PRINTED: 11/30/2023
FORM APPROVED

| CENTERS FOR | MEDICARE & MEDIC | AID SERVICES | | | OMB NO. 093 | 58-039 | |
|---|--|---------------------------------|-----------------------|--|------------------|--------|--|
| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | | |
| | | 155191 | B. WING | | 10/30/2023 | | |
| | | 155191 | b. wind | | 10/30/2023 | | |
| NAME OF P | ROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP COD REENTREE N | | | |
| WESTMI | NSTER VILLAGE P | KENTUCKIANA | CLARKSVILLE, IN 47129 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | DROUBERG N. AM OF CORRECTION | (X5) | | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | ETION | |
| TAG | • | R LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE DATE | | |
| | REGULATORT OF | R ESC IDENTIFT ING INFORMATION | IAU | | DA | I L | |
| F 0000 | | | | | | | |
| | | | | | | | |
| Bldg. 00 | | | | | | | |
| | This visit was for a Recertification and State | | F 0000 | | | | |
| | | This visit included a State | 1 0000 | | | | |
| | _ | | | | | | |
| Residential Licensu | | ile Sulvey. | | | | | |
| | | | | | | | |
| | Survey dates: Octo | ber 23, 24, 25, 26, 27, and 30, | | | | | |
| | 2023. | | | | | | |
| | | | | | | | |
| Facility number: 000100 Provider number: 155191 | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | AIM number: 1002 | 266130 | | | | | |
| | | | | | | | |
| | Census Bed Type: | | | | | | |
| | SNF/NF: 57 | | | | | | |
| | Residential: 83 | | | | | | |
| | Total: 140 | | | | | | |
| | 10141. 140 | | | | | | |
| | G D T | | | | | | |
| | Census Payor Type | : : | | | | | |
| | Medicare: 6 | | | | | | |
| | Medicaid: 42 | | | | | | |
| | Other: 9 | | | | | | |
| | Total: 57 | | | | | | |
| | | | | | | | |
| | Thoso deficiencies | reflect State Findings cited in | | | | | |
| | | · · | | | | | |
| | accordance with 41 | 0 IAC 16.2-3.1. | | | | | |
| | Quality review con | npleted on November 4, 2023. | | | | | |
| | | | | | | | |
| F 0580 | 483.10(g)(14)(i)-(i | | | | | | |
| SS=D | Notify of Changes | s (Injury/Decline/Room, etc.) | | | | | |
| Bldg. 00 | §483.10(g)(14) No | otification of Changes. | | | | | |
| _ | | immediately inform the | | | | | |
| | resident; consult v | | | | | | |
| | · · | | | | | | |
| | | tify, consistent with his or | | | | | |
| her authority, the resident representative(s) | | | | | | | |
| | when there is- | | | | | | |
| (A) An accide | | volving the resident which | | | | | |
| | | nd has the potential for | | | | | |
| | | and percental for | | | | | |

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

TITLE (X6) DATE

Stephanie Wise Administrator 11/17/2023

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

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) | | (X2) M | (X2) MULTIPLE CONSTRUCTION (X3) | | | (3) DATE SURVEY | |
|--|---|-------------------------------|---------------------------------|----------|--|-----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155191 | B. W | ING | | 10/30/ | /2023 |
| | | 1 | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | REENTREE N | | |
| WESTM | INSTER VILLAGE H | (ENTLICKIANA | | | SVILLE, IN 47129 | | |
| V V L O 1 1VII | TOTER VILLAGE ! | XEN I OUNIANA | | OLAIN | OVILLE, IIV 77 120 | | |
| (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 | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | requiring physician intervention; | | | | | | |
| | (B) A significant change in the resident's | | | | | | |
| | | or psychosocial status | | | | | |
| | , | ration in health, mental, or | | | | | |
| | | us in either life-threatening | | | | | |
| | | cal complications); | | | | | |
| | ' ' | er treatment significantly | | | | | |
| | | discontinue an existing | | | | | |
| | form of treatment | | | | | | |
| | | r to commence a new form | | | | | |
| | of treatment); or | | | | | | |
| | (D) A decision to transfer or discharge the | | | | | | |
| | resident from the facility as specified in | | | | | | |
| | §483.15(c)(1)(ii). | | | | | | |
| | | notification under paragraph | | | | | |
| | | ection, the facility must | | | | | |
| | | rtinent information specified | | | | | |
| | - ' ' ' ' | s available and provided | | | | | |
| | upon request to th | | | | | | |
| | | ust also promptly notify the | | | | | |
| | | esident representative, if | | | | | |
| | any, when there is | | | | | | |
| | (A) A change in ro | | | | | | |
| | | ecified in §483.10(e)(6); or | | | | | |
| | 1 ' ' | esident rights under Federal | | | | | |
| | | gulations as specified in | | | | | |
| | paragraph (e)(10) | | | | | | |
| | 1 ' ' | ust record and periodically | | | | | |
| | | ss (mailing and email) and | | | | | |
| | phone number of | | | | | | |
| | representative(s). | | | | | | |
| | \$402.40(~\/45\ | | | | | | |
| | §483.10(g)(15) | omposite distinct part. A | | | | | |
| | | | | | | | |
| | facility that is a composite distinct part (as | | | | | | |
| | defined in §483.5) must disclose in its | | | | | | |
| | admission agreement its physical | | | | | | |
| | configuration, including the various locations that comprise the composite distinct part, | | | | | | |
| | | | | | | | |
| | and must specify | the policies that apply to | | | | | |

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

Event ID:

