  This finding was reviewed with the Administrator				and educated staff on content		
					and where to locate the manu	al,	
					both printed and on-line for fut	ure	
	and Maintenance Director during the exit conference.				reference.		
					IV. How the facility wi	.	
					monitor and quality assurance		
					program:		
					V. The		
					Administrator/Designee will be	;	
					responsible for auditing the Emergency Preparedness ma	nual	
					weekly for four weeks, then	iluai	
					bi-weekly for four weeks. The		
					results of these audits and any	/	
					necessary corrective actions v		
					be discussed during the month	-	
					QAPI meetings with additional education or revision of the pla		
					made on the basis of the finding		
					Monthly meetings will continue	_	
					a minimum of six months then	will	
					be stopped after two consecut		
					months of finding no issues wi		
					the stand down meeting audits	o.	
					VI. Date Complete:		
					12/8/22		
E 0039	403 748(d)(2) 410	6.54(d)(2), 418.113(d)(2),					
SS=F		2.15(d)(2), 483.475(d)(2),					
Bldg		.102(d)(2), 485.625(d)(2),					
	485.68(d)(2), 485	.727(d)(2), 485.920(d)(2),					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/07/2022	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD	-	
WESTMI	NSTER VILLAGE K	ENTUCKIANA			SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
TAG		1.12(d)(2), 494.62(d)(2)		TAG	DET CIE. CT		DATE
	EP Testing Requi						
	§416.54(d)(2), §4	18.113(d)(2), §441.184(d)(2),					
	. , , , .	32.15(d)(2), §483.73(d)(2),					
	§483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)						
	(2), §491.12(d)(2)	. , . , -					
	*[For ASCs at §41	6.54, CORFs at §485.68,					
		ons" under §485.727,					
	CMHCs at §485.9	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [f	acility] must conduct					
		he emergency plan					
	annually. The [fac	ility] must do all of the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	every 2 years; or					
	1 ' '	nunity-based exercise is					
		nduct a facility-based					
		e every 2 years; or					
	· , -	lity] experiences an actual ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
	-	or individual, facility-based					
	functional exercise	e following the onset of the					
	actual event.						
	` '	ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2) s conducted, that may					
	1 ''	limited to the following:					
		scale exercise that is					
	1 ' '	or individual, facility-based					
	functional exercise	-					
	(B) A mock disast	er drill; or					
	(C) A tableton eve	rcise or workshop that is		l			

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			IDENTIFICATION NUMBER  155191	l í	UILDING	NSTRUCTION	COMPL 11/07/	ETED	
		OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) PREF TA	FIX	(EACH DEFICIENC	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	
	the contraction of the contracti	discussion using a slinically-relevant of set of problem state of problem state of problem state of problem state of challenge an emili) Analyze the [farmaintain document exercises, and emilie [For Hospices at 42]. Testing for hose of the patient's home conduct exercises of the patient's home conduct exercises of the hospice of the emergency of	emergency scenario, and a tements, directed pared questions designed questions designe						

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	î ´	UILDING	NSTRUCTION	(X3) DATE COMPI 11/07	LETED
	PROVIDER OR SUPPLIEI		•	2210 GF	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129	•	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	set of problem sta	emergency scenario, and a atements, directed pared questions designed					
	care directly. The exercises to test to per year. The hose (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engatull-scale community (ii) Conduct an activat may include, following:	nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or gency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the dditional annual exercise but is not limited to the					
	community-based functional exercis (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the maintain document exercises, and en	ter drill; or ercise or workshop led by a udes a group discussion					

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/07/2022	
	OF PROVIDER OR SUPPLIEI			2210 GI	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY 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)	ATE	(X5) COMPLETION DATE
	§482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu- facility-based fund (B) If the [PRTF, I an actual natural that requires activ plan, the [facility] its next required f or individual, facil following the onse (ii) Conduct exercise or and th limited to the follo (A) A second full- community-based facility-based fund (B) A mo (C) A tableto is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or pre to challenge an el (iii) Analyze t and maintain doc tabletop exercises	PRTF, Hospital, CAH] must is to test the emergency ar. The [PRTF, Hospital, e following: an annual full-scale exercise e-based; or inunity-based exercise is not act an annual individual, etional exercise; or Hospital, CAH] experiences or man-made emergency exition of the emergency exition of the emergency exition of the emergency exition allowed exercise exercise functional exercise exercise functional exercise exercise that is an [additional] annual exercise exercise that is a or individual, a exercise or workshop that to and includes a group a narrated, emergency scenario, and a extements, directed pared questions designed					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				ETED
		155191	B. W	WING 11/0			/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			REENTREE N		
WESTMI	NSTER VILLAGE K	CENTUCKIANA			SVILLE, IN 47129		
VVLOTIVII	·	CLIVI O OICH IIV		OL7 (I (I (	O VIELE, II 47 123		
(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
	*[For PACE at §46	` <i>,</i> -					
		PACE organization must					
		s to test the emergency					
	plan at least annu	-					
	organization must	<del>-</del>					
		an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ict an annual individual,					
		ctional exercise; or					
	' '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	is exempt from engaging in its next required						
		nity based or individual,					
		ctional exercise following the					
	onset of the emer						
	, ,	an additional exercise every					
		the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited t	_					
	' '	-scale exercise that is					
	· ·	l or individual, a facility					
	based functional e	•					
	(B) A mock disas						
	, ,	ercise or workshop that is					
	· ·	and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	PACE's response to and					
		ntation of all drills, tabletop					
		•					
		nergency events and revise gency plan, as needed.					
	uie FACE'S emerç	gency plan, as needed.					
	*[For LTC Facilitie	os at 8/83 73(d):1					
	_	- , , -					
	(∠) The [LTC facili	ity] must conduct exercises					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MUI A. BUII B. WIN	DING	NSTRUCTION	(X3) DATE COMPL 11/07/	ETED	
	F PROVIDER OR SUPPLIEI			2210 GR	DDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION
TAG	to test the emerge year, including un the emergency pr ICF/IID] must do to (i) Participate in a that is community (A) When a commaccessible, conductive facility-based functional actual natural or requires activation LTC facility is exercipated a full-scalindividual, facility-following the onse (ii) Conduct an actual natural or requires activation LTC facility is exercipated a full-scalindividual, facility-following the onse (iii) Conduct an actual natural or requires activation (iii) Conduct an actual natural requires activation (iii) Conduct an actual natural requires actual natural requires activation (iii) A tabletop extends (C) A tabletop extends (B) A mock disass (C) A tabletop extends (C) A ta	ency plan at least twice per cannounced staff drills using cocedures. The [LTC facility, the following: an annual full-scale exercise chased; or cannounced exercise is not uct an annual individual, ctional exercise. Sility] facility experiences an cannounced emergency plan, the computer from engaging its next ale community-based or chased functional exercise et of the emergency event. In other exercise that is a continual exercise; or content of the exercise that is a continual exercise; or content of the exercise or workshop that is concludes a group a narrated, emergency scenario, and a content of the exercise or workshop that is concludes a group a narrated, emergency scenario, and a content of the exercise or workshop that is concludes a group a narrated, emergency scenario, and a content of the exercise or workshop that is concludes a group and a content of the exercise or workshop that is concludes a group and a content of the exercise or workshop that is concluded and a content of the exercise or workshop that is concluded a group and a content of the exercise or workshop that is concluded a pared questions designed		TAG		TE	DATE
	all drills, tabletop	exercises, and emergency e the [LTC facility] facility's					
	exercises to test t	§483.475(d)]: CF/IID must conduct the emergency plan at least ne ICF/IID must do the					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COMPLETE		ETED	
		155191	B. W	ING		11/07/2022	
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			REENTREE N		
WESTMI	NSTER VILLAGE K	KENTUCKIANA		CLARKSVILLE, IN 47129			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	following:						
		n annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ct an annual individual,					
	•	ctional exercise; or.					
	` '	experiences an actual					
		ade emergency that requires mergency plan, the ICF/IID					
		gaging in its next required					
	•	nity-based or individual,					
		ctional exercise following the					
		_					
	onset of the emergency event.  (ii) Conduct an additional annual exercise						
	, ,	but is not limited to the					
	following:	but to flot inflitted to the					
	_	scale exercise that is					
	community-based						
	-	ctional exercise; or					
	(B) A mock disast						
	` '	ercise or workshop that is					
		and includes a group					
	discussion, using	- ·					
	_	emergency scenario, and a					
	set of problem sta	•					
	-	pared questions designed					
	to challenge an er	·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the ICF/IID's emer	rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	; or					
	(A) When a c	ommunity-based exercise					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  11/07/2022	
	PROVIDER OR SUPPLIEF		2210 G	ADDRESS, CITY, STATE, ZIP CO REENTREE N (SVILLE, IN 47129	D .
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETION
	individual, facility- every 2 years; or.  (B) If the HH natural or man-ma activation of the e exempt from enga full-scale commur facility based fund onset of the emer (ii) Conduct an ad years, opposite th functional exercise of this section is of include, but is not (A) A second community-based facility-based fund (B) A mock d (C) A tableto is led by a facilitat discussion, using clinically-relevant set of problem sta messages, or pre to challenge an er (iii) Analyze the H maintain documer exercises, and en the HHA's emerge  *[For OPOs at §44 (d)(2) Testing. The exercises to test t OPO must do the (i) Conduct a pape or workshop at lea exercise is led by group discussion,	ditional exercise every 2 le year the full-scale or le under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is lor an individual, ctional exercise; or lisaster drill; or lo exercise or workshop that for and includes a group la narrated, lemergency scenario, and a litements, directed lipared questions designed limergency plan. HA's response to and lintation of all drills, tabletop linergency events, and revise lency plan, as needed.  86.360] le OPO must conduct line designed mergency plan. The			

