STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155191	B. WING 02/14/2024				/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R		2210 GI	REENTREE N		
WESTMI	NSTER VILLAGE F	KENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DE ICERCI I		DATE
0000							
Bldg. 00	Home Complaints I IN00428377. This sof Residential Com IN00426475, IN00426 related to the allegar Complaint IN00428 related to the allegar R0027.  Complaint IN00428 the allegations are of Complaint IN00428 the allegation is cited Complaint IN00428 the allegation IN00428	6475 - No deficiencies related to ed.  6486 - No deficiencies related to ed.  7927 - No deficiencies related to ed.  ruary 12, 13 and 14, 2024  00100  155191	F 00	000			
	Census Payor Type	::					

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

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KQ6611 Facility ID: 000100 If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155191		A. BUILDING 00 COMPLETED  B. WING 02/14/2024				
133131	B. W1	_		02/14/	2024	
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD REENTREE N			
WESTMINSTER VILLAGE KENTUCKIANA			SVILLE, IN 47129			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Medicare: 14	N	TAG	DEFICIENC!)		DATE	
Medicaid: 33						
Other: 13						
Total: 60						
These deficiencies reflect State Findings cited in						
accordance with 410 IAC 16.2-3.1.						
Quality review completed on February 21, 2024.						
F 0550 483.10(a)(1)(2)(b)(1)(2)						
SS=D Resident Rights/Exercise of Rights						
Bldg. 00 §483.10(a) Resident Rights.						
The resident has a right to a dignified						
existence, self-determination, and						
communication with and access to persons and services inside and outside the facility,						
including those specified in this section.						
middanig alooc opcomed in and cocaem.						
§483.10(a)(1) A facility must treat each						
resident with respect and dignity and care for						
each resident in a manner and in an						
environment that promotes maintenance or						
enhancement of his or her quality of life, recognizing each resident's individuality. The						
facility must protect and promote the rights of						
the resident.						
§483.10(a)(2) The facility must provide equal access to quality care regardless of						
diagnosis, severity of condition, or payment						
source. A facility must establish and						
maintain identical policies and practices						
regarding transfer, discharge, and the						
provision of services under the State plan for						
all residents regardless of payment source.						
§483.10(b) Exercise of Rights.						
The resident has the right to exercise his or her rights as a resident of the facility and as						

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Event ID:

KQ6611 Facility ID: 000100

If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE C A. BUILDING B. WING				
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE KENTUCKIANA		2210 0	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	
	§483.10(b)(1) The the resident can e without interference or reprisal from the free of interference and reprisal from an or her rights and the facility in the exercite required under this Based on observation review, the facility (Resident B and Reappropriate dinner with reviewed for resident Brindings include:  1. The clinical record on 2/12/24 at 1:22 put was not limited hemiparesis.  On 2/12/24 at 1:15 resting in bed with reach and lunch at container with plast been served in styrojust thought that was served. She thought would serve the mesilver ware. She container with plastic thad one good hand harder to eat.	e resident has the right to be e, coercion, discrimination, the facility in exercising his to be supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.  In the supported by the cise of his or her rights as a subpart.	F 0550	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 F550 Resident Rightsl. Action take for those residents identified: Regarding resident and C, the care plans were updated to reflect additional sassistance with the meal, It is important to note that resident and C have not experienced a significant weight loss.  II. How other residents are identified: An a was performed to identify residents who need additional assistance with meal set up a	en ts B set up t B sany	