Q8V311 Facility ID: 000100

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| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | | ONSTRUCTION | (3) DATE SURVEY | |
|---|---|--------------------------------|------------------|----------------------------------|---|-----------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 155191 | B. W | B. WING 10/30/2023 | | | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | REENTREE N | | |
| WESTM | INSTER VILLAGE I | (ENTLICKIANA | | | (SVILLE, IN 47129 | | |
| VVLOTIVI | | CENTOONANA | | OLAIN | | | |
| (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 | | | | TAG | DEFICIENCY) | DATE | |
| | room changes between its different locations | | | | | | |
| | under §483.15(c)(9). | | - | | | 11/17/0000 | |
| | Based on observation, record review, and | | F 03 | 580 | Please accept this plan of | 11/17/2023 | |
| | interview, the facility failed to ensure notification to the representative of a resident's change in | | | | correction as our credible | | |
| | _ | 22 resident's change in | | | allegation of compliance. The | | |
| | notification of char | | | | facility respectfully requests | a | |
| | notification of char | iges. (Resident 54) | | | desk review to determine | | |
| | Ein din ag in alvida. | | | | compliance. | | |
| | Findings include: The record for Resident 54 was reviewed on | | | | The filing of this plan of | 4- | |
| | | | | | correction does not constitu | | |
| | 10/30/23 at 8:39 a.m. The diagnoses included, but | | | | that the alleged deficiency d in fact exist. This Plan of | ia | |
| | were not limited to, muscle weakness, | | | | correction is filed as evidence | 20 | |
| | hypertension, dementia, Alzheimer's with late | | | | of the facility's desire to | Je | |
| | onset, and chronic | | | | comply with the regulatory | | |
| | onset, and emonie | kidney disease. | | | requirements and continue t | | |
| | The activities note | dated 6/27/23 at 10:28 a.m., | | | provide quality care. | • | |
| | | ent was alert and made all her | | | provide quality care. | | |
| | | sat up in her wheelchair most | | | Plan of Correction F 580 | | |
| | | by the nurses' station and | | | I. Action taken for thos | | |
| | | yone. She could wheel herself | | | residents identified: | | |
| | | would do arts and crafts and | | | Regarding Resident #54, a | | |
| | | en to music. She would come | | | message was left for the famil | ly on | |
| | | ffice and get a snack and hang | | 10/19/23 to contact the faci | | - | |
| | out. | | | | with no return call. On 10/20/ | | |
| | | | | | resident representative came | | |
| | The activities note. | dated 9/14/23 at 12:14 p.m., | | | the facility as was updated on | | |
| | | ent seemed confused most | | | resident's condition. | | |
| | days, however she | would sit in the hall by the | | | II. How other residents | are | |
| | 1 - | talk to everyone. She would | | | identified: | | |
| | | ities office and hang out and | | | An audit of all current residen | ts' | |
| | | vas always friendly with | | | progress notes for the past 30 | | |
| | activities staff. | | | | days was completed for | | |
| | | | | | documentation of family | | |
| | The Quarterly MDS (Minimum Data Set) | | | | notification of residents with a | | |
| | assessment, dated 9/29/23, indicated the resident | | | | change in condition. Any issu | ies | |
| | was moderate cognitively impaired, used a | | | | identified of records lacking | | |
| | wheelchair with pa | rtial to moderate assistance | | | documentation of the notificat | ion, | |
| | where the helper di | d less than half the work, and | | | the responsible party was upo | lated | |
| needed substantial to maximum assistance with | | | | on the residents' condition. | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | JRVEY | | | |
|--|--|--|------|-------------------------------------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 00 | COMPLET | ΓED |
| | | 155191 | B. W | ING | 10/30/2023 | | |
| | | | | CTREET | ADDRESS CITY STATE ZIR COD | <u> </u> | |
| NAME OF | PROVIDER OR SUPPLIEI | R | | | ADDRESS, CITY, STATE, ZIP COD | | |
| VA/EOTA | INIOTED VIII I AOE I | ZENITI IOIZIANIA | | | GREENTREE N | | |
| WESTM | INSTER 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 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE (| COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | (IL | DATE |
| | transfers and mobil | ity related activities of daily | | | | | |
| | living. | | | | III. System in place: | | |
| | | | | | The policy and procedure "Ch | ange | |
| The nurse's note, dated 10/12/23 at 8:53 a.m., | | | | in Resident Condition or Statu | - | | |
| indicated nursing staff requested the resident to | | | | | will be followed by facility tear | n | |
| | be seen by the nurs | e practitioner (NP) related to | | | members. The resident/resident | | |
| | her leaning to the r | ight while up in her wheelchair | | | representative will be notified | if | |
| | _ | r functional condition. New | | | there is a change in condition | | |
| orders were received during the visit for | | | | | If the resident's first contact is | | |
| laboratory testing and urinalysis. Staff would | | | | unreachable, the staff will pro- | | | |
| continue to monitor. | | | | to the next contact as applical | | | |
| | | | | | The resident whose family is i | | |
| | The record lacked documentation of any | | | | need of being contacted will b | | |
| | notification to the resident's representative of the | | | | placed on the 24-hour report | | |
| | | ent's condition or new orders | | | until contact is made. The nursing | | |
| | until the nursing no | | | team will be provided with training | | | |
| | | | | | related to the procedures as | | |
| | The nurse's note, da | ated 10/19/23 at 1:00 p.m., | | | outlined in the policy. | | |
| | | nail message was left for the | | | Any team member who is four | nd | |
| | | ative requesting a return call | | | not to be in compliance, will b | | |
| | regarding a non-em | | | | re-educated and counseled as | | |
| | | | | | necessary with progressive | | |
| | The record lacked | documentation of any further | | | discipline. | | |
| | | the resident's representative | | | The IDT will review resident | | |
| | or other emergency | _ | | | progress notes during the mo | rning | |
| | | | | | meeting for documentation of | - | |
| | The nurse's note, da | ated 10/20/23 at 6:16 p.m., | | | family notification as needed. | | |
| | indicated the reside | ent's family member was there | | | issues identified in the mornin | | |
| | to see her and had | questions regarding her | | | meeting will be addressed wit | - | |
| | current condition as | nd said she was going to have | | | staff for additional necessary | | |
| | | sentative call the nurse. The | | | action/notification. | | |
| | nurse spoke with th | ne resident's representative | | | IV. How the facility will | | |
| | _ | nt condition. She informed her | | | monitor and Quality Assurar | nce | |
| | 1 | alysis results, her continued | | | program: | | |
| | leaning to the right and loss of ability to function | | | | The facility will monitor by have | /ing | |
| | | ined a CT (computed | | | an IDT stand down meeting ir | | |
| | tomography) scan could let them know if she had | | | | afternoon, during which reside | | |
| | a stroke or not. She also explained it could just be | | | | progress notes for change of | | |
| | | essing. The representative | | | condition revisions/updates | | |
| | | Nurse Practitioner see the | | | discussed in the morning clini | cal | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY | | |
|--|---|--|-----------------|--|--------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDIN | A. BUILDING <u>00</u> COM | | |
| | | 155191 | B. WING | | 10/30/2023 | |
| | | | STR | EET ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | IO GREENTREE N | | |
| WESTMI | INSTER VILLAGE P | KENTUCKIANA | | ARKSVILLE, IN 47129 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFI | CROSS-REFERENCED TO THE APPROP | E COMPLETION | |
| TAG | | | TAC | DEFICIENCY) | DATE | |
| | resident again on the following Monday and see if | | | meeting will be audited by the | ie | |
| | she thought a CT scan was necessary. She | | | DON/Designee for family | | |
| | | ed after she was seen to see | | notification. Should concern | ` ' | |
| | what the NP though | nt before she made a decision. | | identified, immediate correc | ive | |
| | D : 1 . | . 10/24/22 4.9.25 | | action shall be taken. | | |
| | 1 | ion, on 10/24/23 at 8:35 a.m., | | The Director of Nursing/Des | _ | |
| | | rse Aide) 9 was attempting to | | will provide the results from | | |
| | | hile she was in bed. The | | audits to the Quality Assura | ıce | |
| | | ved to be leaning to the right, | | Performance Improvement | | |
| | mumbling when spoken to, and was not | | | Committee (QAPI). These fi | naings | |
| | participating well in eating her breakfast when | | | will be reviewed for | 127 | |
| | cued. CNA 9 indicated the resident was not very | | | recommendations by the Qu | ality | |
| | responsive and had declined. | | | Assurance Performance | A DI) | |
| | Duning on internsion | r on 10/26/22 at 10:28 a m tha | | Improvement Committee (Q | • | |
| | _ | v on 10/26/23 at 10:28 a.m., the | | These findings and review v | | |
| | _ | ative indicated overall they | | completed monthly and sub | nitted | |
| | | the resident having a stroke. If | | to QAPI for a period of four | | |
| | | ere was nothing they could do, | | months. The Committee wil | | |
| | 1 - | o put her through the sent out, but she did not feel | | provide guidance for further | | |
| | | ole lot of communication. On | | as needed. The QAPI team | | |
| | | t a work function and her family | | meet once a month until fac | | |
| | | was beside herself because the | | attains 100% compliance fo consecutive months. | 4 | |
| | | g to the right and mumbling. | | The Director of Nurses/Desi | anee | |
| | 1 | said was it sounded like she | | will be responsible for the | grice | |
| | | he from the facility had called | | coordination and monitoring | | |
| | | o messages, and they did not | | ocordination and monitoring | | |
| | | ly on the list. She could have | | | | |
| | | facility said they had called | | | | |
| | | but she did not receive any | | | | |
| | • | She spoke with LPN (Licensed | | | | |
| | _ | on 10/20/23 who told her the | | | | |
| | | g to the right on 10/12/23 and | | | | |
| | | rk. They did not notify her of | | | | |
| | the change or the or | | | | | |
| | During an interview on 10/26/23 at 1:59 p.m., LPN | | | | | |
| | 7 indicated the resident had been her normal self | | | | | |
| | | vacation, however when she | | | | |
| | | iced the resident was leaning | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | X3) DATE SURVEY | | |
|--|---|-----------------------------------|--------------------------------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETE | | | ETED | |
| | | 155191 | B. W | ING | | 10/30/ | /2023 |
| | | l . | <u> </u> | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIEF | 8 | | | REENTREE N | | |
| \\/EQTMI | NSTER VILLAGE K | CENTUCKIANA | | | SVILLE, IN 47129 | | |
| WESTIVII | NOTER VILLAGE N | RENTOCKIANA | | CLARK | SVILLE, IN 47 129 | | |
| (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 | ΓE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | to the right and it pr | rogressively worsened. One | | | | | |
| | day she'd be sitting up straight and normal, the | | | | | | |
| | | to just mumbling and | | | | | |
| | | . She was letting food fall out | | | | | |
| | | hey now had to use a lift for | | | | | |
| | | came on suddenly, or it came | | | | | |
| | | ey didn't notice it until it was | | | | | |
| | _ | t few days she had been | | | | | |
| | | edications in applesauce. Her | | | | | |
| | | lert, feeding herself completely. | | | | | |
| | She ate everything in front of her and told staff if | | | | | | |
| | she had to use the restroom. She was alert, | | | | | | |
| | coherent, able to hold a conversation, and | | | | | | |
| | | tand and pivot. Someone said | | | | | |
| | they left messages f | | | | | | |
| | _ | when she talked to them, she | | | | | |
| | - | o messages. It was a whole run | | | | | |
| | | notify family of changes as | | | | | |
| | | them. She would document | | | | | |
| | | progress note. If she called | | | | | |
| | | she would call again and | | | | | |
| | - | reach them to discuss it. She | | | | | |
| | | contacts on the emergency | | | | | |
| | list. She would also | document each attempt. | | | | | |
| | Duning on interview | v, on 10/30/23 at 8:24 a.m., Unit | | | | | |
| | _ | d she'd asked the NP to look at | | | | | |
| | _ | leaning to the right and being | | | | | |
| | | representative was hard to | | | | | |
| | | alled her on 10/12/23 to notify | | | | | |
| | _ | ed she'd left two voicemails. | | | | | |
| | - | when they got orders. She | | | | | |
| | · | very time she made a phone | | | | | |
| | | standard. She did not contact | | | | | |
| | * | ergency contacts on her face | | | | | |
| | | | | | | | |
| | sheet. It was her error that notification was not documented on the initial 10/12/23 when the | | | | | | |
| | physician was conta | | | | | | |
| | 1 -7 20114 | | | | | | |
| | The most current C | hange in a Resident's | | | | | |
| | 1 | - | ı | | | | I |

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Event ID:

Q8V311 Facility ID: 000100

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191 | | (X2) MULTIPLE (A. BUILDING B. WING | | | |
|--|---|--|---------------------|---|-----------------------------|
| | ROVIDER OR SUPPLIER | | 2210 | r address, city, state, zip cod GREENTREE N KSVILLE, IN 47129 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | 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 |
| F 0641 SS=B Bldg. 00 | limited to, " Our frepresentative (spor resident's medical/n (e.g., changes in lev resident rights, etc.) instructed by the resident's representation significant change is mentally, or psychomedical emergencie within twenty-four occurring in the residential occurring in the | | F 0641 | Plan of Correction F 641 I. Action Taken for the residents identified: Regarding Residents # 58, 37 51, 53, 28, 38, 20, and 10, Mi assessments for these reside were modified. This modificat did not affect a change in the resident's case mix status or require revision of the resider plan of care. II. How other residents identified: No residents were affected by coding error of section N. No changes in the plan of care werequired. | DS Ints ion iots' are y the |