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AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155191		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2022				
	DF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	prepared question emergency plan. actual natural or requires activatio OPO is exempt for required testing e of the emergency (ii) Analyze the Omaintain docume exercises, and enthe [RNHCI's and needed.  *[RNCHIs at §40 (d)(2) Testing. The exercises to test to RNHCI must do to (i) Conduct a papatal least annually. It group discussion narrated, clinically scenario, and a societate diesigned to challe (ii) Analyze the Romaintain docume exercises, and enthe RNHCI's emergased on record refailed to conduct explan at least twice plan at least twice	PO's response to and ntation of all tabletop nergency events, and revise OPO's] emergency plan, as a.748]:  e RNHCI must conduct the emergency plan. The he following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a y-relevant emergency et of problem statements, as, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the facility exercises to test the emergency per year, including drills using the emergency or year, including drills using the emergency or facility must do the annual full-scale exercise that d; or inty-based exercise is not an annual individual,	E 0039	The filing of this plan of correction does not constitut that the alleged deficiency of in fact exist. This Plan of correction is filed as eviden of the facility's desire to comply with the regulatory requirements and continue provide quality care. Please accept this plan of correction as our credible	did ce			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		A. BUILDING COMPI			(X3) DATE SURVEY COMPLETED 11/07/2022		
	PROVIDER OR SUPPLIEF NSTER VILLAGE 1		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
(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	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ty experiences an actual natural gency that requires activation			allegation of compliance <b>E039</b>		
	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a				EP Training Requirements		
		or individual, facility-based			I. Action taken for		
		l exercise for 1 year following			those residents identified:		
	the onset of the actu				No individual resident was		
		itional exercise that may			identified.		
	a. A second full-sca	imited to the following:			The facility located the Active		
					Shooter and Work Place Viole	ence	
	community-based or an individual, facility-based functional exercise.				tabletop exercise that was conducted by the Indiana Stat		
	b. A mock disaster drill; or				Police on July 25, 2022. This	.e	
	c. A tabletop exercise or workshop that is led by a				exercise and test were perform	med	
	facilitator that includes a group discussion, using				at the facility. The facility also	neu	
		y-relevant emergency scenario,			scheduled a Dec 5, 2022 table	etop	
		n statements, directed			tornado exercise based on the	·	
	_	red questions designed to			HVA.		
	challenge an emerg	-					
	(iii) Analyze the L7	ΓC facility's response to and			II. How other resider	nts	
	maintain document	ation of all drills, tabletop			are identified:		
	exercises, and emer	rgency events, and revise the			All residents have the potentia	al to	
	LTC facility's emer	gency plan, as needed in			be affected.		
	accordance with 42						
		rice could affect all occupants			III. System in place:		
	in the facility.				The facility updated the		
					Emergency Preparedness Ma		
	Findings include:				and educated staff on content		
					and where to locate the manu		
		The Emergency Preparedness			both printed and on-line for fu	ture	
		2 between 9:30 a.m. and 1:50 inistrator and Maintenance			reference.		
	^				N/ Have the feetility was		
		e facility was unable to tion of a community based			IV. How the facility w		
	^	d exercise during the past 12			monitor and quality assuran	∪ <del>∈</del>	
		s was confirmed by the			program: The Administrator/Designee v	vill he	
		e time of record review.			responsible for auditing the	VIII DE	
	1 101111111111111111111111111111111111	- mile of feeding feetiew.			Emergency Preparedness ma	nual	
	This finding was re	viewed with the Administrator			weekly for four weeks, then		
		Director during the exit			bi-weekly for four weeks. The		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <del></del>	COMP	E SURVEY PLETED 7/2022
	PROVIDER OR SUPPLIEF		2210 G	ADDRESS, CITY, STATE, ZII GREENTREE N (SVILLE, IN 47129	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
E 0041 SS=F Bldg	§482.15(e) Conditive (e) Emergency and The hospital must standby power systemergency plans this section and in procedures plans (i) and (ii) of this signal (ii) of this signal (iii) of this signal (iii) of this signal (iiii) of this signal (iiiiii) of this signal (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.		results of these audit necessary corrective be discussed during QAPI meetings with education or revision made on the basis of Monthly meetings with a minimum of six more be stopped after two months of finding not the stand down meeting.  V. Date Cor 12/8/22	e actions will the monthly additional of the plan of the findings. Il continue for onths then will consecutive issues with ting audits.	

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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  (X3) DATE SURVEY  COMPLETED  11/07/2022						
	PROVIDER OR SUPPLIER NSTER VILLAGE 1		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION			
	12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), an structure is built o structure or building 482.15(e)(2), §48 Emergency gener The [hospital, CAI implement the em	and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new r when an existing ng is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must lergency power system						
	requirements four	յ, and [maintenance] nd in the Health Care FPA 110, and Life Safety						
	Emergency gener and LTC facilities source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel emergency generators must be wit will keep emergency perational during the s it evacuates.						
	§483.73(g), and O The standards inc this section are ap reference by the I Federal Register in 552(a) and 1 CFR the material from You may inspect a Information Reson Boulevard, Baltim Archives and Rec (NARA). For information	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in opproved for incorporation by Director of the Office of the n accordance with 5 U.S.C. a part 51. You may obtain the sources listed below. a copy at the CMS curce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or						
	~	es.gov/federal_register/code						

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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	A. BUILDING COMPLETED			LETED	
		155191	B. W	B. WING 11/07/2022			/2022	
		l .		STPEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIE	3			REENTREE N			
WESTMI	NSTER VILLAGE K	(ENTLICKIANA			(SVILLE, IN 47129			
V V LO I IVII		CENT O O IN IN IN		OLAIN	1			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1	ations/ibr_locations.html.						
	, , ,	this edition of the Code are						
	1 .	eference, CMS will publish a						
		ederal Register to						
	announce the cha	_						
	1 ' '	Protection Association, 1						
	Batterymarch Par							
	Quincy, MA 02169	⊌, www.ntpa.org,						
	1.617.770.3000.	th Cana Facilities Octo						
	(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.							
		•						
	NFPA 99, issued	rim amendment (TIA) 12-2 to						
	· ·	•						
	(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.							
		FPA 99, issued March 7,						
	2013.	FFA 99, ISSUEU MAICH 1,						
		FPA 99, issued August 1,						
	2013.	177 00, iosaca 7tagast 1,						
		FPA 99, issued March 3,						
	2014.							
	(vii) NFPA 101, Li	fe Safety Code, 2012						
	edition, issued Au	· ·						
	· ·	IFPA 101, issued August						
	11, 2011.	-						
	(ix) TIA 12-2 to NI	FPA 101, issued October					1	
	30, 2012.							
	(x) TIA 12-3 to NF	FPA 101, issued October						
	22, 2013.							
	` '	FPA 101, issued October					1	
	22, 2013.							
	1 ' '	Standard for Emergency and						
		ystems, 2010 edition,						
		chapter 7, issued August 6,						
	2009						10/00/2222	
		view and interview, the facility	E 0	041	The filing of this plan of		12/08/2022	
	_	t the emergency power system			correction does not constitu			
		and maintenance requirements			that the alleged deficiency d	ıd		
		Care Facilities Code, NFPA			in fact exist. This Plan of			
	i illi and lite Natet				L COMPOSTION IS THAN 36 AVAILANT	20		