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Facility ID: 000100

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155191	B. W	B. WING			2024
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
\4/50T\4	NOTED \	(ENTLIQUIANIA			REENTREE N		
WESTMI	NSTER VILLAGE K	KENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	T.E.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Assistant Dietary N	Manager indicated they were			issues identified; the resident	care	
		ecause the company, whom			plans were updated.The facilit		
		h, left. When they left, they			interviewed residents regardin	•	
		ware. They ordered dishes in			their dining experience and an	-	
		nere was a supply issue. They			concerns identified as a result	-	
		were currently waiting on the			the interviews were addressed		
	_	were ordered. If the residents			care plans updated if	· ana	
		they usually send all			needed. III. System in		
	disposable utensils	-			place:		
					An inventory of plates and		
	During an interview	v on 2/13/24 at 11:40 a.m., the			silverware was completed and	the	
	_	(ED) indicated they did have			equipment was ordered to pro		
		iting on the bases (plate			plates and silverware for meal		
		sidents eat in their rooms, the			plates and silvermans for modifi	·.	
	· ·	yrofoam. They were currently			Facility staff were re-inservices	sd	
	·	ts. The previous contracted			on Resident Rights and provid		
		left before the contract was up		additional meal assistance as			
		f 2022 and took a lot of the			needed for residents meals.		
		24 at 1:45 p.m., the ED indicated			The data for residente intedie.		
		ring supplies all along but just			Dietary Staff were re-inservice	d on	
		h. They thought they could			the use of disposable utensils		
	_	to go to the dining room, but			Styrofoam serving containers		
	1 -	. They had several other		emergency use only.			
		ne meal cart was put on the					
		id, however, order the cart			In the event of an emergency		
	today as well as the				situation in which disposable		
					containers are utilized, the		
	2. The clinical reco	ord for Resident C was reviewed			Administrator will approve the		
		p.m. The diagnosis included,			usage.		
		to, left sided hemiplegia and			IV. How the facility wi	II	
	hemiparesis.	, 1 2			monitor and quality assurance		
	·				program:The		
	During an observati	ion on 2/12/24 at 1:05 p.m.,			Administrator/Designee will be	1	
	_	m meal containers on the			responsible for the coordinatio		
	resident's bedside ta				and monitoring of meal service		
					rounds that will be completed		
	During an interview	v on 2/12/24 at 2:20 p.m., the			times a week for four weeks, the		
		his meals had been served in			weekly for four weeks, then		
		sometime. He sometimes had			monthly for three months. The		
		e to the high edges of the			results of these audits and any		
	l ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				I	,	

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Event ID:

KQ6611 Facility ID: 000100

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/14/2024	
	PROVIDER OR SUPPLIER		2210 0	ADDRESS, CITY, STATE, ZIP COD GREENTREE N KSVILLE, 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)	
F 0684 SS=D Bldg. 00	container the meals  Review of the meal policy, dated Octob dining dishes and fl meals as needed dur. The emergency measurious weather consignificant staff sho  On 2/14/24 at 2:55 copy of the docume dated December 20 limited to, "Federal certain basic rights The rights include todignified exister todignified exister This Citation relates 3.1-3(a)  483.25 Quality of Care § 483.25 Quality of Care is a applies to all treat facility residents. Ecomprehensive as	service and supplements er 2022, indicated disposable atware would be used to serve ring emergency meal service. al service was defined as a dition, a power outage, or a rtage, etc.  p.m., the ED provided a current ent titled "Resident Rights" 16. It included, but was not and state laws guarantee to all residents of this facility. the resident's right encedignity"  s to Complaint IN00428146  of care a fundamental principle that ment and care provided to	TAG	necessary corrective actions be discussed during the mont QAPI meetings with additional education or revision of the plimade on the basis of the finding. The Committee will provide guidance for further action as needed. The QAPI team will nonce a month until the facility attains 100% compliance for consecutive months.	hly an ngs.
	treatment and care professional stand comprehensive pe and the residents' Based on interview failed to ensure qua	e in accordance with lards of practice, the erson-centered care plan, choices. and record review, the facility rterly smoking assessments 2 of 3 residents reviewed for	F 0684	The filing of this plan of correction does not constitute that the alleged deficiency din fact exist. This Plan of correction is filed as evidence of the facility's desire to	lid

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Event ID:

KQ6611

Facility ID: 000100

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			ETED
		155191	B. WI	B. WING 02/14/202			
					_		
NAME OF I	PROVIDER OR SUPPLIEF	8			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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					comply with the regulatory		
	1. The clinical reco	rd for Resident B was reviewed			requirements and continue t	0	
		o.m. The diagnoses included,			provide quality care.		
		d to, left sided hermiplegia and			Please accept this plan of		
		r and major depressive			correction as our credible		
	disorder.	3 1			allegation of compliance		
					anogation of compilation		
	The care plan, dated	d 12/21/21, indicated the			F684		
	resident required su	pervision with smoking and to					
		assessment quarterly and as			Quality of Care		
	needed.						
					I. Action taken for		
	Review of Resident	t B's smoking risk assessments			those residents identified:		
		y assessment was last					
	completed on 8/17/	-			Regarding resident B and C,		
					Smoking safety assessments		
	The clinical record	lacked documentation of a			were completed.		
	quarterly assessmen	nt for November 2023.			'		
					II. How other		
	During an interview	y on 2/12/24 at 2:48 p.m., the			residents are identified:		
	Director of Nursing	g indicated when the quarterly					
	assessments were s	et up in the new system, the			An audit of the 5 residents w	ho	
	smoking assessmen	its were not included. RN			reside in the facility that smok	е	
	(Registered Nurse)	3 indicated per facility policy,			was completed, any smoking		
	smoking assessmen	its were to be completed	assessments needed were				
	quarterly.				completed.		
		rd for Resident C was reviewed			III. System in place:		
		p.m. The diagnoses included,					
		d to, left sided hemiplegia and			The Nurse Managers were		
	hemiparesis and de	mentia.			re-educated on timely comple		
					of Smoking Safety Assessme	nts.	
	_	d 2/17/22, indicated the					
		for injury related to smoking			Smoking Safety Assessments	S	
	and to update the sr	noking assessment quarterly			were scheduled to be complete	ted	
	and as needed.				quarterly in the EMR system of	n	
					all residents who smoke that		
	Review of Resident	t C's smoking risk assessments			reside in the facility and for an	ıy	
	indicated a quarterl	y assessment was completed			newly admitted residents who	-	
	on 8/17/23.				smoke.		