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Facility ID: 000100

If continuation sheet

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| | C MEDICARE & MEDIC | | | | OMB NO. 0938-039 | |
|---|---|----------------------------------|--------------------------------|---|---------------------------------------|--|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155191 | B. WING | | 10/30/2023 | |
| | | 1 | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | REENTREE N | | |
| WESTMI | NSTER VILLAGE K | (ENTUCKIANA | CLARKSVILLE, IN 47129 | | | |
| VVLOTIVII | | LITTOURINA | OLANN | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY | DATE | |
| | clopidogrel 75 mg, | once daily. | | An audit was completed of all | | |
| | | | | residents, section N on the mo | ost | |
| | The Admission MD | OS assessment, dated 9/7/23, | | recent OBRA Assessment. No |) | |
| | indicated the reside | nt received an anticoagulant 6 | | other residents were identified | to | |
| | | assessment indicated for | | be marked incorrectly for secti | on | |
| | | staff would check the form | | N. | | |
| | | platelet medication (e.g., | | III. System in place: | | |
| | | lease, dipyridamole, | | | | |
| | - | ken by the resident at any time | | The MDS coordinator was re- | | |
| during the 7-day observation period (or since | | | inserviced on the requirements | s of | | |
| admission/entry or reentry if less than 7 days). | | | section N of the MDS by the M | | | |
| admission end y or rectitly it less than / days). | | | consultant. | | | |
| The medications aspirin and clopidogrel were | | | The MDS Coordinator will mar | . L | | |
| classified as a platelet-aggregation inhibitors. | | | _ | | | |
| | ciassified as a plate | ici-aggregation millonois. | | Section N correctly after review the medication administration | wiiig | |
| | The record leafer 1 | logumentation indicating an | | | viae | |
| | | locumentation indicating an | | record. Following the re-inservice | | |
| | | t of the resident's antiplatelet | | and understanding of the inter | IL OI | |
| | therapy on Section | IN OI THE MIDS. | | section N. | | |
| | 2 771 | | | IV. How the facility will | | |
| | | esident 31 was reviewed on | | monitor and quality assurance | ce | |
| | | n. The diagnoses included, but | | program: | | |
| | | venous insufficiency, | | The MDS Coordinator/Designe | | |
| | cardiomyopathy, ar | nd hypertension. | | will run a report once per week for | | |
| | | | | MDS assessments section N f | | |
| | | er, dated 3/31/23, indicated the | | accuracy of the data. Any issu | ues | |
| | | opidogrel 75 mg tablet, once | | identified by this report will be | | |
| | daily. | | | addressed by modification if | | |
| | | | | needed at that time. | | |
| | | S assessment, dated 9/20/23, | | The results from the MDS | | |
| | indicated the reside | nt received an anticoagulant 7 | | Coordinator or designee's wee | ekly | |
| | days per week. The | assessment indicated for | | audits of the MDS assessmen | ts. | |
| | antiplatelet therapy | staff would check the form | | The documentation will be | | |
| | indicating if an anti | platelet medication (e.g., | | presented to the Quality | | |
| | aspirin/extended re | lease, dipyridamole, | | Assurance Performance | | |
| | - | ken by the resident at any time | | Improvement Committee (QAF | 기). | |
| | | eservation period (or since | | The findings will be reviewed, | , , , , , , , , , , , , , , , , , , , | |
| | | reentry if less than 7 days). | | recommendations made by the | | |
| | | | | Quality Assurance Performance | | |
| | The medication clo | pidogrel was classified as | | Improvement Committee (QAF | | |
| | platelet-aggregation | | | on a monthly basis or until the | * | |
| I | 1 | | 1 | I see a morning basis of arith the | l l | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|--|---|--------------------------|--------|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | | | |
| | | 155191 | B. W | 'ING | | 10/30/2023 | |
| NAME OF P | PROVIDER OR SUPPLIER | . | | | ADDRESS, CITY, STATE, ZIP COD | | |
| WESTMI | NSTER VILLAGE K | ENTUCKIANA | | | SVILLE, IN 47129 | | |
| (X4) ID | SUMMARY | 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 | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE | |
| | Th | I | | | facility has ha 100% complian | СУ | |
| | The record lacked documentation indicating an accurate assessment of the resident's antiplatelet | | | | for 4 consecutive months. | | |
| | | - | | | The Director of Nurses/Design | ee | |
| | therapy on section i | N of the MDS assessment. | | | will be responsible for the coordination and monitoring. | | |
| | 3. The record for Re | esident 57 was reviewed on | | | Coordination and monitoring. | | |
| | | m. The diagnoses included, but | | | | | |
| | | atherosclerotic heart disease | | | | | |
| | | ary artery without angina, | | | | | |
| | | onormalities of gait and | | | | | |
| | mobility. | | | | | | |
| | | | | | | | |
| | The physician's order, dated 5/11/23, indicated the | | | | | | |
| | | opidogrel 75 mg, once daily, | | | | | |
| | | neart disease of native | | | | | |
| | coronary artery with | hout angina pectoris. | | | | | |
| | The Ouarterly MDS | S assessment, dated 8/17/23, | | | | | |
| | | nt received an anticoagulant 7 | | | | | |
| | | assessment indicated for | | | | | |
| | antiplatelet therapy | staff would check the form | | | | | |
| | indicating if an anti | platelet medication (e.g., | | | | | |
| | aspirin/extended rel | ease, dipyridamole, | | | | | |
| | | ken by the resident at any time | | | | | |
| | | servation period (or since | | | | | |
| | admission/entry or | reentry if less than 7 days). | | | | | |
| | The mediantian 1 | wide and wee aloos!C - 1 | | | | | |
| | platelet-aggregation | pidogrel was classified as | | | | | |
| | piatelet-aggregation | i mmonors. | | | | | |
| | The record lacked d | locumentation indicating an | | | | | |
| | | t of the resident's antiplatelet | | | | | |
| | | N of the MDS assessment. | | | | | |
| | | | | | | | |
| | | esident 51 was reviewed on | | | | | |
| | | m. The diagnoses included, but | | | | | |
| | were not limited to, cerebrovascular disease, aftercare following surgery on the skin and | | | | | | |
| | | | | | | | |
| | | -groin debridement, a | | | | | |
| | personal history of | other venous thrombosis and | | | | | |

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

Event ID:

Q8V311 Facility ID: 000100

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| [· | | X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY | | | | | |
|---|---|--|--------------------------|-------------------------------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | | | |
| | | 155191 | B. WI | NG | | 10/30/ | /2023 |
| | PROVIDER OR SUPPLIER | | | 2210 GF | ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | | | (X5) |
| PREFIX | | | | PROVIDER'S PLAN (EACH CORRECTIVE AC | | | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | NIE. | DATE |
| | | al history of transient ischemic | | | | | |
| | attack (TIA), and co | erebral infarction, heart failure, | | | | | |
| | unspecified, and peripheral vascular disease. | | | | | | |
| | the resident receive | ders, dated 7/20/23, indicated an aspirin tablet, delayed a clopidogrel tablet, 75 mg, | | | | | |
| | The Quarterly MDS | S, dated 9/20/23, indicated the | | | | | |
| | resident received an anticoagulant 7 days per | | | | | | |
| week. The assessment indicated for antiplatelet | | | | | | | |
| | therapy staff would check the form indicating if an | | | | | | |
| | _ | tion (e.g., aspirin/extended | | | | | |
| | | ole, clopidogrel) was taken by | | | | | |
| | - | time during the 7-day (or since admission/entry or | | | | | |
| | reentry if less than | • | | | | | |
| | rectity if less than | r days). | | | | | |
| | The medications as | pirin and clopidogrel were | | | | | |
| | classified as platele | t-aggregation inhibitors. | | | | | |
| | The clinical lacked | documentation indicating an | | | | | |
| | | t of the resident's antiplatelet | | | | | |
| | | of the MDS assessment. | | | | | |
| | | esident 53 was reviewed on | | | | | |
| | 10/25/23 at 2:12 p.1 | m. The diagnoses included, but | | | | | |
| | were not limited to, | , acute ischemic heart disease, | | | | | |
| | | rt disease of native coronary | | | | | |
| | artery without angir | na pectoris, and bradycardia. | | | | | |
| | The Annual MDS a | assessment, dated 10/5/23, | | | | | |
| | | ent received an anticoagulant 7 | | | | | |
| | | assessment indicated for | | | | | |
| | antiplatelet therapy | staff would check the form | | | | | |
| | _ | platelet medication (e.g., | | | | | |
| | aspirin/extended release, dipyridamole, | | | | | | |
| | 1 2 / | ken by the resident at any time | | | | | |
| | | oservation period (or since | | | | | |
| | admission/entry or | reentry if less than 7 days). | | | | | |

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Event ID:

Q8V311 Facility ID: 000100

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| r ´ | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | SURVEY | |
|--|---|---|--------------------------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | | | |
| | | 155191 | B. W | ING | | 10/30/ | 2023 |
| NAME OF P | DOMDED OF CURPLIES | | | STREET A | DDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | C | | | REENTREE N | | |
| WESTMI | NSTER VILLAGE K | KENTUCKIANA | | CLARKS | 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 | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | The Medication Ad | ministration Records (MARs) | | | | | |
| between 4/29/23 and 10/25/23 indicated the | | | | | | | |
| resident received Plavix 75 mg on a daily basis. | | | | | | | |
| | | | | | | | |
| | | ssified as a platelet-aggregation | | | | | |
| inhibitor. | | | | | | | |
| | The record leafer 1 : | locumentation indicating an | | | | | |
| | | t of the resident's antiplatelet | | | | | |
| | | - | | | | | |
| | therapy on Section N of the MDS. | | | | | | |
| 6. The record for Resident 28 was reviewed on | | | | | | | |
| | _ | n. The diagnoses included, but | | | | | |
| | | atherosclerotic heart disease | | | | | |
| | of native coronary a | artery without angina pectoris. | | | | | |
| | The Quarterly MDS | S assessment, dated 9/2/23, | | | | | |
| | | nt received an anticoagulant 7 | | | | | |
| | | assessment indicated for | | | | | |
| | | staff would check the form | | | | | |
| | indicating if an anti | platelet medication (e.g., | | | | | |
| | aspirin/extended rel | lease, dipyridamole, | | | | | |
| | | ken by the resident at any time | | | | | |
| | - | servation period (or since | | | | | |
| | admission/entry or | reentry if less than 7 days). | | | | | |
| | The Medication Ad | ministration Records (MARs) | | | | | |
| | | d 10/25/23 indicated the | | | | | |
| | | e Plavix 75 mg on a daily basis. | | | | | |
| | | <i>G</i> | | | | | |
| | The Plavix was clas | ssified as a platelet-aggregation | | | | | |
| | inhibitor. | | | | | | |
| | 771 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | | | |
| | | locumentation indicating an | | | | | |
| accurate assessment of the resident's antiplatelet therapy on Section N of the MDS. 7. The record for Resident 38 was reviewed on | | | | | | | |
| | | | | | | | |
| | | m. The diagnoses included, but | | | | | |
| | | a personal history of transient | | | | | |
| | | r steems motory of dumbiont | | | | | |