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/07/2022	
	PROVIDER OR SUPPLIEF NSTER VILLAGE K			2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, IN 47129		
(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)		ON
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
140	CFR 483.73(e)(2).  1. Based on record facility failed to may of monthly generated generator during the 6.4.4.1.1.4(a) of 20 testing of the general electrical system to 110, the Standard for Powers Systems, Construction of the Standard for Inspection by the jurisdiction. This difference is a season of the standard for	review and interview, the intain a complete written record or load testing for 1 of 1 e past 12 months. Chapter 12 NFPA 99 requires monthly ator serving the emergency be in accordance with NFPA or Emergency and Standby hapter 8. Chapter 6.4.4.2 of a written record of inspection, ising period, and repairs for the ularly maintained and available e authority having efficient practice could affect all visitors.  View on 11/07/22 between 9:30 with the Administrator and for present, there was no the emergency generator for percentage of load during sets during the past 12 months. Evided always said "NA" or it ed on interview at the time of Maintenance Director agreed mentation provided on the oad test form for percentage of		TAU	of the facility's desire to comply with the regulatory requirements and continue to provide quality care. Please accept this plan of correction as our credible allegation of compliance E041 Hospital CAH and LTC Emerging Power  I. Action taken for those residents identified: The facility contacted the generator service provider to provide required service and training for the maintenance a upkeep of the emergency generators. This included documenting the emergency generator monthly test for percentage of load; actual loa percentage to establish the required 30% of the name pla rating; annual fuel quality test.  II. How other resider are identified: All residents have the potential be affected.  III. System in place:	o dency	
	This finding was re	viewed with the Administrator irector during the exit			Maintenance personnel were educated on how to schedule perform and document emerg generator testing.		
	facility failed to exe	review and interview, the ercise the generator annually to nts of NFPA 110, 2010 Edition,			IV. How the facility w monitor and quality assuran program:		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r /		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG	<del></del>	COMPL	
		155191	B. WING			11/07/	2022
NAME OF F			STF	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C	22	10 GF	REENTREE N		
WESTMI	NSTER VILLAGE K	KENTUCKIANA	CL	ARKS	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	G		:II I	DATE
		nergency and Standby Powers			The Administrator/Designee w responsible for auditing the	ili be	
	Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least				Emergency Preparedness ma	nual	
	_	minimum of 30 minutes, using			weekly for four weeks, then	iluai	
	one of the following	<del>-</del>			bi-weekly for four weeks. The		
		nintains the minimum exhaust			results of these audits and any	,	
		recommended by the			necessary corrective actions w		
	manufacturer				be discussed during the month		
		temperature conditions and at			QAPI meetings with additional		
	•	cent of the EPS (Emergency			education or revision of the pla		
	Power Supply) nam	-			made on the basis of the findir	-	
		es diesel-powered EPS			Monthly meetings will continue		
		not meet the requirements of			a minimum of six months then		
		ised monthly with the available			be stopped after two consecut		
		Power Supply System) load and nually with supplemental			months of finding no issues wi the stand down meeting audits		
		Test) at not less than 50 percent			the stand down meeting addition	·.	
	· ·	tte kW rating for 30 continuous					
	_	less than 75 percent of the EPS			V. Date Complete:		
		g for 1 continuous hour for a			12/8/22		
	total test duration o	f not less than 1.5 continuous					
	hours. This deficien	nt practice could affect all					
	occupants.						
	Findings include:						
	Based on record re	view on 11/07/22 between 9:30					
	-	with the Administrator and					
		tor present, the generator load					
		on showed the actual load					
		liesel powered generator was					
		ased on interview at the time					
	·	ne Maintenance Director said					
		nder load on a monthly basis it achieves the required 30 %					
		ating. Additionally, the					
	_	tor acknowledged a load bank					
		or had not occurred within the					
	past 12 month perio						
	·						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155191		UILDING	NSTRUCTION	COMPL 11/07	ETED	
	PROVIDER OR SUPPLIER NSTER VILLAGE K		2210 GI	.ddress, city, state, zip cod REENTREE N SVILLE, IN 47129		
(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
	_	viewed with the Administrator irector during the exit				
	facility failed to ensign was performed for a generators. NFPA 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA 110, Standby Power Sys NFPA 110, Section shall be performed approved by ASTM.	review and interview, the sure an annual fuel quality test 1 of 1 diesel powered 99, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance andard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient at all residents, as well as staff				
	a.m. and 1:50 p.m. Maintenance Direct documentation of a dated 06/08/22, how documentation of at the diesel generator on interview at the Maintenance Direct have a diesel generator with the facility's gowas determined that taken by the current This finding was re	n annual fuel quality test for available for review. Based time of record review, the for stated the facility does ator but after having spoken enerator inspection vendor it t a fuel sample has not been				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 11/07/2022				
	ROVIDER OR SUPPLIER		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	*	ICY 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
K 0000 Bldg. 01	_	Recertification and State	K 0	000			
	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).  Survey Date: 11/07/22  Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130  At this Life Safety Code survey, Westminster Healthcare Kentuckiana was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies.						
	Type V (000) construction The facility has a find etection in the correction and batter all resident sleeping	ity was determined to be of ruction and fully sprinkled. re alarm system with smoke ridors, spaces open to the ry operated smoke detectors in grooms. The facility has a had a census of 60 at the time					
		idents have customary access all areas providing facility kled.					
	Quality Review con	npleted on 11/16/22					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155191			JILDING	01	COMPL 11/07	ETED	
	ROVIDER OR SUPPLIER			2210 GF	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(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
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
3 -	•	d means of egress shall not					
		a latch or a lock that					
		f a tool or key from the					
		s using one of the following					
	special locking arr	-					
		OR SECURITY THREAT					
	LOCKING						
	Where special locl	king arrangements for the					
	clinical security needs of the patient are						
	used, only one locking device shall be permitted on each door and provisions shall						
	be made for the ra	apid removal of occupants					
	by: remote control	of locks; keying of all					
	locks or keys carri	ed by staff at all times; or					
	other such reliable	e means available to the					
	staff at all times.						
	18.2.2.2.5.1, 18.2.	2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS	LOCKING					
	ARRANGEMENTS	S					
	Where special locl	king arrangements for the					
	safety needs of the	e patient are used, all of					
	the Clinical or Sec	curity Locking requirements					
	are being met. In a	addition, the locks must be					
	electrical locks tha	at fail safely so as to					
	release upon loss	of power to the device; the					
		ed by a supervised					
	automatic sprinkle	r system and the locked					
		l by a complete smoke					
	detection system (	or is constantly monitored					
		ation within the locked					
		he sprinkler and detection					
	-	ged to unlock the doors					
	upon activation.						
	18.2.2.2.5.2, 19.2.						
	DELAYED-EGRES						
	ARRANGEMENTS	S					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155191	B. W	ING		11/07/	2022
	PROVIDER OR SUPPLIER NSTER VILLAGE K		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S BLAN 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'	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, superstance of the contents and the contents are controlled in accordance of the contents and the contents are contents.	lelayed-egress locking in accordance with permitted on door g low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system.  2.4 COLLED EGRESS AGEMENTS a Egress Door assemblies lance with 7.2.1.6.2 shall  2.4 BY EXIT ACCESS AGEMENTS t access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an ised automatic sprinkler	K 0		The filing of this plan of correction does not constitut that the alleged deficiency di in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  Please accept this plan of correction as our credible	d ee	12/08/2022
	(b) The force shall a continuously applie	not be required to be d for more than 3 seconds.			allegation of compliance <b>K222</b> Egress Doors		
	I (c) The initiation of	the release process shall	ı				

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/07/2022 155191 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE activate an audible signal in the vicinity of the Action taken for door opening. those residents identified: (d) Once the lock has been released by the No individual resident was application of force to the releasing device, identified. relocking shall be by manual means only. This The outside exit door signage was deficient practice could affect up to 5 residents, as corrected to state 15 second well as staff and visitors. delayed egress as required. Findings include: How other residents are identified: Based on observations on 11/07/22 between 1:50 All residents have the potential to p.m. and 4:30 p.m. during a tour of the facility with be affected. the Administrator and Maintenance Director, the outside exit door near the entrance to the III. System in place: Assisted Living corridor was equipped with a An audit of all outside emergency delayed egress sign, however, the sign indicated egress door signage was it was only a 5 second delayed egress instead of a completed to ensure the required required 15 second delayed egress sign. The door information was displayed. did release from the magnetic lock after pushing on the panic bar for 15 seconds. Based on How the facility will interview at the time of observation, the monitor and quality assurance Maintenance Director said the "1" must have program: gotten scratched off the sign, and he would The Administrator/Designee will be replace the sign as soon as possible. responsible for auditing the preventative maintenance logs This finding was reviewed with the Administrator weekly for four weeks, then and Maintenance Director during the exit bi-weekly for four weeks. The conference. results of these audits and any necessary corrective actions will 3.1-19(b) be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive

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months of finding no issues with the stand down meeting audits.

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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 11/07/2022				
	PROVIDER OR SUPPLIEF		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 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			
				V. Date Complete: 12/8/22				
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automati option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system e areas shall be separated to by smoke resisting rs in accordance with 8.4.						
	d. Soiled Linen Ro gallons) e. Trash Collection							
	(over 50 square for g. Laboratories (if Hazard - see K32)	orage Rooms/Spaces eet) classified as Severe 2)						
		ation and interview, the sure a hazardous area outside 1	K 0321	The filing of this plan of correction does not constitu	12/08/2022			