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

PRINTED: 05/31/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/14/2024				
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE KENTUCKIANA			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	on 2/12/24 at 2:48 provided a current, titled "Smoking Pol but was not limited policy of this facilit accordance with Cit Regulations related ability to smoke saf quarterly"	lacked documentation of a at for November 2023.  p.m., the Director of Nursing undated copy of the document icy - Residents". It included, to, "Policy StatementIt is the y to be administered, in ry, County, State and Federal to smokingA resident's fely will be re-evaluated		IV. How the facility we monitor and quality assurant program:  The Don/Designee will be responsible for auditing the completion of smoking assessments weekly on resident newly admitted to the facility were smoke and timely completion quarterly Smoking Safety Assessments for those current residents who smoke weekly four weeks, then monthly. The results of these audits will be presented to the QAPI team monthly.  The Committee will provide guidance for further action as	ents vho of t for e			
				needed. The QAPI team will n once a month until the facility attains 100% compliance for 4 consecutive months.				
R 0000								
Bldg. 00	Complaints IN0042 and IN00427927. T Investigation of Nur IN00428146, IN004	the Investigation of Residential 8146, IN00426475, IN00426486, This visit included the raing Home Complaints 425548 and IN00428377.  The Investigation of Nursing N00425548, IN00428146 and	R 0000					

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

PRINTED: 05/31/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191		(X2) MULTI A. BUILDI B. WING		nstruction <u>00</u>	(X3) DATE : COMPL 02/14/	ETED		
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE KENTUCKIANA			STREET ADDRESS, CITY, STATE, ZIP COD 2210 GREENTREE N CLARKSVILLE, IN 47129					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION 5548 - Federal/State deficiency	TA	.G	DEFICIENCY)		DATE	
	related to the allega	tions is cited at F684.						
	_	8146 - Federal/State deficiency tions is cited at F550 and						
	Complaint IN00428 the allegations are c	3377 - No deficiencies related to cited.						
	Complaint IN00426 the allegation is cited	6475 - No deficiencies related to ed.						
	Complaint IN00426 the allegation is cited	6486 - No deficiencies related to ed.						
	Complaint IN00427 the allegation is cited	7927 - No deficiencies related to ed.						
	Survey dates: Febr	uary 12, 13 and 14, 2024						
	Facility number: 00	00100						
	Residential Census:	80						
	This State Resident accordance with 41	ial Finding is cited in 0 IAC 16.2-5.						
	Quality review com	pleted on February 21, 2024.						
R 0027	410 IAC 16.2-5-1. Residents' Rights	` '						
Bldg. 00	(b) Residents have	e the right to a dignified						
	existence, self-det	termination, and th and access to persons						
	and services insid	e and outside the facility.						
		e right to exercise their nt of the facility and as a						
		of the United States. on, interview and record	R 0027		The filing of this plan of		03/07/2024	

State Form Event ID: KQ6611 Facility ID: 000100 If continuation sheet Page 8 of 10