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Event ID:

Q8V311

Facility ID: 000100

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155191 | | (X2) MULTIPLE CO A. BUILDING B. WING | | | |
|--|---|---|---------------------|---|---------------|
| | PROVIDER OR SUPPLIEF | | 2210 G | ADDRESS, CITY, STATE, ZIP COD GREENTREE N KSVILLE, IN 47129 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION A) and cerebral infarction. | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | BE COMPLETION |
| | 8/18/23, indicated to abnormal bruising of anticoagulant theral 5/8/23, indicated to to perform labwork observe for signs arbruising or bleeding. The Quarterly MDS indicated the reside | S assessment, dated 8/24/23, nt received an anticoagulant 7 | | | |
| | antiplatelet therapy indicating if an anti aspirin/extended re- clopidogrel) was tal during the 7-day ob admission/entry or | assessment indicated for staff would check the form platelet medication (e.g., lease, dipyridamole, ken by the resident at any time servation period (or since reentry if less than 7 days). er, dated 5/19/23, indicated to | | | |
| | The Plavix (clopide platelet-aggregation | | | | |
| | | locumentation indicating an tof the resident's antiplatelet N of the MDS. | | | |
| | 10 indicated the res | on 10/26/23 at 1:48 p.m., RN ident took Plavix as an ould monitor the resident for 3. | | | |
| | 10/25/23 at 10:56 a were not limited to, | esident 20 was reviewed on .m. The diagnoses included, but hypertensive heart disease, herosclerotic heart disease, and | | | |

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Facility ID: 000100

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|----------------------------------|--------|------------------------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155191 | B. W | ING | | 10/30 | /2023 |
| | | | | CTREET | DDDEGG CITY CTATE ZID COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| VA/EOTA | NOTEDAWLAGE | CENTUO CIANA | | | REENTREE N | | |
| WESTMI | NSTER VILLAGE K | KENTUCKIANA | | CLARK | SVILLE, IN 47129 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID PROVIDER'S PLAN OF CORREC | | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | T- | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 16 | DATE |
| | an abdominal aortic | | | | | | |
| | | • | | | | | |
| | The physician's ord | er, dated 1/9/23, indicated to | | | | | |
| | administer clopidog | | | | | | |
| | | , | | | | | |
| | The clopidogrel wa | s classified as a | | | | | |
| | platelet-aggregation | | | | | | |
| | | | | | | | |
| | The Significant Cha | ange MDS assessment, dated | | | | | |
| | _ | he resident received an | | | | | |
| | · · | rs per week. The assessment | | | | | |
| | | atelet therapy staff would | | | | | |
| | _ | cating if an antiplatelet | | | | | |
| | | pirin/extended release, | | | | | |
| | , , , | dogrel) was taken by the | | | | | |
| | | during the 7-day observation | | | | | |
| | 1 | nission/entry or reentry if less | | | | | |
| | than 7 days). | mission/entry of feeting it less | | | | | |
| | man / days). | | | | | | |
| | The record looked of | locumentation indicating an | | | | | |
| | | t of the resident's antiplatelet | | | | | |
| | | | | | | | |
| | therapy on Section | N of the MDS. | | | | | |
| | 0 Th | :1101 | | | | | |
| | | esident 10 was reviewed on | | | | | |
| | | m. The diagnoses included, but | | | | | |
| | | hypertensive heart disease | | | | | |
| | | eerebrovascular disease, | | | | | |
| | | systolic (congestive) and | | | | | |
| | | re) heart failure, presence of | | | | | |
| | | and nonrheumatic aortic | | | | | |
| | (valve) stenosis. | | | | | | |
| | | 1.150 | | | | | |
| | | Quarterly MDS assessment, | | | | | |
| | · · · · · · · · · · · · · · · · · · · | ated the resident received an | | | | | |
| | | rs per week. The assessment | | | | | |
| | | atelet therapy staff would | | | | | |
| | | cating if an antiplatelet | | | | | |
| | | pirin/extended release, | | | | | |
| | | dogrel) was taken by the | | | | | |
| | resident at any time | during the 7-day observation | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|--|------|--------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | ЛLDING | 00 | COMPL | |
| | | 155191 | B. W | ING | | 10/30/ | 2023 |
| NAME OF F | ROVIDER OR SUPPLIER | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| MESTMI | NSTER VILLAGE Þ | CENTUCKIANIA | | | REENTREE N | | |
| WESTIVII | NSTER VILLAGE P | RENTOCKIANA | | CLARK | SVILLE, IN 47129 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | • | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | R LSC IDENTIFYING INFORMATION mission/entry or reentry if less | | TAG | | | DATE |
| | than 7 days). | mission entry of rectivity it less | | | | | |
| | The physician's orders, dated 1/5/23, indicated to | | | | | | |
| | - | delayed release, 81 mg and | | | | | |
| | clopidogrel 75 mg, | daily. | | | | | |
| | | pidogrel were classified as | | | | | |
| | platelet-aggregation | n inhibitors. | | | | | |
| | The record lacked of | locumentation indicating an | | | | | |
| | accurate assessmen | t of the resident's antiplatelet | | | | | |
| | therapy on Section | N of the MDS. | | | | | |
| | _ | v on 10/30/23 at 8:20 a.m., the | | | | | |
| | | indicated for her assessments, | | | | | |
| | | the resident to gather | | | | | |
| | | l as reviewing the MAR and dministrative Record). She was | | | | | |
| | ` | coding of medication on the | | | | | |
| | | vix was the antiplatelet with the | | | | | |
| | Coumadin and Eliq | uis being the anticoagulant. | | | | | |
| | | d wrong before she figured out | | | | | |
| | _ | g. It had not been brought to | | | | | |
| | • | MDS consultant. She talked | | | | | |
| | | assessments were reviewed by had not brought any issues | | | | | |
| | | attention. She would make | | | | | |
| | - | ed. She didn't have a policy | | | | | |
| | | out she did follow the RAI | | | | | |
| | (Resident Assessme | ent Instrument) manual. | | | | | |
| | 3.1-31(b) | | | | | | |
| F 0684 | 483.25 | | | | | | |
| SS=D | Quality of Care | | | | | | |
| Bldg. 00 | § 483.25 Quality of | | | | | | |
| | • | a fundamental principle that | | | | | |
| | applies to all treat facility residents. | ment and care provided to | | | | | |
| | iacinty residerits. | มลงงน UII แเซ | | | | | |

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Event ID:

Q8V311

Facility ID: 000100

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | X2) MULTIPLE CONSTRUCTION (X3) D | | (X3) DATE | 3) DATE SURVEY | |
|--|---|--|----------------------------------|------------------------------|--|----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> COMPLE | | | ETED |
| | | 155191 | B. W | ING | | 10/30/ | /2023 |
| | | <u> </u> | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | REENTREE N | | |
| WESTMI | NSTER VILLAGE H | KENTUCKIANA | | | SVILLE, IN 47129 | | |
| | | | 1 | | , I | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | , | NCY MUST BE PRECEDED BY FULL | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| | l ' | ssessment of a resident, the re that residents receive | | | | | |
| | I - | re in accordance with | | | | | |
| | | dards of practice, the | | | | | |
| | · · | erson-centered care plan, | | | | | |
| | and the residents | | | | | | |
| | | view and interview the facility | F 00 | 584 | Plan of correction F 684 | | 11/17/2023 |
| | | esident's treatment was timely | 1 00 | | I. Action Taken for the | | 11/1//2023 |
| | | reviewed for Quality of Care. | | | residents identified: | | |
| | (Resident 31) | ` , | | | Regarding resident 31, as sta | ted | |
| | | | | | in the 2567, the resident recei | | |
| | The record for Resi | ident 31 was reviewed on | | | the one-time dose of the | | |
| | 10/26/23 at 9:07 a.m. The diagnoses included, but | | | | medication. | | |
| | were not limited to | , type 2 diabetes mellitus with | | | II. How other residents are | | |
| | diabetic chronic kid | dney disease, other skin | | | identified: | | |
| | changes, and obesit | ty. | | | An audit was completed on al | l | |
| | | | | | residents for the last 30 days | | |
| | The fax sheet cover | r, dated 6/17/23, indicated the | | | regarding timely administratio | n of | |
| | facility sent a fax for | or Resident 31 of a urinalysis | | | oral antifungal medications. N | No | |
| | and culture results | to the physician. The staff | | | other residents were identified | d. | |
| | | sician wanted to continue | | | III. System in place: | | |
| | | rmed the physician the | | | The nursing staff were | | |
| | resident was having | g symptoms of a yeast | | | re-inserviced on calling the M | D or | |
| | infection. | | | | NP timely, timely treatment ar | nd | |
| | | | | | following up. | | |
| | | ysician responded with a fax. | | | The facility has an onsite Nurs | | |
| | | as received on 6/19/23 at 4:51 | | | Practitioner Program to provide | | |
| | - | to continue the antibiotics and | | | more timely response and acc | | |
| | ` | ntifungal) 150 mg (milligram), | | | to residents. This NP program | n | |
| | one time. | | | | started July 2023. | | |
| | T 11 1 1 | i de la compania | | | Nursing staff will continue to fo | | |
| | | documentation indicating the | | | up with the physician or NP as | S | |
| | , | 6/17/23) was received and the | | | needed. Nurses were | _ | |
| | | ne treatment for a yeast | | | re-inserviced on the use of the | | |
| | l ' | y manner. The resident was not | | | EDK to initiate initial doses of | | |
| | treated for five day | s (dated 6/22/23). | | | medication and re-inserviced | | |
| | The trop 1 | and dated 6/20/22 at 0.52 | | | the Nurse Practitioner Program | | |
| | | og, dated 6/20/23 at 9:53 p.m., | | | Any team member who is four | | |
| | | y sent the same fax as on | | | not to be in compliance will be | | |
| | 0/1//23. The physic | cian faxed back and indicated to | | | re-educated and counseled as | S | I |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|--|-------|----------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | LETED |
| | | 155191 | B. W | ING | | 10/30 | /2023 |
| | | 1 | I | STREET / | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | R | | | REENTREE N | | |
| /A/EQTA/I | NSTER VILLAGE K | ZENTLICKIANA | | | SVILLE, IN 47129 | | |
| VVESTIVII | . VILLAGE P | ALIVI OCIVIAIVA | | OLAIN | | | |
| (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 | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | refer to the faxed re | esponse sent on 6/19/23. | | | necessary with progressive | | |
| | | | | | discipline. | | |
| | | ated 6/21/23 at 7:01 a.m., | | | The IDT will review resident | | |
| | indicated the physician replied regarding current | | | | physician orders and progress | | |
| | | s. He wrote please refer to the | | | notes from the previous day to |) | |
| | | ers from 6/19/23. The | | | ensure timely treatment has | | |
| | 1 | one-time dose of Diflucan 150 | | | occurred. Any issues identifie | d in | |
| | mg, by mouth to tre | eat for a yeast infection. | | | the morning meeting will be | | |
| | Th | -4-1 (/22/22 -4 2-22 | | | addressed with the staff for ne | | |
| | | ated 6/22/23 at 2:22 p.m., ent was to continue the | | | for additional follow-up/action. | | |
| | | | | | N/ | | |
| | | ary tract infection. A new order 22/23 to give a one dose of | | | IV. How the facility will | | |
| | Diflucan 150 mg fo | _ | | | monitor and quality assuran | ce | |
| | Diffucali 130 liig id | or a yeast infection. | | | program: The facility will monitor by have | ina o | |
| | The review of the N | MAP (Medication | | | stand down meeting in the | ilig a | |
| | | cord), dated 6/22/23, indicated | | | afternoon, during which reside | nt | |
| | | ng was given at 2:22 p.m. | | | progress notes and orders wil | | |
| | the Diffuedit 130 in | ig was given at 2.22 p.m. | | | audited for follow up from the | i be | |
| | During an interviey | v on 10/26/23 at 11:40 a.m., the | | | morning meeting by the | | |
| | _ | Nursing) indicated the pharmacy | | | DON/Designee for timely | | |
| | | ons once a day. If the order | | | treatment. Should concern(s) | he | |
| | | dication would be delivered the | | | identified, immediate correctiv | | |
| | | ility needed the medication | | | action shall be taken. | · · | |
| | | ey would get the medication | | | The Director of Nursing /Design | nee | |
| | from a local pharma | - | | | will provide the results from th | - | |
| | • | | | | audits to the Quality Assurance | | |
| | During an interview | v on 10/26/23 at 1:30 p.m., RN | | | Performance Improvement | | |
| | | a nurse sent a fax to the doctor, | | | Committee (QAPI). These find | lings | |
| | | the pertinent charting list. If | | | will be reviewed for | Ü | |
| | | der back from the physician, | | | recommendations by the Qua | lity | |
| | 1 | nt the order in the computer | | | Assurance Performance | - | |
| | | e nurse's notes. She did not | | | Improvement Committee (QAI | PI). | |
| | know why the resid | lent's order had been missed. | | | These findings and review will | • | |
| | Someone should ha | meone should have seen the faxed orders. The | | | completed monthly and submi | | |
| | facility had a NP (N | Nurse Practitioner) on call seven | | | to QAPI for a period of 4 mont | | |
| | days a week and twenty-four hours a day | | | | The Committee will provide | | |
| | available. The resid | lent should not have had to | | | guidance for further action as | | |
| | wait 5 days for the | medication. | 1 | | needed. The QAPI team will n | neet | |
| | | | 1 | | once a month until we reach 1 | 00% | İ |

| l í | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING (0) COMPLETEI | | | | | |
|-----------|----------------------|--|------|--|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155191 | | A. BUILDING 00 COMPLETED B. WING 10/30/202: | | | |
| | | 133191 | Б. W | _ | | 10/30/2 | 2023 |
| NAME OF P | PROVIDER OR SUPPLIE | R | | | ADDRESS, CITY, STATE, ZIP COD REENTREE N | | |
| WESTMI | NSTER VILLAGE F | KENTUCKIANA | | CLARKSVILLE, 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) | TE | COMPLETION |
| TAG | | w on 10/30/23 at 1:00 p.m., the | + | TAG | compliancy for 4 consecutive | | DATE |
| | _ | faxed request was sent to the | | | months. | | |
| | | 23. The physician sent a faxed | | | The Director of Nurses/Design | nee | |
| | order back on 6/19/ | /23. The resident received the | | | will be responsible for the | | |
| | | 2/23. The resident went 3 days | | | coordination and monitoring. | | |
| | | tion instead of five days. A NP | | | | | |
| | | intil July. The physician was I have been called for the | | | | | |
| | medication. | nave been called for the | | | | | |
| | medication. | | | | | | |
| | The Physician Drug | g Orders policy, dated 1/23, | | | | | |
| | included, but was n | not limited to, " Prescriptions | | | | | |
| | _ | only when a clear and complete | | | | | |
| | 1 | n lawfully authorized to | | | | | |
| | l ~ | ed. Verbal telephone orders will / licensed nurse or pharmacist | | | | | |
| | 1 | riting by the physician on a | | | | | |
| | timely basis" | Titling by the physician on a | | | | | |
| | | | | | | | |
| | 3.1-37(a) | | | | | | |
| F 0812 | 483.60(i)(1)(2) | | | | | | |
| SS=E | Food | | | | | | |
| Bldg. 00 | | re/Prepare/Serve-Sanitary | | | | | |
| | , · · · | safety requirements. | | | | | |
| | The facility must - | - | | | | | |
| | 8483.60(i)(1) - Pro | ocure food from sources | | | | | |
| | (, , , | idered satisfactory by | | | | | |
| | federal, state or lo | | | | | | |
| | (i) This may includ | de food items obtained | | | | | |
| | 1 | producers, subject to | | | | | |
| | applicable State a | and local laws or | | | | | |
| | regulations. | door not prohibit as assume | | | | | |
| | | does not prohibit or prevent ng produce grown in facility | | | | | |
| | | to compliance with | | | | | |
| | 1 - | rowing and food-handling | | | | | |
| | practices. | ziiig and iood nanding | | | | | |
| | l · | does not preclude residents | | | | | |

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

Event ID:

Q8V311 Facility ID: 000100

If continuation sheet Page 17 of 35

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | | | | (X3) DATE | SURVEY | |
|-----------|--------------------------|---|-------|---------|---|-----------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED | |
| | | 155191 | B. W. | B. WING | | | /2023 | |
| | | <u> </u> | | CTREET | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | REENTREE N | | | |
| WESTMI | INSTER VILLAGE K | CENTUCKIANA | | | (SVILLE, IN 47129 | | | |
| WESTIVII | VILLAGE N | CENTOCKIANA | | CLARK | | | | |
| (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 | |
| | from consuming for | oods not procured by the | | | | | | |
| | facility. | | | | | | | |
| | | | | | | | | |
| | - ,,,,, | ore, prepare, distribute and | | | | | | |
| | | ordance with professional | | | | | | |
| | standards for food | | | | | | | |
| | | on and interview, the facility | F 0 | 812 | The filing of this plan of | | 11/17/2023 | |
| | | kitchen was maintained in a | | | correction does not constitu | | | |
| | · · | 3 of 3 observations. This | | | that the alleged deficiency di | ıd | | |
| | _ | ad the potential to affect all 57 | | | in fact exist. This Plan of | | | |
| | residents currently | residing at the facility. | | | correction is filed as evidend | e | | |
| | F' 1' ' 1 1 | | | | of the facility's desire to | | | |
| | Findings include: | | | | comply with the regulatory | _ | | |
| | 1 Design a 41 a in 141 a | 14 | | | requirements and continue t | 0 | | |
| | _ | l tour of the kitchen on 10/23/23 llowing concerns were | | | provide quality care. | | | |
| | observed: | nowing concerns were | | | F812 | | | |
| | observed. | | | | The facility does store, prepar | 0 | | |
| | - There was a heavy | y buildup of white under the | | | distribute and serve food in | ᠸ, | | |
| | dishwasher and dirt | - | | | accordance with food service | | | |
| | distiwasher and and | ty distriction. | | | safety. | | | |
| | - The back splatter | guard of the stove had a | | | Caroty. | | | |
| | _ | of brown and black grease to it. | | | I Action taken for | | | |
| | 1 | 8 | | | those residents identified: | | | |
| | - There was a coating | ng of brown substance on the | | | No residents were identified. | | | |
| | | riddle. Dietary Cook 4 | | | The kitchen was thoroughly | | | |
| | | eds to be cleaned. We don't | | | cleaned and repairs made to | | | |
| | use that that often. | We set stuff on it and that | | | include but not be limited to: | | | |
| | makes it turn brown | n. We use it for grilled cheeses | | | The heavy lime buildup under | the | | |
| | sometimes. It was o | cleaned about a week ago." | | | dishwasher and dirty dish cou | nter | | |
| | | | | | was removed. | | | |
| | · · | y buildup of grease on the | | | The back splatter guard on the | Э | | |
| | table under the grid | ldle. The cook indicated she | | | stove was cleaned. | | | |
| | needed to clean that | t up. | | | The flat top griddle was cleane | ed. | | |
| | | | | | The flat top griddle table was | | | |
| | | erate buildup of grease and | _ | | cleaned. | | | |
| | _ | f the Vulcan oven as well as | | | The Vulcan stove was cleaned | | | |
| | the wall behind, and | d the floor underneath of it. | | | well as the wall behind it and t | he | | |
| | | | | | floor around it. | | | |
| | - There was a heavy | y coating of dust observed to | | | The wall, fan and hoses in bot | h | | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|--|---------------------------------------|--------|----------------------------|---|---------|------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLE | ETED | |
| | | 155191 | B. W | ING | | 10/30/2 | 2023 | |
| | | | | CTDEET | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | REENTREE N | | | |
| WESTM | INSTER VILLAGE I | ZENTLICKIANA | | | SVILLE, IN 47129 | | | |
| VVESTIVII | INSTER VILLAGE | KENTOCKIANA | | CLARK | SVILLE, IN 47 129 | | | |
| (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 | ATE | COMPLETION | |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | be swaying, hanging on the wall, fan and hose in | | | | the walk-in freezer and | | | |
| | the walk-in freezer and fridge. - In the walk-in fridge there were two molded | | | | refrigerators were cleaned. | | | |
| | | | | | The milk was removed and de | ebris | | |
| | | | | | under racks in the walk-in | | | |
| | | an unidentifiable substance | | | refrigerator were cleaned up. | | | |
| | which was growing | · · · · · · · · · · · · · · · · · · · | | | The ceiling vents outside of the | ne dry | | |
| | | 2 inches tall, and a gallon of | | | storage room, in front of the | | | |
| | milk on the floor u | nder the metal rack. | | | reach-in refrigerator and abov | | | |
| | | | | | steam table were wiped dowr | II | | |
| | | spots, appearing to be mildew, | | | The steam table and base we | re | | |
| | | ceiling outside the dry storage, | | | cleaned. | | | |
| | | n in fridge, and above the steam | | | The baseboards, corners and | | | |
| | table. | | | | walls in the kitchen were clea | ned. | | |
| | | | | | | | | |
| | | vas coated in a layer of brown | | | II How other residen | its | | |
| | _ | which was streaking down the | | | are identified: | | | |
| | steam table base. | | | | No residents identified or affe | cted. | | |
| | Thomas vyas a haavy | y buildup of grime along the | | | III Custom in place. | | | |
| | | the corners and along the walls | | | III System in place: | | | |
| | throughout the kite | _ | | | The dietary staff were provide | ;u | | |
| | unoughout the kite | nen. | | | with cleaning schedules and training regarding kitchen | | | |
| | 2 During a follow- | up tour of the kitchen, on | | | sanitation that was completed | Lon | | |
| | _ | m., the following concerns | | | 11/10/2023. | 1 011 | | |
| | remained: | mi, the following concerns | | | The Dietary Manager and/or | | | |
| | | | | | Designee will be responsible | for | | |
| | - There was a heav | y buildup of white under the | | | the coordination of cleaning | | | |
| | dishwasher and dir | - | | | schedules and completion of | | | |
| | | | | | tasks. | | | |
| | - The back splatter | guard of the stove had a | | | | | | |
| | _ | of brown and black grease to it. | | | IV How the facility wi | ıı | | |
| | 1 | | | | monitor and quality assuran | II | | |
| | - There were black | spots, appearing to be mildew, | | | program: The | | | |
| | to the vents in the ceiling outside the dry storage, | | | | Administrator/Designee will be | e | | |
| | in front of the reach in fridge, and above the steam | | | | responsible for monitoring by | | | |
| | table. | - | | | completing a kitchen sanitation | | | |
| | | | | | tour/audit twice weekly. Shou | | | |
| | - There was a heav | y buildup of grease on the | | | concerns be identified, immed | | | |
| | | ldle. Dietary Cook 4 indicated | | | corrective action shall be take | II | | |
| | _ | lean right after you left, I didn't | | | The results of these audits an | ıd | | |

11/30/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/30/2023 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE get under I need maintenance to get under there." any necessary corrective actions will be discussed during the - There was a moderate buildup of grease and monthly QAPI meetings with grime on the side of the Vulcan oven as well as additional education or revision of the wall behind, and the floor underneath of it. the plan made on the basis of the findings. Monthly meetings will - There was a heavy coating of dust observed to continue for a minimum of 6 be swaying, hanging on the wall, fan and hose in months. the walk-in freezer and fridge. - In the walk-in fridge there were two molded grapes, a puddle of an unidentifiable substance which was growing white fuzzy mold approximately 1 to 2 inches tall, and a gallon of milk on the floor under the metal rack. - The steam table was coated in a layer of brown and white buildup, which was streaking down the steam table base. - There was a heavy buildup of grime along the baseboards and in the corners and along the walls throughout the kitchen. 3. During a follow-up tour, on 10/27/23 at 9:00 a.m., all the above concerns as observed on 10/26/23 remained unchanged. During an interview on 10/27/23 at 9:05 a.m., Dietary Aide 5 indicated they tried to clean the floors at least once a week. It depended on how bad it got. Their garbage disposal backed up the other day and she cleaned the floor up as good as she could. The white buildup on the floor had been there for years. They had the people and

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people now.

they had the time to clean it. They used to have staffing issues and didn't have time to clean everything like they should, but they had more

Event ID:

Q8V311

Facility ID: 000100

If continuation sheet

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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 | A. BU | JILDING | 00 | COMPI | LETED |
| | | 155191 | B. W | ING _ | | 10/30 | /2023 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | | REENTREE N | | |
| WESTMI | NSTER VILLAGE K | FNTLICKIANA | | | SVILLE, IN 47129 | | |
| VVEO I IVII | THE TEN VILLAGE N | | | SLAIN | O VILLE, IIV 77 120 | | |
| (X4) ID | SUMMARY S | 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 | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCY) | | DATE |
| | - | with the Dietary Manager on | | | | | |
| | | n., she indicated the floor | | | | | |
| | | han it used to. They said it | | | | | |
| | | water they used to have. | | | | | |
| | | ter softener and staff were | | | | | |
| | | clean up the lime buildup. It | | | | | |
| | | e. Maintenance was supposed | | | | | |
| | | an the vents every week. She | | | | | |
| | | ey had the mildew buildup. | | | | | |
| | | p cleaning the kitchen once a and the staff. Staff should be | | | | | |
| | | oing under and behind | | | | | |
| | | ey were not deep cleaning it | | | | | |
| | | uff up under the equipment. | | | | | |
| | | t up stock was supposed to | | | | | |
| | | ler the racks in the fridges and | | | | | |
| | | as to get the kitchen as clean | | | | | |
| | - | to be, but it had been a | | | | | |
| | | he first had to get staff in the | | | | | |
| | | to work the whole kitchen | | | | | |
| | | did not have cleaning | | | | | |
| | | to use them, but staff were | | | | | |
| | | ing off tasks and not | | | | | |
| | • • | d she had quit using them. She | | | | | |
| | | ny current cleaning checklists | | | | | |
| | for the kitchen. | g | | | | | |
| | | | | | | | |
| | The most current Di | ietary Sanitation Practices | | | | | |
| | | t was not limited to, " All | | | | | |
| | * | will practice standard sanitary | | | | | |
| | procedures 9. Clea | an equipment and work units | | | | | |
| | - | y, weekly and monthly cleaning | | | | | |
| | | ding any additional specific | | | | | |
| | assignments that are | e designated by the food | | | | | |
| | service director 13 | 3. The kitchen, dining area and | | | | | |
| | appliances are clean | ned following facility policy" | | | | | |
| | | | | | | | |
| | 3.1-21(i)(3) | | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Q8V311 Facility ID: 000100 If continuation sheet Page 21 of 35

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/30/2023 |
|----------|-------------------------------------|--|--|--|---------------------------------------|
| | ROVIDER OR SUPPLIER | | 2210 G | ADDRESS, CITY, STATE, ZIP COD REENTREE N SVILLE, IN 47129 | |
| | | | | , I | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX | • | CY MUST BE PRECEDED BY FULL | PREFIX | CROSS-REFERENCED TO THE APPROPRI | |
| TAG | | LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY | DATE |
| F 0883 | 483.80(d)(1)(2) | | | | |
| SS=E | | eumococcal Immunizations | | | |
| Bldg. 00 | - , , | za and pneumococcal | | | |
| | immunizations | TI 6 111 | | | |
| | - ' ' ' ' | uenza. The facility must | | | |
| | | nd procedures to ensure | | | |
| | that- | the influence income inching | | | |
| | ., | the influenza immunization, | | | |
| | | ne resident's representative n regarding the benefits and | | | |
| | | cts of the immunization; | | | |
| | - | s offered an influenza | | | |
| | | ober 1 through March 31 | | | |
| | | ne immunization is | | | |
| | = | dicated or the resident has | | | |
| | | unized during this time | | | |
| | period; | unized daring this time | | | |
| | (iii) The resident o | r the resident's | | | |
| | , , | s the opportunity to refuse | | | |
| | immunization; and | | | | |
| | | medical record includes | | | |
| | ` ' | at indicates, at a minimum, | | | |
| | the following: | , | | | |
| | (A) That the reside | ent or resident's | | | |
| | , , | s provided education | | | |
| | | efits and potential side | | | |
| | effects of influenza | a immunization; and | | | |
| | (B) That the reside | ent either received the | | | |
| | influenza immuniz | ation or did not receive the | | | |
| | influenza immuniz | ation due to medical | | | |
| | contraindications | or refusal. | | | |
| | | | | | |
| | - ',',' | eumococcal disease. The | | | |
| | • | op policies and procedures | | | |
| | to ensure that- | | | | |
| | | the pneumococcal | | | |
| | • | ch resident or the resident's | | | |
| | | eives education regarding | | | |
| | | otential side effects of the | | | |
| | immunization; | | | | |

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

Event ID:

Q8V311

Facility ID: 000100

If continuation sheet

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11/30/2023 PRINTED: FORM APPROVED