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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	01	COMPL	ETED
		155191	B. W	ING		11/07/	2022
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			REENTREE N		
WESTMI	NSTER VILLAGE K	(ENTUCKIANA			SVILLE, IN 47129		
	T		-		T	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		osed by smoke resisting separated from the exit			that the alleged deficiency d	ıa	
	_	-			in fact exist. This Plan of correction is filed as evidence		
	discharge. This deficient practice could affect at least 5 residents, staff, and visitors.					æ	
	least 5 residents, starr, and visitors.				of the facility's desire to comply with the regulatory		
	Findings include:				requirements and continue t	•	
	1 mangs metader				provide quality care.	O	
	Based on observations on 11/07/22 between 1:50				Please accept this plan of		
	p.m. and 4:30 p.m. during a tour of the facility with				correction as our credible		
	the Administrator and Maintenance Director,				allegation of compliance		
	there were four large totes with bio-hazardous				K321		
	material stored within an approximately eight foot				Hazardous Areas - Enclosure		
	by six-foot metal linked fenced in area directly						
	outside and exposed to the exit discharge near the				I. Action taken for		
	Assisted Living ent	rance corridor. Based on			those residents identified:		
	interview at the tim	e of observation, this was			No individual resident was		
	acknowledged by the	ne Administrator and			identified.		
	Maintenance Direct	tor.			Facility purchased and installe	ed a	
					storage building that is stand		
	3.1-19(b)				alone and secure for hazardo	JS	
					waste containers waiting for		
		ration and interview, the			pickup. It is installed away froi	m	
		sure the corridor door to 1 of			emergency exits. The facility		
		area doors, such as a storage			removed cardboard boxes of i		
	_	wided with a self closing			from the Staff Development R		
		ent practice could affect at			and installed a self-closing de	vice	
	least 5 residents, sta	arr, and visitors.			on the door to the room.		
	Findings include:				II. How other resider	40	
	Findings include.				are identified:	ILS	
	Based on observation	ons on 11/07/22 between 1:50			All residents have the potential	al to	
		during a tour of the facility with			be affected.	11 10	
		nd Maintenance Director, the			be allected.		
		Room was full of over 30			III. System in place:		
		well as wood pallets. The			Staff were educated on where	to	
		s room was not provided with a			store Hazardous waste for		
		This room was over 50 square			pick-up.		
		on interview at the time of					
		aintenance Director agreed the			IV. How the facility w	ill	
		s Staff Development Room was			monitor and quality assurant		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       01       COMPLETE         B. WING       11/07/202			PLETED	
	PROVIDER OR SUPPLIER NSTER VILLAGE K		22	REET ADDRESS, CITY, STATE, ZIP C 10 GREENTREE N ARKSVILLE, IN 47129	OD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE A	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION
TAG	not provided with a  This finding was re	self-closing device.  viewed with the Administrator irector during the exit	TAC	program: The Administrator/Desi responsible for auditing preventative maintenar weekly for four weeks, bi-weekly for four week results of these audits necessary corrective a be discussed during th QAPI meetings with ad education or revision o made on the basis of the Monthly meetings will do a minimum of six mont be stopped after two comonths of finding no is the stand down meetin  V. Date Comp. 12/8/22	g the noce logs then is. The and any octions will be monthly iditional for the plan in findings. Continue for the then will consecutive sues with g audits.	DATE
SS=E Bldg. 01	Cooking Facilities Cooking Facilities Cooking equipment accordance with Noventilation Contrology Testing to a toasters and toasters are used cooking in accordate accordance such a toasters are used cooking in accordate accordance a	IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2022			
	PROVIDER OR SUPPLIER		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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	Cooking facilities   NFPA 96 per 9.2.3 enclosed as hazal be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observatio failed to ensure the Therapy room was a in use. LSC 19.3.2. compartment, reside equipment that is us fewer persons shall the cooking facility conditions: (1) The space conta is not a sleeping roo (2) The space conta shall be separated fit complying with 19. (3) The requirement and (13) are met. 19.3.2.5.3(9) states following is provide (a) A locked switch restricted location, if facility that deactive (b) The switch is us or range whenever to supervision. This deficient pract residents while in the Findings include:  Based on observation p.m. and 4:30 p.m. the Administrator as	in 18.3.2.5.4, 19.3.2.5.1 is, 9.2.3, TIA 12-2 on and interview, the facility cook top in 1 of 1 Physical shut off at the switch when not 5.4 states within a smoke ential or commercial cooking sed to prepare meals for 30 or be permitted, provided that complies with all the following ining the cooking equipment om. ining the cooking equipment from the corridor by partitions 3.6.2 through 19.3.6.5. ts of 19.3.2.5.3(1) through (10)	K 0324	The filing of this plan of correction does not constituthat the alleged deficiency of in fact exist. This Plan of correction is filed as evident of the facility's desire to comply with the regulatory requirements and continue provide quality care. Please accept this plan of correction as our credible allegation of compliance K324 Cooking Facilities  I. Action taken for those residents identified: No individual resident was identified. An emergency shut off switch installed on the cooktop stowlocated in the Therapy Room  II. How other residents are identified: All residents have the potentible affected.  III. System in place: Staff were educated on the location of the emergency shus witch.	n was e i. ents ial to	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155191 B. WING 11/07/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Therapy room. When checked, and not in use, How the facility will the stove top appliance was not deactivated from monitor and quality assurance the individual cooktop power source. Based on program: interview at the time of observation, the The Administrator/Designee will be Maintenance Director confirmed the cooktop responsible for auditing the stove was not deactivated when not in use. preventative maintenance logs weekly for four weeks, then This finding was reviewed with the Administrator bi-weekly for four weeks. The and Maintenance Director during the exit results of these audits and any conference. necessary corrective actions will be discussed during the monthly 3.1-19(b) QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. Date Complete: 12/8/22 K 0345 **NFPA 101** SS=F Fire Alarm System - Testing and Bldg. 01 Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72,

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National Fire Alarm and Signaling Code. Records of system acceptance, maintenance

Based on record review and interview, the facility

failed to maintain 1 of 1 fire alarm system in

and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72

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The filing of this plan of

correction does not constitute

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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	UILDING	01	COMPLETED
		155191	B. W	ING		11/07/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	2			REENTREE N	
VA/ECTAI	NOTED VIII ACE I	CENTUICIZIANIA				
WESTIMI	NSTER VILLAGE K	RENTUCKIANA		CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	accordance with NI	FPA 72, as required by LSC 101			that the alleged deficiency di	id
	Sections 19.3.4.5.1 and 9.6. NFPA 72, Section				in fact exist. This Plan of	
	14.3.1 states that unless otherwise permitted by				correction is filed as evidence	e
		ctions shall be performed in			of the facility's desire to	
	_	e schedules in Table 14.3.1, or			comply with the regulatory	
		red by the authority having			requirements and continue to	0
		14.3.1 states that the following			provide quality care.	
	must be visually inspected semi-annually:				Please accept this plan of	
	a. Control unit trouble signals				correction as our credible	
	b. Remote annunciators				allegation of compliance	
	c. Initiating devices (e.g. duct detectors, manual				K345	
	fire alarm boxes, heat detectors, smoke detectors,				Fire Alarm System	
	etc.)				The Additional System	
	d. Notification appliances				I. Action taken for	
	e. Magnetic hold-open devices				those residents identified:	
		ice could affect all occupants			No individual resident was	
	in the facility.	nee could affect all occupants			identified.	
	in the facility.				Maintenance did a visual	
	Findings include:				inspection of the 43 hard wired	٦
	i manigs metade.				smoke detectors. The visual	1
	Based on record res	view on 11/07/22 between 9:30				
		with the Administrator and		inspection was documented in		
	-	tor present, there was			preventative maintenance reco	Jius.
		vided regarding a visual			II. How other residen	nto
	_					iis
		arm system inspection dated se Maintenance Staff, however,			are identified:	ul to
	1	provided only included the			All residents have the potential be affected.	ii iO
		Fpull stations and			pe allected.	
	•	-			III Contant in place.	
		not include the 43 hard wired			III. System in place:	
		cated throughout the facility.			The 43 hard wired smoke	
	The most recent and				detectors were added to the	
		st/inspection was dated			semi-annual inspection list.	
		n interview at the time of record			],, ,, ,, ,, ,,,	
		nance Director confirmed the			IV. How the facility wi	
	_	f the fire alarm system's			monitor and quality assurance	ce
		0/22 did not include the			program:	
	racility's 43 hard wi	ired smoke detectors.			The Administrator/Designee w	/III be
					responsible for auditing the	
		viewed with the Administrator			preventative maintenance logs	3
	and Maintenance D	rirector during the exit			weekly for four weeks, then	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155191		A. BUILDING  B. WING	01	COMPLETED 11/07/2022	
	ROVIDER OR SUPPLIER NSTER VILLAGE K		2210 G	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, 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
14 00 10	conference. 3.1-19(b)			bi-weekly for four weeks. The results of these audits and any necessary corrective actions we discussed during the month QAPI meetings with additional education or revision of the plamade on the basis of the finding Monthly meetings will continue a minimum of six months then be stopped after two consecut months of finding no issues with the stand down meeting audits.  V. Date Complete: 12/8/22	vill an an ags. a for will ive th
K 0346 SS=C Bldg. 01	services for more period, the authori be notified, and the evacuated or an a provided for all particular particular provided for all particular provided for all particular provided to see 9.6.1.6  Based on record revifailed to provide a cordection of 60 of 6 procedures to be fol alarm system has to four hours or more if accordance with LS	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the fire alarm system has	K 0346	The filing of this plan of correction does not constitute that the alleged deficiency di in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  Please accept this plan of correction as our credible	d e

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED	
		155191	B. W	ING		11/07/		
					_			
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
					REENTREE N			
WESTMI	NSTER VILLAGE K	KENTUCKIANA		CLARK	SVILLE, 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	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE	
					allegation of compliance			
	Based on record rev	view on 11/07/22 between 9:30			K346			
	a.m. and 1:50 p.m.	with the Administrator and			Fire Alarm System – Out of			
	-	tor present, the facility			Service			
	provided fire watch documentation from the							
	Emergency Prepare	edness plan, however, it was			I. Action taken for			
	incomplete. The pl	lan did include the phone			those residents identified:			
		OH, however, the plan failed to			No individual resident was			
		the Indiana Department of			identified.			
	_	h the web link for contacting the			The Emergency Preparedness	s		
	Incident Reporting	System located on the IDOH			plan was updated to include the			
	Gateway, furthermo	ore, the fire watch did not			Indiana Department of Health			
		tion to indicate the person			weblink for contacting the Inci	dent		
		watch has been properly			Reporting System located on			
		an interview at the time of			IDOH Gateway, in the case th			
	record review, the I	Maintenance Director			the fire alarm system was place			
		watch lacked the previously			out of service for more than fo			
	mentioned informat	tion.			hours in a 24-hour period. Tra	ining		
					on this procedure was provide	-		
	This finding was re	eviewed with the Administrator			the maintenance personnel			
	and Maintenance D	Director during the exit			responsible for reporting it.			
	conference.							
					II. How other resider	nts		
	3.1-19(b)				are identified:			
					All residents have the potentia	al to		
					be affected.			
					III. System in place:			
					The facility updated the			
					Emergency Preparedness pla	n		
					and educated maintenance			
					personnel on contents and wh	nere		
					to locate the manual, both prir	nted		
					and on-line for future referenc	e.		
					IV. How the facility w	ill		
					monitor and quality assuran	ce		
					program:			
					V. The			
					Administrator/Designee will be	9		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155191	B. W	ING		11/07/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N				
WESTMI	NSTER VILLAGE K	ENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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
K 0351 SS=E Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II comprotection measure substituted for sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and	Installation  Ind hospitals where required be, are protected approved automatic accordance with NFPA he Installation of Sprinkler  Instruction, alternative hes are permitted to be inkler protection in specific for local regulations prohibit had a required in patient sleeping rooms the closet does not exceed sprinkler coverage covers tas required by NFPA 13,			responsible for auditing the Emergency Preparedness plat weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions who discussed during the month QAPI meetings with additional education or revision of the plat made on the basis of the finding Monthly meetings will continue a minimum of six months then be stopped after two consecut months of finding no issues with the stand down meeting audits.  Date Complete: 12/8/22	y vill hly lan ngs. e for will tive	