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
1 ,		155191	B. W		<del></del>	02/14/	
		1.33.3.		_		1 32,	<b>-</b> -·
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					REENTREE N		
WESTMI	NSTER VILLAGE I	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 APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review, the facility	failed to ensure residents			correction does not constit	ute	
	` /	served meals on appropriate			that the alleged deficiency	did	
	dinner ware for 1 o	f 3 residents reviewed for			in fact exist. This Plan of		
	resident rights.				correction is filed as evider	nce	
					of the facility's desire to		
	Findings include:				comply with the regulatory		
					requirements and continue	to	
		for Resident H was reviewed			provide quality care.		
	on 2/14/24 at 12:01	p.m. The diagnosis included,			Please accept this plan of		
	but was not limited	to, diabetes and arthritis			correction as our credible		
					allegation of complianceR02	7	
		p.m., the resident was observed			Resident		
		cliner in her apartment. A			RightsI. Action tak	en	
	styrofoam food cor	ntainer was observed in the			for those residents		
	residents trash can.	She indicated they had been			identified:Regarding resider	nt H,	
	serving meal on sty	rofoam since COVID started			no resident was identified by	the	
	and sending plastic	forks, spoons and knives.			surveyor, however, the facilit	У	
	You can't cut anyth	ning with a plastic knife. If you			interviewed residents regard	ing	
	push down too hard	d when trying to cut			their dining experience and a	any	
	something, the uter	nsil either breaks or you cut the			concerns identified as a resu	It of	
	bottom of the styro	foam container which creates a			the interviews were addresse	ed.	
	mess on your table	. It would be nice to get meals			II. How other		
		ith regular utensils. They do			residents are identified:The	•	
	serve that way in the	ne dining room, but she			facility interviewed residents		
	preferred to eat in l	ner room where it was quiet and			regarding their dining experie		
	less chaotic.				and any concerns identified	as a	
					result of the interviews were		
		5 a.m., the Assistant Dietary			addressed. III. Syste	em	
	_	they were using styrofoam			in place:		
	because the compa	ny, whom they contracted			An inventory of plates and		
		ey left, they took all of the dish			silverware was completed ar	nd the	
		l dishes in October and then			equipment was ordered to pr	ovide	
		issue. They do have plates but			plates and silverware for me	als.	
	were currently wait	ting on the plate warmers that					
	were ordered. If res	sidents eat in their rooms, they			Facility staff were re-inservic	ed on	
	usually send all dis	posable utensils and			Resident Rights and providir	ıg	
	styrofoam.				additional meal assistance a	s	
					needed for resident's meals.		
	On 2/13/24 at 11:4	0 a.m., the Executive Director					
	(ED) indicated they	y did have plates, but were			Dietary Staff were re-inservio	ced on	

State Form Event ID: KQ6611 Facility ID: 000100 If continuation sheet Page 9 of 10

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

PRINTED: 05/31/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUI	A. BUILDING <u>00</u>		COMPLETED		
155191		B. WIN	B. WING		02/14/2024		
			<del></del>				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
VACCOTAL	NOTED VIII I AGE I	TENTLICIZIANIA			REENTREE N		
WESTIMI	NSTER VILLAGE K	ENTUCKIANA		CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	waiting on the bases	s (plate warmers). If the			the use of disposable utensils	and	
	residents eat in their	r rooms, the meals are sent in			Styrofoam serving containers	for	
	Styrofoam. They we	ere currently waiting on tray			emergency use only.		
	carts. The previous	contracted company they had					
		act was up in late December of			In the event of an emergency		
	2022 and took a lot	of the supplies. On 2/14/24 at			situation in which disposable		
	_	ndicated they had been ordering			containers are utilized the		
	supplies all along b	ut just did not have enough.			Administrator will approve the		
		could get more residents to go			usage.		
	to the dining room,	but that did not happen. They			IV. How the facility w	ill	
	had several other ex	penditures and the meal cart			monitor and quality assurand	ce	
	was put on the back	burner. She did, however,			program:The		
	order the cart today	as well as the dish ware.			Administrator/Designee will be	)	
					responsible for the coordination	n	
	Review of the meal	service and supplements			and monitoring of meal service	9	
	policy, dated Octob	er 2022, indicated disposable			rounds that will be completed	five	
	_	atware would be used to serve		times a week for four weeks, then			
		ring emergency meal service.			weekly for four weeks, then		
		al service was defined as a			monthly for three months. The		
		dition, a power outage, or a			results of these audits and any		
	significant staff sho	rtage, etc.			necessary corrective actions v	vill	
					be discussed during the montl	-	
		p.m., the ED provided a current,			QAPI meetings with additional		
		document titled "Residents			education or revision of the pla		
	-	ncluded, but was not limited to,			made on the basis of the findir	ngs.	
		l withfull recognition of you			The Committee will provide		
	dignity"				guidance for further action as		
					needed. The QAPI team will n	neet	
	This Citation relates	s to Complaint IN00428146			once a month until the facility		
					attains 100% compliance for 4		
					consecutive months.		
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