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 COMPLETED 00 B. WING 10/30/2023 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 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization: and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility F 0883 Plan of Correction F 883 11/17/2023 failed to ensure residents were offered Action taken for pneumococcal vaccinations as recommended by those residents identified: the CDC (Centers for Disease Control) for 4 of 5 Regarding Residents #32, 39, 50 residents reviewed for pneumococcal and 41, the Physician was notified immunizations. (Residents 31, 32, 41, and 50) of the pneumonia vaccine per the PneumoRecs VaxAdviser App for Findings include: each individual resident. The resident/responsible party was 1. The record for Resident 31 was reviewed on provided education and a 10/23/23 at 10:40 a.m. The record indicated Pneumonia Vaccine Resident 31 was 86 years old and had received Consent/Declination form. Prevnar 13 (PCV13 (pneumococcal conjugate Vaccines were given as ordered vaccine) on 11/6/19. by the physician. Ш How other residents Upon admission on 7/14/21, the resident's are identified: Responsible Party signed the consent form All residents were added in to the declining the administration of the pneumococcal PneumoRecs VaxAadvisor App to vaccine. No further attempts were made since identify which PNA vaccine the

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7/14/21 for the resident to receive the

recommended second dose of either PCV20 or

PPSV23 (pneumococcal polysaccharide vaccine)

Event ID:

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Facility ID: 000100

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resident qualified for. Any resident

determined due for a Pneumonia

Vaccine, the physician was

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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. B | UILDING | 00 | COMPLETED |
| | | 155191 | B. W | ING | | 10/30/2023 |
| | | | | CED DEET | A DODDEGG CHTM CTATE THE COD | |
| NAME OF F | PROVIDER OR SUPPLIER | R | | | ADDRESS, CITY, STATE, ZIP COD | |
| VALECTAL | NOTEDIALLAGE | (ENTLIQUIANIA | | | 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 | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY | DATE |
| | after one year as re- | commended by the current | | | notified and education and | |
| | CDC guidance. | | | | pneumonia vaccine | |
| | | | | | consent/declination form was | |
| | 2. The record for R | esident 32 was reviewed on | | | provided. | |
| | 10/23/23 at 10:50 a | .m. The record indicated | | | III System in place: | |
| | Resident 32 was 93 | years old and had received | | | The Infection Preventionist Nu | ırse |
| | one dose of a pneur | mococcal vaccine on 6/11/19 at | | | was inserviced on immunization | ons |
| | an outside setting. | | | | to include pneumonia vaccine | on |
| | | | | | 11/1/2023 | |
| | | 6/8/21, the resident signed the | | | Licensed nurses were inservice | ced |
| | consent form declir | ning the administration of the | | | on immunizations. | |
| | pneumococcal vacc | eine. No further attempts were | | | The new Pneumonia Vaccine | |
| | made since 6/8/21 f | for resident to receive the | | | consent/declination form and | |
| | recommended seco | nd dose of either PCV20 or | | | education pamphlets were pla | iced |
| | PPSV23 (pneumoc | occal polysaccharide vaccine) | | | in the admission packet for ne | ew |
| | after one year as re- | commended by the current | | | residents. | |
| | CDC guidance. | | | | The first week of every month | , the |
| | | | | | IP Nurse will review immuniza | ition |
| | | the Infection Preventionist on | | | schedule of all resident | |
| | | .m., indicated she was unable to | | | immunizations. This will be | |
| | | pneumococcal vaccine the | | | ongoing. | |
| | resident had receive | ed. | | | All residents due for Pneumor | nia |
| | | | | | Vaccines will be provided with | 1 |
| | | esident 41 was reviewed on | | | education, consents and the | |
| | | .m. The record indicated the | | | physician will be notified for th | ne |
| | | ars old and had received the | | | appropriate orders. | |
| | PPSV 23 (pneumoo | coccal polysaccharide vaccine) | | | IV How the facility wil | II |
| | on 3/30/20. | | | | monitor and quality assuran | ce |
| | | | | | program: | |
| | | documentation of any offer for | | | The DON or designee will mo | nitor |
| | | ive the recommended second | | | compliance by review of the | |
| | | 20 or PCV15 after one year as | | | monthly report to ensure resid | |
| | recommended by the | ne current CDC guidance. | | | who gave consent received th | |
| | | | | | Pneumonia Vaccine. Any issu | |
| | 4. The record for Resident 50 was reviewed on | | | | identified at the time of the rev | |
| | 10/23/23 at 11:10 a.m. The record for Resident 50 | | | | will be addressed at that time. | |
| | indicated the resident was 89 years old and had | | | | The Director of Nursing/Desig | |
| | received the Prevna | ar 13 vaccine on 11/22/20. | | | will provide the results from th | |
| | | | | | audits to the Quality Assurance | e |
| | The record lacked of | documentation of any offer for | | | Performance Improvement | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------------------|---|----------------------------|---------|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155191 | B. WI | NG | | 10/30/ | /2023 |
| | | | | CTREET | ADDRESS OF A STATE SID COD | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| VA/EOTA4 | NOTED VIII AGE I | CENTURO CIANIA | | | REENTREE N | | |
| WESTMI | 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 | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | the resident to recei | ive the recommended second | | | Committee (QAPI). These find | lings | |
| | dose of either PCV | 20 or PPSV23 (pneumococcal | | | will be reviewed for | | |
| | polysaccharide vacc | cine) after one year as | | | recommendations by the Qual | ity | |
| | recommended by the | ne current CDC guidance. | | | Assurance Performance | | |
| | | | | | Improvement Committee (QAF | 기). | |
| | | h the Infection Preventionist on | | | These findings and review will | | |
| | | n., she indicated they became | | | completed monthly and submi | | |
| | _ | of the need to be offering | | | to QAPI for a period of 4 mont | hs. | |
| | | the pneumococcal vaccine. | | | The Committee will provide | | |
| | | ocused on getting the new | | | guidance for further action as | | |
| | | to administer as their priority | | | needed. The QAPI team will n | | |
| | | d focus on giving the | | | once a month until we reach 1 | 00% | |
| | additional pneumoc | coccal vaccines. | | | compliance for 4 consecutive | | |
| | 11. | id d. T.C. d | | | months. This monitoring will be | | |
| | | ew with the Infection | | | ongoing and presented quarte | rly | |
| | | /26/23 at 10:50 a.m., she | | | thereafter. | | |
| | | not updated administering cines since March 2022. | | | The Director of Nursing in | | |
| | Pileumococcai vacc | tines since March 2022. | | | coordination with the Infection Prevention Nurse will be | | |
| | Guidance for Pneur | nococcal Vaccine Timing for | | | responsible for the coordination | vn. | |
| | | d from the CDC's website on | | | and monitoring for compliance | | |
| | | ance included, but was not | | | | • | |
| | | e sure your patients are up to | | | | | |
| | | occal vaccination Adults | | | | | |
| | | rs old Complete pneumococcal | | | | | |
| | - | . Prior vaccines PPSV23 | | | | | |
| | | PCV20 Option B PCV15 | | | | | |
| | | ion A PCV20 Option B | | | | | |
| | PPSV23" | | | | | | |
| | | | | | | | |
| | 3.1-13(a) | | | | | | |
| | | | | | | | |
| F 0908 | 483.90(d)(2) | | | | | | |
| SS=E | Essential Equipme | ent, Safe Operating | | | | | |
| Bldg. 00 | Condition | | | | | | |
| | - , , , , | intain all mechanical, | | | | | |
| | | ient care equipment in safe | | | | | |
| | operating conditio | | | | | | |
| | | on and interview, the facility | F 09 | 808 | The filing of this plan of | | 11/17/2023 |
| | failed to ensure ade | quate maintenance of essential | | | correction does not constitu | te | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DAT | | | (X3) DATE | SURVEY | | |
|--|------------------------|-------------------------------------|-------|-----------------------|--|----------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPI | ETED | |
| | | 155191 | B. W | ING | | 10/30 | /2023 | |
| | | <u>!</u> | • | STREET A | ADDRESS, CITY, STATE, ZIP COD | • | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | REENTREE N | | | |
| WESTMI | NSTER VILLAGE I | 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 APPROPR | IATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | • • | for 3 of 3 observations. This | | | that the alleged deficiency | did | | |
| | ^ | ad the potential to affect all 57 | | | in fact exist. This Plan of | | | |
| | residents currently | residing at the facility. | | | correction is filed as evider | ice | | |
| | | | | | of the facility's desire to | | | |
| | Findings include: | | | | comply with the regulatory | | | |
| | | | | | requirements and continue | to | | |
| | _ | our on 10/23/23 at 9:30 a.m., in | | | provide quality care. | | | |
| | the walk-in freezer | | | | | | | |
| | | e on the floor spanning from | | | F908 | | | |
| | | enance Assistant 6 was using a | | | The facility maintains all | | | |
| | | oan to break up and scoop up | | | mechanical, electrical, and p | | | |
| | _ | siting it into a 13-gallon trash | | | care equipment in safe opera | ating | | |
| | | fway full of ice. The broken ice | | | condition. | | | |
| | _ | oor was approximately | | | | | | |
| | _ | nch thick and appeared to have | | | I Action taken for | | | |
| | | pproximately 4 feet from the fan | | | those residents identified: | | | |
| | | ridge. There was a heavy | | | No residents were identified. | _ | | |
| | | wing from the condenser pipe | | | The ice was removed from the | ne floor | | |
| | | Maintenance Assistant 6 | | | of the freezer. | | | |
| | | sure how long the ice had | | | The condensate drain line wa | | | |
| | _ | . He had been notified on the | | | cleaned and ice plug remove | | | |
| | - | ast a few minutes prior to the | | | The ice formations were rem | | | |
| | observation. | | | | from the outside of the pipe a | | | |
| | D | 10/22/22 + 2.45 | | | condenser hose under the fa | | | |
| | _ | w on 10/23/23 at 9:45 a.m., the | | | Pipe was cleaned and pipe w | - | | |
| | | ndicated the ice had been an | | | replaced. Refrigeration vend | | | |
| | | e weeks. They had an issue in | | | called in to check systems. U | ınıt | | |
| | _ | rility had replaced the | | | is working properly. | da a :- | | |
| | | ney had done that, it was now | | | Frost was removed from the | | | |
| | | in. They had to chop up the ice | | | A new gasket system was plantage | aced | | |
| | | Thursday. The ice that was in | | | on door. | | | |
| | I | built up since the prior | | | | -4- | | |
| | | e over the weekend must have | | | II How other reside | IIIS | | |
| | | hey kept there to catch the | | | are identified: | . | | |
| | | That's why it was so bad. It | | | No residents were identified | UI | | |
| | _ | lem if someone didn't move the | | | affected. | | | |
| | bucket. | | | | | | | |
| | Dumin or our instance. | v on 10/26/22 of 11:25 41 | | | III System in place: | | | |
| | _ | w on 10/26/23 at 11:25 a.m., the | | | Maintenance provided a clea | - | | |
| | Maintenance Direc | tor indicated back in June they | | | schedule and education rega | ıraıng | l | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|--|-----------------------------------|----------------------------|--------|--|------------------|------------|
| AND PLAN | AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | a. building <u>00</u> | | COMPLETED | | |
| | | 155191 | B. WING 10/30/ | | | 2023 | |
| | | | | CTREET | ADDRESS SITY STATE ZIR SOD | | |
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| VA/ECTA | NOTED VIII I AGE I | (FAITHOULIANIA | | | REENTREE N | | |
| WESTMII | NSTER VILLAGE K | LENTUCKIANA | | 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 | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | \TE | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | VIE. | DATE |
| | had to replace the c | ompressor because it was | | | equipment maintenance. It wa | as | |
| | - | ot that done and then they had | | | completed 11/10/2023. | | |
| | | ondensate line on a regular | | | The Maintenance Supervisor | | |
| | | pened on the first day of | | | and/or Dietary Manager will b | e | |
| | | ed. He had someone going in | | | responsible for the coordination | | |
| | | the freezer. They kept the | | | cleaning schedules and | | |
| | - | precaution in case it backed | | | completion of tasks. | | |
| | | ned the condensate line it | | | 22 | | |
| | | ney had been cleaning it out | | | IV | II . | |
| | | notter it got worse. Dietary | | | monitor and quality assuran | | |
| | | ng it as well. He should have | | | program: The | | |
| | | e the ice got as bad as it did. | | | Administrator/Designee will be | _ | |
| | | ened over the weekend, they | | | responsible for monitoring by | | |
| | | dietary staff. The line would | | | completing a kitchen sanitation | 'n | |
| | | ter would build up and freeze, | | | tour/audit twice weekly. Shou | | |
| | | defrost it had nowhere to go. | | | concerns be identified, immed | | |
| | | out to anyone to service the | | | corrective action shall be take | | |
| | | d to upper management, but he | | | | | |
| | | approved. They did not have | | | The results of these audits an | | |
| | | | | | any necessary corrective action | JIIS | |
| | - | rvicing. He had someone | | | will be discussed during the | | |
| | | lnesday checking all the | | | monthly QAPI meetings with | | |
| | | y had to have them come in | | | additional education or revision | | |
| | daily. | | | | the plan made on the basis of | | |
| | D 1 1 | 10/06/22 + 0.15 | | | findings. Monthly meetings wi | II | |
| | _ | ion on 10/26/23 at 9:15 a.m., the | | | continue for a minimum of 6 | | |
| | | observed to still have a trash | | | months. | | |
| | | with ice accumulating in it. | | | | | |
| | - | e, new ice formations on the | | | | | |
| | | h an icicle forming which was | | | | | |
| | | . There was frost beginning to | | | | | |
| | form on the door of | the freezer. | | | | | |
| | | | | | | | |
| | - | ion on 10/27/23 at 9:00 a.m., in | | | | | |
| | | there was a bucket trash can | | | | | |
| | | no ice in it this time. There | | | | | |
| | _ | ice formations, as well as the | | | | | |
| | | day prior, on the condenser | | | | | |
| | hose with multiple | icicle formations. The frost on | | | | | |
| | the door was heavie | er than the day prior. | | | | | |
| | | | | | | | |