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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 COMPLETED 01 B. WING 11/07/2022 155191 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility K 0351 12/08/2022 The filing of this plan of failed to ensure 1 of 1 outside entrance overhead correction does not constitute canopy was provided with adequate sprinkler that the alleged deficiency did coverage in accordance with NFPA 13, Standard in fact exist. This Plan of for the Installation of Sprinkler Systems. NFPA 13, correction is filed as evidence 2010 edition, Section 8.15.7.1 states unless the of the facility's desire to requirements of 8.15.7.2, 8.15.7.3, or 8.15.7.4 are comply with the regulatory met, sprinklers shall be installed under exterior requirements and continue to roofs, canopies, porte-cocheres, balconies, decks, provide quality care. or similar projections exceeding 4 ft (1.2 m) in Please accept this plan of width. This deficient practice could residents, correction as our credible staff, and visitors while entering or exiting the allegation of compliance Physical Therapy entrance/exit area. K351 Sprinkler System - Installation Findings include: Action taken for I. Based on observations on 11/07/22 between 1:50 those residents identified: p.m. and 4:30 p.m. with the Administrator and No individual resident was Maintenance Director during a tour of the facility, identified. the outside entrance/exit area to the Physical The facility was able to contact Therapy area was provided with a 21 foot by 6 the manufacturer/installer of the foot overhead canvas canopy. There was a outside awning. It meets fire rating sprinkler head on the outside of the building to requirements and does not require this area, however, it would not provide adequate additional sprinkler installation. sprinkler coverage to the entire canvas canopy. This was acknowledged by the Administrator and How other residents Maintenance Director at the time of observation. are identified: Furthermore, the Maintenance Director said he did All residents have the potential to not think there was documentation of a flame be affected. spread rating of the canvas canopy available for review. System in place: The maintenance supervisor will This finding was reviewed with the Administrator assure that any and all new install and Maintenance Director during the exit of regulated material meet this conference. standard and documentation is keep in appropriate file. 3.1-19(b)

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/02/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155191	B. W	ING		11/07	/2022
				CEDEE	TADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	2			T ADDRESS, CITY, STATE, ZIP COD GREENTREE N		
WESTMI	NSTER VILLAGE K	KENTUCKIANA			RKSVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DLAN 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					IV. How the facility w	ill	
					monitor and quality assuran		
					program:		
					The Administrator/Designee w	ill be	
					responsible for auditing the ne		
					installation file weekly for four		
					weeks, then bi-weekly for four		
					weeks. The results of these ar		
					and any necessary corrective		
					actions will be discussed durir	ng	
					the monthly QAPI meetings w	ith	
					additional education or revisio	n of	
					the plan made on the basis of	the	
					findings. Monthly meetings will	il	
					continue for a minimum of six		
					months then will be stopped a	fter	
					two consecutive months of fin-	ding	
					no issues with the stand dowr	ı	
					meeting audits.		
					V. Date Complete:		
					12/8/22		
14.0050							
K 0353	NFPA 101						
SS=D		- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
		er and standpipe systems					
	•	ted, and maintained in					
		NFPA 25, Standard for the					
	·	g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
		sting are maintained in a					
		nd readily available.					
	a) Date sprinkler	system last checked					

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b) Who provided system test

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155191	B. W	ING		11/07/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(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	TC	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	c) Water system	supply source					
	Provide in REMAR coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on observ facility failed to ensum the smoke compartment properly cleaned. No 5.2.1.1.1 sprinklers leakage; shall be from the installed in the coup-right, pendent, of 5.2.1.1.2 any sprink the following shall be following shall corrosion (3) Physithe glass bulb heat a Loading (6) Paintin sprinkler manufacture.	RKS information on non-required or partial er system.	K 0	353	The filing of this plan of correction does not constitut that the alleged deficiency di in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  Please accept this plan of correction as our credible allegation of compliance K353  Sprinkler System – Maintenant and Testing	id ce o	12/08/2022
	Based on observation p.m. and 4:30 p.m. the Administrator at there was one sprint Records Office next covered with dust/d time of observation agreed the sprinkler Office was covered properly cleaned.  This finding was re	ons on 11/07/22 between 1:50 during a tour of the facility with and Maintenance Director, kler head in the Medical to the air supply vent heavily irt. Based on interview at the the Maintenance Director head in the Medical Records with dust/dirt and should be viewed with the Administrator irector during the exit			I. Action taken for those residents identified: No individual resident was identified. Sprinkler head in Medical Recoffice was cleaned. The closes Room 124 was cleaned and it removed to provide an 18" clearance from the sprinkler hear identified: All residents have the potential be affected.  III. System in place: The facility did an audit of resigned in the sprinkler has a substitution of the sprinkler has a substitution	t in ems ead. <b>nts</b>	

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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. B	UILDING	01	COMPL	ETED
		155191	B. W	'ING		11/07/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			REENTREE N		
WESTMI	NSTER VILLAGE F	KENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3.1-19(b)				address any issues to ensure		
					proper sprinkler function. Clea	-	
		vation and interview, the			education provided to mainter	ıance	
	-	sure the sprinkler head in 1 of			department personnel.		
	_	lent room closets was					
	maintained to allow the sprinkler head to function to it's full capability. This deficient practice could				IV. How the facility w		
		•			monitor and quality assuran	ce	
	affect at least 2 resi	dents.			program:		
	Findings indede				The Administrator/Designee w	/III be	
	Findings include:				responsible for auditing the		
	Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the				preventative maintenance log	S .	
					weekly for four weeks, then bi-weekly for four weeks. The		
					results of these audits and any		
		oom 124 had storage stacked			necessary corrective actions v		
		f the sprinkler head. Based on			be discussed during the month		
		ne of observation, the			QAPI meetings with additiona	-	
		tor acknowledged the close			education or revision of the pla		
		nches of the sprinkler head.			made on the basis of the findi		
	Storage William SIA	nenes of the sprinker nead.			Monthly meetings will continue	-	
	This finding was re	viewed with the Administrator			a minimum of six months then		
	_	Director during the exit			be stopped after two consecut		
	conference.				months of finding no issues w		
					the stand down meeting audit		
	3.1-19(b)						
	. '						
					Date Complete: 12/8/22		
K 0354	NFPA 101						
SS=C	Sprinkler System						
Bldg. 01	Sprinkler System						
		er system is impaired, the					
		on of the impairment has					
		areas or buildings involved					
	•	I risks are determined,					
	recommendations						
	_	esignated representative,					
		tment and other authorities					
	naving jurisdiction	have been notified. Where	1		1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/07/2022 155191 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility K 0354 12/08/2022 The filing of this plan of failed to provide a complete written policy correction does not constitute containing procedures to be followed for the that the alleged deficiency did protection of 60 of 60 residents in the event the in fact exist. This Plan of automatic sprinkler system has to be placed correction is filed as evidence out-of-service for 10 hours or more in a 24-hour of the facility's desire to period in accordance with LSC, Section 9.7.5. LSC comply with the regulatory 9.7.6 requires sprinkler impairment procedures requirements and continue to comply with NFPA 25, 2011 Edition, the Standard provide quality care. for the Inspection, Testing and Maintenance of Please accept this plan of Water-Based Fire Protection Systems. NFPA 25, correction as our credible 15.5.2 requires nine procedures that the allegation of compliance impairment coordinator shall follow. A.15.5.2 (4) K354 (b) states a fire watch should consist of trained Sprinkler System – Out of Service personnel who continuously patrol the affected area. Ready access to fire extinguishers and the Action taken for ability to promptly notify the fire department are those residents identified: important items to consider. During the patrol of No individual resident was the area, the person should not only be looking identified. for fire, but making sure that the other fire The facility The Emergency protection features of the building such as egress Preparedness plan was updated to routes and alarm systems are available and include the Indiana Department of functioning properly. This deficient practice Health weblink for contacting the could affect all occupants in the facility. Incident Reporting System located on the IDOH Gateway, in the case Findings include: that the sprinkler system was placed out of service for more than Based on record review on 11/07/22 between 9:30 ten hours in a 24-hour period. a.m. and 1:50 p.m. with the Administrator and Training on this procedure was Maintenance Director present, the facility provided to the maintenance provided fire watch documentation from the personnel responsible for reporting Emergency Preparedness plan, however, it was it. incomplete. The plan did include the phone

