STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING _____ B. WING _____	R-C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE KENTUCKIANA	**2210 GREENTREE N CLARKSVILLE, IN 47129**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to Investigation of Nursing Home Complaint IN00390005 completed on September 30, 2022.

This visit was in conjunction with the PSR to Investigation of Residential Complaint IN00387203 completed on September 2, 2022 and the PSR to the Recertification and State Licensure Survey and the State Residential Licensure Survey completed on October 25, 2022.

Nursing Home Complaint IN00390005 - Corrected

Residential Complaint IN00387203 - Corrected

Survey dates: December 5 and 6, 2022.

Facility number: 000100
Provider number: 155191
AIM number: 100266130

Census Bed Type:
SNF/NF: 56
Residential: 84
Total: 140

Census Payor Type:
Medicare: 9
Medicaid: 36
Other: 11
Total: 56

Westminster Village Kentuckiana was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING _____ B. WING _____	R-C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE KENTUCKIANA	**2210 GREENTREE N CLARKSVILLE, IN 47129**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Investigation of Nursing Home Complaint IN00390005. Quality review completed on December 12, 2022.	{F 000}		