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155191	A. BU B. W		01	COMPL 11/07/		
		100181	B. W	_		11/0//	ZUZZ	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD			
WESTMI	NSTER VILLAGE K	(ENTUCKIANA		2210 GREENTREE N CLARKSVILLE, IN 47129				
	Г		1				OVE)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΈ	DATE	
		OH, however, the plan failed to						
	include contacting t	the Indiana Department of			II. How other reside	nts		
		h the web link for contacting the			are identified:			
	Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly				All residents have the potentia	al to		
					be affected.			
					III. System in place:			
	_	in interview at the time of			The facility updated the			
		Maintenance Director			Emergency Preparedness pla	ın		
		vatch lacked the previously			and educated maintenance	ļ		
	mentioned informat	tion.			personnel on contents and wh			
					to locate the manual, both prin			
	_	viewed with the Administrator			and on-line for future reference	e.		
	conference.	irector during the exit			IV. How the facility w	iII		
	conference.				monitor and quality assuran			
	3.1-19(b)				program:			
					The Administrator/Designee v	vill be		
					responsible for auditing the			
					Emergency Preparedness pla	n		
					weekly for four weeks, then			
					bi-weekly for four weeks. The			
					results of these audits and an necessary corrective actions v	-		
					be discussed during the mont			
					QAPI meetings with additiona	-		
					education or revision of the pl			
					made on the basis of the findi	ngs.		
					Monthly meetings will continue			
					a minimum of six months ther			
					be stopped after two consecu			
					months of finding no issues w the stand down meeting audit			
					ine stand down meeting addit	э.		
					V. Date Complete:			
					12/8/22			
K 0363	K 0363 NFPA 101							
SS=B	Corridor - Doors							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	r í	ILDING	nstruction 01	(X3) DATE : COMPL 11/07/	ETED
	ROVIDER OR SUPPLIER			2210 GF	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, 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
Bldg. 01	than required enclexits, or hazardour of smoke and are solid-bonded core capable of resisting minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or composition of the door complying with the door closed with a composition of the door release when the apprinted. Nonrate unlimited height and meeting 19.3.6.3.6 frames shall be lated to the materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies.	rials have positive latching atches are prohibited by these requirements do not spaces that do not contain bustible material.  In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the res. Hold open devices that door is pushed or pulled are red protective plates of the permitted. Dutch doors of are permitted. Door celed and made of steel or compliance with 8.3,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUIT         A. BUILDING       01       COMPLET         B. WING       11/07/20					
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	failed to ensure 1 of had a clearance between the bottom This was confirmed Maintenance Direct This finding was re	on and interview, the facility over 100 doors to the corridor ween the bottom of the door at 1 inch. This deficiency could ents, staff and visitors while in m.  ons on 11/07/22 between 1:50 during a tour of the facility with and Maintenance Director, the ad a gap of 2.75 inches of the door and the floor. I by the Administrator and for at the time of observation.  viewed with the Administrator irector during the exit	K 03	363	The filing of this plan of correction does not constit that the alleged deficiency in fact exist. This Plan of correction is filed as evider of the facility's desire to comply with the regulatory requirements and continue provide quality care. Please accept this plan of correction as our credible allegation of compliance K363 Corridor - Doors  I. Action taken for those residents identified: No individual resident was identified. The facility installed a door s to the bottom of the door to the Pantry. A hardwired smoke detector was also installed in Pantry.  II. How other residents are identified: All residents have the potent be affected.  III. System in place: The facility performed an audifice doors to ensure no other issues were found.  IV. How the facility we monitor and quality assurate program: The Administrator/Designee	weep he the hets ial to	12/08/2022

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	OF CORRECTION	IDENTIFICATION NUMBER  155191	A. BUILDING B. WING	01	COMPLETED 11/07/2022
	ROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, 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
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical with NFF Code. Existing insights service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure a just compartments was pedition. Article 406 Receptacles shall be terminals are not existed.	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0511	responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions were discussed during the month QAPI meetings with additional education or revision of the play made on the basis of the finding Monthly meetings will continue a minimum of six months then be stopped after two consecut months of finding no issues with the stand down meeting audits.  V. Date Complete: 12/8/22  The filing of this plan of correction does not constitut that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care. Please accept this plan of	vill hely land higs. The form will sive with the standard see and the st

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	01	COMPLETED	
		155191	B. W	ING		11/07/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			REENTREE N		
WESTMI	NSTER VILLAGE I	(ENTUCKIANA			SVILLE, IN 47129		
		CERT CORD, III,		OL7 (I (I)	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		11 (07/001			correction as our credible		
		ons on 11/07/22 between 1:50			allegation of compliance		
		during a tour of the facility with			K511		
		and Maintenance Director,			Utilities – Gas and Electric		
	there was an electrical junction box observed in the interstitial space above the drop ceiling at the separation fire doors between the Assisted Living						
					I. Action taken for		
	-	<del>-</del>			those residents identified:		
		nit with no cover plate and			No individual resident was		
	_	res. Based on interview at the a, the Maintenance Director			identified.		
		junction box with several			The facility electrician placed	a	
		wires was not provided with a			cover on the junction box.		
	junction box cover	•			II. How other resider	nte	
	Junetion box covers	•			are identified:	11.5	
	This finding was re	eviewed with the Administrator			All residents have the potential	al to	
		Director during the exit			be affected.	ai 10	
	conference.	sheetor during the exit			be affected.		
	Conterence.				III. System in place:		
	3.1-19(b)				The facility did an audit of jun	ction	
					boxes to insure there were no		
					other issues identified.		
					IV. How the facility w	ill	
					monitor and quality assuran		
					program:		
					The Administrator/Designee v	vill be	
					responsible for auditing the		
					preventative maintenance log	s	
					weekly for four weeks, then		
					bi-weekly for four weeks. The		
					results of these audits and an	у	
					necessary corrective actions	will	
					be discussed during the mont	hly	
					QAPI meetings with additiona	d l	
					education or revision of the pl	an	
					made on the basis of the findi	-	
					Monthly meetings will continu		
					a minimum of six months ther		
					be stopped after two consecu		
					months of finding no issues w	rith	

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	ING _		11/07	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			REENTREE N		
WESTMI	NSTER VILLAGE K	ENTUCKIANA		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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the stand down meeting audits	S.	
					V. Date Complete:		
					12/8/22		
K 0711	NFPA 101						
SS=F	Evacuation and R	elocation Plan					
Bldg. 01	Evacuation and R	elocation Plan					
	There is a written	plan for the protection of all					
	-	eir evacuation in the event					
	of an emergency.						
		eriodically instructed and					
	-	their duties under the plan,					
		plan is readily available					
		erator or with security. The					
	-	e basic response required					
	•	7.2.1.2 and provides for all					
		lan components per					
	18/19.2.2.	10.74.2.40.7.24.2					
	_	18.7.1.3, 18.7.2.1.2,					
	19.7.2.1.2, 19.7.2	, 19.7.1.1 through 19.7.1.3,					
		view and interview, the facility	K 0	711	The filing of this plan of		12/08/2022
		complete facility specific	KU	/11	correction does not constitu	to	12/06/2022
	-	lan for the protection of 60 of			that the alleged deficiency di		
		rately address all life safety			in fact exist. This Plan of	u	
		em addressing all items			correction is filed as evidence	e.	
		101, 2012 edition, Section			of the facility's desire to		
		.2.2 requires a written health care			comply with the regulatory		
		ty plan that shall provide for			requirements and continue to	0	
	the following:	· -			provide quality care.		
	(1) Use of alarms				Please accept this plan of		
	(2) Transmission of	alarm to fire department			correction as our credible		
	(3) Emergency pho	ne call to fire department			allegation of compliance		
	(4) Response to alar				K711		
	(5) Isolation of fire				Evacuation and Relocation Pla	an	
	(6) Evacuation of ir						
	(7) Evacuation of si	moke compartment			I. Action taken for		

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	PARTMENT OF HEALTH AND HUMAN SERVICES  NTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMEN	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191		JILDING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/07/2022		
NAME OF 1	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N					
WESTM	NSTER VILLAGE P	KENTUCKIANA		CLARKSVILLE, IN 47129				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	NCY 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	
		loors and building for			those residents identified:			
	evacuation				No individual resident was			
	(9) Extinguishment				identified.			
		states any required aisle or			Education provided to staff or			
		e less than 48 inches in clear			to respond to battery powere	d		
		g as means of egress from			smoke detector in resident			
		oms. Projections into the			sleeping rooms. Education			
	-	ll be permitted for wheeled			provided to staff on how to			
		d the relocation of wheeled a fire or similar emergency is			evacuate a smoke compartm	ent.		
		ritten fire safety plan and			II. How other reside			
		or the facility. The wheeled			are identified:	IIIS		
	equipment is limite				All residents have the potenti	al to		
	i. Equipment in use				be affected.	ai iu		
		ncy equipment not in use			be affected.			
	_	transport equipment			III. System in place:			
		tice could affect all occupants			The facility updated the Fire			
	in the event of an e				Safety Plan and educated sta	aff on		
		mergeney.			contents and where to locate			
	Findings include:				manual, both printed and on-			
					for future reference.			
	Based on a review	of the facility's "Fire Policy and						
		07/22 between 9:30 a.m. and 1:50			IV. How the facility w	/ill		
		inistrator and Maintenance			monitor and quality assurar			
	_	e plan did not address the			program:			
	following items:				The Administrator/Designee	will be		
	a. Staff response to	battery powered smoke			responsible for auditing the fi	re drill		
	alarms located in re	esident sleeping rooms.			logs weekly for four weeks, th			
	c. The evacuation	of the smoke compartment.			bi-weekly for four weeks. The			
	Based on interview	at the time of record review,			results of these audits and ar			
	the Maintenance D	irector acknowledged and			necessary corrective actions	will		
	agreed that the fire	safety plan did not address the			be discussed during the mon	thly		
	previously mention	ned items.			QAPI meetings with additional	al		
					education or revision of the plan			
	This finding was re	eviewed with the Administrator			made on the basis of the find	ings.		
	and Maintenance D	Director during the exit			Monthly meetings will continu	ie for		

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conference.

3.1-19(b)

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a minimum of six months then will be stopped after two consecutive

months of finding no issues with the stand down meeting audits.

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	OF CORRECTION	IDENTIFICATION NUMBER  155191	A. BUILDING B. WING	01	COMPLETED 11/07/2022
	PROVIDER OR SUPPLIER		2210 0	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	alarm signal and seconditions. Fire drand unexpected tile conditions, at leas The staff is familia aware that drills all routine. Where drag:00 PM and 6:00 announcement manualible alarms.  19.7.1.4 through 1 Based on record revitable document fire alarm signal to department during the 19.7.1.4 requires fire occupancies shall in fire alarm signal and conditions. This deresidents.  Findings include:  Based on review of on 11/07/22 betwee the Administrator and present, all 12 fire determined the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the staff in the past 12 month prodocumentation for the p	t quarterly on each shift.  r with procedures and is re part of established  ills are conducted between  AM, a coded  ay be used instead of	K 0712	V. Date Complete: 12/8/22  The filing of this plan of correction does not constitut that the alleged deficiency of in fact exist. This Plan of correction is filed as eviden of the facility's desire to comply with the regulatory requirements and continue provide quality care. Please accept this plan of correction as our credible allegation of compliance K712  Fire Drills  I. Action taken for those residents identified: No individual resident was identified.  The facility undated fire drill	did

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED	
		155191	B. WING		11/07/2022	
AND PLAN	PROVIDER OR SUPPLIE  SUMMARY  (EACH DEFICIENT OF THE TENNION OF TH	IDENTIFICATION NUMBER 155191  R KENTUCKIANA  STATEMENT OF DEFICIENCIE RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION review, the Maintenance diged there was no information reports to verify that alarm was received by the	A. BUILDING B. WING  STREET 2210 G		COMPLETED 11/07/2022  (X5) COMPLETION DATE  ation m to  hts  all to	
K 0761 SS=B Bldg. 01	3-1.19(0)			IV. How the facility wimonitor and quality assurant program: The Administrator/Designee wiresponsible for auditing the preventative maintenance logweekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions with be discussed during the monti QAPI meetings with additional education or revision of the plamade on the basis of the finding Monthly meetings will continue a minimum of six months them be stopped after two consecut months of finding no issues with stand down meeting audits.  V. Date Complete: 12/8/22	ill ce vill be s vill hly an ngs. e for will tive	

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12/02/2022 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/07/2022 155191 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation, record review, and K 0761 The filing of this plan of 12/08/2022 interview; the facility failed to ensure an annual correction does not constitute inspection and testing of 1 of 1 oxygen room fire that the alleged deficiency did door assembly was completed in accordance with in fact exist. This Plan of LSC 19.1.1.4.1.1. Communicating openings in correction is filed as evidence dividing fire barriers required by 19.1.1.4.1 shall be of the facility's desire to permitted only in corridors and shall be protected comply with the regulatory by approved self-closing fire door assemblies. requirements and continue to (See also Section 8.3.) LSC 8.3.3.1 Openings provide quality care. required to have a fire protection rating by Table Please accept this plan of 8.3.4.2 shall be protected by approved, listed. correction as our credible labeled fire door assemblies and fire window allegation of compliance assemblies and their accompanying hardware, K761 including all frames, closing devices, anchorage, Maintenance, Inspection and and sills in accordance with the requirements of Testing - Doors NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise Action taken for specified in this Code. NFPA 80 5.2.1 states fire those residents identified: door assemblies shall be inspected and tested not No individual resident was less than annually, and a written record of the identified. inspection shall be signed and kept for inspection Maintenance Supervisor by the AHJ. NFPA 80, 5.2.4.1 states fire door immediately inspected oxygen assemblies shall be visually inspected from both room fire door assembly. sides to assess the overall condition of door assembly. How other residents are identified: NFPA 80, 5.2.4.2 states as a minimum, the All residents have the potential to following items shall be verified: be affected. (1) No open holes or breaks exist in surfaces of either the door or frame. System in place: (2) Glazing, vision light frames, and glazing beads The facility updated the annual fire are intact and securely fastened in place, if so door inspection form to include the equipped. oxygen room door. Education was (3) The door, frame, hinges, hardware, and provided to maintenance personnel noncombustible threshold are secured, aligned, on fire door inspection. and in working order with no visible signs of

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damage.

(4) No parts are missing or broken.

listed in 4.8.4 and 6.3.1.7.

(5) Door clearances do not exceed clearances

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IV.

I.

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program:

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How the facility will

monitor and quality assurance

The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPI	LETED	
		155191	B. W	ING		11/07	
				_			
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					REENTREE N		
WESTMI	NSTER VILLAGE R	CENTUCKIANA		CLARK	SVILLE, IN 47129		
(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
	(6) The self-closing	g device is operational; that is,			Administrator/Designee will be	<del></del>	
	the active door com	apletely closes when operated			responsible for auditing the		
	from the full open p	position.			preventative maintenance log		
	(7) If a coordinator is installed, the inactive leaf				weekly for four weeks, then		
	closes before the active leaf.				bi-weekly for four weeks. The		
		are operates and secures the	1		results of these audits and any	V	
	door when it is in the	-	1		necessary corrective actions v	-	
	(9) Auxiliary hardware items that interfere or				be discussed during the month		
	prohibit operation are not installed on the door or				QAPI meetings with additional	•	
	frame.				education or revision of the pla		
	(10) No field modifications to the door assembly				made on the basis of the findi		
	have been performed that void the label.				Monthly meetings will continue	•	
	(11) Gasketing and edge seals, where required, are				a minimum of six months then		
		their presence and integrity.			be stopped after two consecut		
	This deficient pract	cice could affect up to 40			months of finding no issues w		
	residents, as well as	s staff, and visitors in the 100			the stand down meeting audits		
	Unit.						
	Findings include:						
					V. Date Complete:		
	Based on record rev	view on 11/07/22 between 9:30			12/8/22		
	a.m. and 1:50 p.m.	with the Administrator and					
	Maintenance Direct	tor present, the facility was					
	unable to provide d	ocumentation for an annual					
	inspection of the ox	xygen transfilling room fire					
	door assembly. Ba	sed on interview at the time of					
	record review, the l	Maintenance Director said					
	there was no docun	nentation of an annual					
	inspection of the ox	xygen transfilling room fire					
	door assembly. Ba	sed on observations during a					
	tour of the facility v	with the Administrator and					
	Maintenance Direct	tor between 1:50 p.m. and 4:30					
	p.m., there was one	oxygen transfilling room fire					
	door assembly note	ed in the facility.					
	This finding was re	viewed with the Administrator					
	and Maintenance D	irector during the exit					
	conference.						
	3.1-19(b)						

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/07/2022
	PROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N (SVILLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manuloads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar and readily availal and circuits are m and separate from Minimizing the pos emergency power consideration for re-	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised exercised in a conditions include the cold start and the local conditions include the cold start and the local transfer of all EES inducted by competent in ance and testing of stored forces (Type 3 EES) are in the life and all transfer of all in the life and all transfer of all in the life and the local start and the local transfer of all in the life and the local start and life a			
		riew and interview, the facility the emergency power system	K 0918	The filing of this plan of correction does not constitu	12/08/2022 ute

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/07/2022 155191 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE N WESTMINSTER VILLAGE KENTUCKIANA CLARKSVILLE, IN 47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE inspection, testing, and maintenance requirements that the alleged deficiency did found in the Health Care Facilities Code, NFPA in fact exist. This Plan of 110, and Life Safety Code in accordance with 42 correction is filed as evidence CFR 483.73(e)(2). of the facility's desire to comply with the regulatory 1. Based on record review and interview, the requirements and continue to facility failed to maintain a complete written record provide quality care. of monthly generator load testing for 1 of 1 Please accept this plan of generator during the past 12 months. Chapter correction as our credible 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly allegation of compliance testing of the generator serving the emergency K918 electrical system to be in accordance with NFPA Electrical Systems – Essential 110, the Standard for Emergency and Standby Electric Systems Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, Action taken for performance, exercising period, and repairs for the those residents identified: generator to be regularly maintained and available No individual resident was for inspection by the authority having identified. The facility contacted the jurisdiction. This deficient practice could affect all residents, staff and visitors. generator service provider to provide required service and Findings include: training for the maintenance and upkeep of the emergency Based on record review on 11/07/22 between 9:30 generators. This included a.m. and 1:50 p.m. with the Administrator and documenting the emergency Maintenance Director present, there was no generator monthly test for documentation on the emergency generator percentage of load; actual load monthly test form for percentage of load during percentage to establish the the monthly load tests during the past 12 months. required 30% of the name plate The information provided always said "NA" or it rating; annual load bank test; and was left blank. Based on interview at the time of annual fuel quality test. record review, the Maintenance Director agreed there was no documentation provided on the How other residents II. monthly generator load test form for percentage of are identified: load during the past 12 months. All residents have the potential to

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conference.

This finding was reviewed with the Administrator and Maintenance Director during the exit

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be affected.

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System in place:

The facility educated maintenance personnel on how to perform

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	T OF HEALTH AND HU R MEDICARE & MEDIO					MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	ILDING	onstruction <u>01</u>	COMP	E SURVEY PLETED 7/2022
	PROVIDER OR SUPPLIE		2210 G	ADDRESS, CITY, STATE, ZIP COD GREENTREE N KSVILLE, IN 47129		
WESTM  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIENT REGULATORY OF STATE OF THE PROPERTY OF	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  I review and interview, the ercise the generator annually to ents of NFPA 110, 2010 Edition, mergency and Standby Powers 8.4.2. Section 8.4.2 states diesel rvice shall be exercised at least a minimum of 30 minutes, using g methods: aintains the minimum exhaust is recommended by the g temperature conditions and at recent of the EPS (Emergency			of load and  will ance e will be manual se will inthly mal plan dings. The manual cutive with	(X5) COMPLETION DATE
	occupants.  Findings include:	in praesion sould arrest air		12/8/22		
	a.m. and 1:50 p.m. Maintenance Directesting documentate percentage for the	eview on 11/07/22 between 9:30 with the Administrator and tor present, the generator load ion showed the actual load diesel powered generator was Based on interview at the time				

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of record review, the Maintenance Director said the generator ran under load on a monthly basis but was not sure if it achieves the required 30 %

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPI	
		155191	B. W	ING		11/07	/2022
NAME OF 1	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					REENTREE N		
WESTM	INSTER VILLAGE I	KEN I UCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ating. Additionally, the		TAG	DEFICIENCI )		DATE
	_	tor acknowledged a load bank					
	test for the generator had not occurred within the						
	past 12 month period						
	1						
		eviewed with the Administrator					
	and Maintenance D	Director during the exit					
	conference.						
	2 1 10/b)						
	3.1-19(b)						
	3. Based on record review and interview, the						
	facility failed to ensure an annual fuel quality test						
	was performed for 1 of 1 diesel powered						
	_	99, Health Care Facilities Code,					
		on 6.5.4.1.1.2 states Type 2 EES					
		al System) generator sets shall					
	_	sted in accordance with					
		Section 6.4.4.1.1.3 states					
		be performed in accordance and and for Emergency and					
		stems, 2010 Edition, Chapter 8.					
		1 8.3.8 states a fuel quality test					
		at least annually using tests					
	_	A standards. This deficient					
	practice could affect	ct all residents, as well as staff					
	and visitors.						
	F: 1: : 1 1						
	Findings include:						
	Based on record re	view on 11/07/22 between 9:30					
		with the Administrator and					
		tor present, there was					
	documentation of a	in annual generator inspection					
	dated 06/08/22, how	wever, there was no					
		n annual fuel quality test for					
		r available for review. Based					
		time of record review, the					
		tor stated the facility does					
	I have a diesel gener	ator but after having spoken	1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	A. BUILDING <u>01</u> CO	
		155191	B. WING		11/07/2022
			STRE	ET ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	S.		GREENTREE N	
WESTMI	NSTER VILLAGE K	ENTUCKIANA		RKSVILLE, IN 47129	
(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
		enerator inspection vendor it			
		t a fuel sample has not been			
	taken by the current	vendor.			
	_	viewed with the Administrator			
		irector during the exit			
	conference.				
	3.1-19(b)				
	3.1-19(0)				
K 0920	NFPA 101				
SS=D	Electrical Equipme	ent - Power Cords and			
Bldg. 01	Extens				
	Electrical Equipme	ent - Power Cords and			
	Extension Cords				
	Power strips in a p	patient care vicinity are only			
	used for compone	nts of movable			
	patient-care-relate	ed electrical equipment			
	(PCREE) assemb	les that have been			
	assembled by qua	lified personnel and meet			
	the conditions of 1	0.2.3.6. Power strips in			
		cinity may not be used for			
	, -	personal electronics),			
		n care resident rooms that			
		E. Power strips for PCREE			
		UL 60601-1. Power strips			
		the patient care rooms			
	,	) meet UL 1363. In			
	•	ooms, power strips meet			
		s. All power strips are			
	•	precautions. Extension			
		d as a substitute for fixed			
	_	re. Extension cords used moved immediately upon			
		purpose for which it was			
	•	ts the conditions of 10.2.4.			
		9), 10.2.4 (NFPA 99), 400-8			
	•	(D) (NFPA 70), TIA 12-5			
	,,,	on and interview, the facility	K 0920	The filing of this plan of	12/08/2022
		ower strip was not used as a	1 1 0 9 2 0	correction does not constitu	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  G 01	(X3) DATE SURVEY COMPLETED 11/07/2022
	PROVIDER OR SUPPLIEF		221	EET ADDRESS, CITY, STATE, ZIP COD 10 GREENTREE N ARKSVILLE, IN 47129	
(X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF substitute for fixed and 1 of 48 resident utilities to comply or requires electrical or with NFPA 70, Nat Edition. NFPA 70, unless specifically p cables shall not be or wiring of a structura affect one resident at Findings include:  Based on observation p.m. and 4:30 p.m. the Administrator at following was note a. There were two held hair dryer plug Beauty Shop. b. Room 115 had at plugged into the sat Based on interview Maintenance Direct the power strip in the This finding was re-	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION wiring in 1 of 1 Beauty Shop t rooms. LSC 19.5.1 requires with Section 9.1. LSC 9.1.2 viring and equipment to comply tional Electrical Code, 2011 Article 400.8 requires that, permitted, flexible cords and used as a substitute for fixed e. This deficient practice could and staff.  ons on 11/07/22 between 1:50 during a tour of the facility with and Maintenance Director, the d: curling irons and one hand tiged into a power strip in the	ID PREFITACE	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	COMPLETION DATE  Cy did f dence  ry ue to  wer ds for d: s ower  evices in hem into medical  idents ential to  se: audit of o identify s e use of
				\/ How the facilit	av will

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATI COMF 11/07	E SURVEY PLETED 7/2022
	PROVIDER OR SUPPLIER NSTER VILLAGE K		2210 G	ADDRESS, CITY, STATE, ZI REENTREE N SVILLE, IN 47129	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
				monitor and quality program: The Administrator/D responsible for audit rooms/public areas fequipment cords we weeks, then bi-week weeks. The results of and any necessary of actions will be discuthe monthly QAPI madditional education the plan made on the findings. Monthly me continue for a minim months then will be two consecutive mono issues with the stimeeting audits.  V. Date Cot 12/8/22	esignee will be ting resident for electrical sekly for four of these audits corrective ssed during seetings with or revision of e basis of the setings will sum of six stopped after nths of finding tand down	
K 0923 SS=D Bldg. 01	Storag Gas Equipment - Storage Greater than or ec Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or within space of non- or li	Cylinder and Container  Cylinder and Container  qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2  cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors)				

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that can be secured. Oxidizing gases are not

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	01	COMPLETED	
		155191	B. Wl	ING		11/07/	2022
	PROVIDER OR SUPPLIEF			2210 G	ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129		
(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		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
TAG	stored with flamm from combustibles sprinklered) or en noncombustible or minimum 1/2 hr. fit Less than or equal in a single smoke cylinders available patient care areas of less than or equived to be stored cylinders must be as specified in 11. A precautionary sign on each door or groom, where the saminimum "CAU" STORED WITHIN Storage is planned order of which the supplier. Empty of from full cylinders cylinders with intee threshold pressure established. Emplayold confusion. Care protected from 11.3.1, 11.3.2, 11.99) Based on observation	ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a size protection rating.  If to 300 cubic feet compartment, individual er for immediate use in with an aggregate volume used to 300 cubic feet are not red in an enclosure.  If handled with precautions are of a cylinder storage sign includes the wording as FION: OXIDIZING GAS(ES) INO SMOKING."  If so cylinders are used in the cylinders are segregated. When facility employs gral pressure gauge, a er considered empty is thy cylinders are marked to Cylinders stored in the open	K 0		The filing of this plan of correction does not constitute		DATE 12/08/2022
	such as oxygen wer in 1 of 6 smoke con Care Facilities Cod- states storage for no volume equal to or meters (300 cubic f and 11.3.3.2. NFPA precautions in hand	re properly secured from falling inpartments. NFPA 99, Health e, 2012 Edition, Section 11.3.3 conflammable gases with a total less than greater than 8.5 cubic feet) shall comply with 11.3.3.1 A 99, Section 11.3.3.2 states ling cylinders specified in accordance with 11.6.2. Section			that the alleged deficiency di in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.  Please accept this plan of correction as our credible	d e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED
		155191	B. W	ING		11/07/2022
NAME OF P	PROVIDER OR SUPPLIEF			1	ADDRESS, CITY, STATE, ZIP COD	
\\\EQT\\II		(ENTLICKIANA			REENTREE N	
VV⊏21VII	NSTER VILLAGE K	ACIN I UUNIAINA		CLARK	(SVILLE, IN 47129	<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION freestanding cylinders shall be		TAG		DATE
	` ′	supported in a proper cylinder			allegation of compliance <b>K923</b>	
		deficient practice could affect			Gas Equipment – Cylinder an	d
		t Clean Utility room.			Container Storage	
	Findings include:				I. Action taken for	
					those residents identified:	
	Based on observations on 11/07/22 between 1:50				No individual resident was	
		during a tour of the facility with			identified.	und
	the Administrator and Maintenance Director, there was one small E size oxygen cylinder on the				The facility immediately removes small O2 cylinder from the 200	
	counter in the 200 Unit Clean Utility room				Hall clean utility room and pla	
	freestanding and was not supported in a proper				it in the appropriate O2 storage	
	cylinder stand or otherwise secured from falling.				room.	,-
	1 -	at the time of the observation,				
	the Maintenance Di	rector acknowledged the small			II. How other resider	nts
		der freestanding on the			are identified:	
		Unit Clean Utility room not			All residents have the potentia	al to
		der stand or otherwise			be affected.	
	secured from falling	ğ.			III. System in place:	
	This finding was re	viewed with the Administrator			The facility educated staff on	how
	_	irector during the exit			O2 storage and proper proced	
	conference.	C			3 12 [12 [13 [13 [13 [13 [13 [13 [13 [13 [13 [13	
					IV. How the facility w	ill
	3.1-19(b)				monitor and quality assuran	ce
					program:	
					The Administrator/Designee w	
					responsible for O2 auditing ro	unas
					weekly for four weeks, then bi-weekly for four weeks. The	
					results of these audits and an	
					necessary corrective actions v	-
					be discussed during the mont	
					QAPI meetings with additiona	-
					education or revision of the pl	
					made on the basis of the findi	ngs.
					Monthly meetings will continue	
					a minimum of six months ther	
					be stopped after two consecut	tive I

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155191	B. WING	G		11/07/	2022
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 LISC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
1710	REGUENTORT OR	EDG IDENTI TING IN ORDER		7710	months of finding no issues with the stand down meeting audits		DITE
					V. Date Complete: 12/8/22		

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