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

Event ID:

Q8V311 Facility ID: 000100

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

PRINTED: 11/30/2023 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155191 | | (X2) MULTIPI A. BUILDIN B. WING | LE CONSTRUCTION IG 00 | COMPI | (X3) DATE SURVEY COMPLETED 10/30/2023 | |
|--|---|--|------------------------|---|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER NSTER VILLAGE 1 | | 221 | EET ADDRESS, CITY, STATE, ZIP CO 10 GREENTREE N ARKSVILLE, IN 47129 | D . | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFI TAG | CROSS-REFERENCED TO THE API | ULD BE | (X5) COMPLETION DATE |
| R 0000 | policy, included, bu malfunctions and n the dietary manages Procedure: 1. When malfunctions, the d The dietary manage department by phot letting them know l equipment is neede help or the purchase | Malfunctions and Repairs at was not limited to, " All eed for repairs are reported to an an maintenance department. In a piece of equipment ietary manager is notified. 2. For notifies the maintenance are or in writing if needed, show quickly that piece of d. 3. If repairs require outside the of parts, this must be an the facility administrator" | | | | |
| R 0000 | | | | | | |
| Bldg. 00 | Survey. This visit is State Licensure Sur | State Residential Licensure included a Recertification and evey. ber 23, 24, 25, 26, 27, and 30, | R 0000 | | | |
| | Facility number: 00 | 00100 | | | | |
| | Residential Census | : 83 | | | | |
| | These State Resider accordance with 41 | ntial Findings are cited in 0 IAC 16.2-5. | | | | |
| | Quality review com | npleted on November 4, 2023. | | | | |
| R 0144 Bldg. 00 | (a) The facility sha a state of good re | .5(a) Ifety Standards - Deficiency all be clean, orderly, and in pair, both inside and out, reasonable comfort for all | | | | |

State Form Event ID: Q8V311 Facility ID: 000100 If continuation sheet Page 28 of 35

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|-----------|--|--|--------|------------------------|---|------------------|----------|
| AND PLAN | AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BU | JILDING | 00 | COMPLETED | |
| | 155191 | | B. WI | NG | | 10/30/2023 | |
| | | 1 | | STREET | ADDRESS, CITY, STATE, ZIP COD | | \dashv |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | REENTREE N | | |
| WESTMI | NSTER VILLAGE K | (ENTUCKIANA | | | (SVILLE, IN 47129 | | |
| | T | | | | T | T | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF | | (X5) | т |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION | 1 |
| TAG | | on and interview, the facility | D O | TAG | | DATE | |
| | | kitchen was maintained in a | R 0 | 144 | Please accept this plan of correction as our credible | 11/17/2023 | 3 |
| | | 3 of 3 observations. This | | | | _ | |
| | 1 | ad the potential to affect all 83 | | | allegation of compliance. The | | |
| | _ | residing at the facility. | | | facility respectfully requests desk review to determine | a | |
| | lesidents currently | residing at the facility. | | | compliance. | | |
| | Findings include: | | | | Comphance. | | |
| | i manigs merade. | | | | The filing of this plan of | | |
| | 1. During the initial | tour of the kitchen on 10/23/23 | | | correction does not constitu | te | |
| | | lowing concerns were | | | that the alleged deficiency di | | |
| | observed: | | | | in fact exist. This Plan of | | |
| | | | | | correction is filed as evidence | e l | |
| | - There was a heavy buildup of white under the | | | | of the facility's desire to | | |
| | dishwasher and dirty dish counter. | | | | comply with the regulatory | | |
| | | • | | | requirements and continue t | o | |
| | - The back splatter | guard of the stove had a | | | provide quality care. | | |
| | moderate buildup o | f brown and black grease to it. | | | · | | |
| | | | | | R0144 | | |
| | - There was a coating | ng of brown substance on the | | | The facility does store, prepar | e, | |
| | | riddle. Dietary Cook 4 | | | distribute and serve food in | | |
| | | ds to be cleaned. We don't | | | accordance with food service | | |
| | | We set stuff on it and that | | | safety. | | |
| | | n. We use it for grilled cheeses | | | | | |
| | sometimes. It was c | eleaned about a week ago." | | | I Action taken for | | |
| | | | | | those residents identified: | | |
| | · | y buildup of grease on the | | | No residents were identified. | | |
| | | dle. The cook indicated she | | | The kitchen was thoroughly | | |
| | needed to clean that | t up. | | | cleaned and repairs made to | | |
| | Tri 1 | . 1 11 6 1 | | | include but not be limited to: | | |
| | | erate buildup of grease and | | The heavy lime buildup | | II. | |
| | _ | f the Vulcan oven as well as d the floor underneath of it. | | | dishwasher and dirty dish cou was removed. | nter | |
| | the wan bening, and | the moor underneath of it. | | | | | |
| | - There was a heavy | y coating of dust observed to | | | The back splatter guard on the stove was cleaned. | ; | |
| | | g on the wall, fan and hose in | | | | ,d | |
| | the walk-in freezer | | | | The flat top griddle was cleaned. | u. | |
| | uie waik-iii iieezer | and muge. | | | The flat top griddle table was cleaned. | | |
| | In the walk-in frid | lge there were two molded | | | The Vulcan stove was cleaned | 1 25 | |
| | | an unidentifiable substance | | | well as the wall behind it and t | | |
| | which was growing | | | | floor around it. | | |
| | I willen was growing | , willie luzzy illolu | 1 | | ן ווסטו מוטעווע ונ. | | |

State Form Event ID: Q8V311 Facility ID: 000100 If continuation sheet Page 29 of 35

| 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 <u>00</u> COM | | | ETED |
| | | 155191 | B. W | | | | /2023 |
| | | | | CTREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | REENTREE N | | |
| WESTM | NOTED VILLAGE I | ZENTLICKIANIA | | | SVILLE, IN 47129 | | |
| VVE31IVII | NSTER VILLAGE | RENTUCKIANA | | CLARK | SVILLE, IN 47 129 | | |
| (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 O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | approximately 1 to | 2 inches tall, and a gallon of | | | The wall, fan and hoses in bot | :h | |
| | milk on the floor u | nder the metal rack. | | | the walk-in freezer and | | |
| | | | | | refrigerators were cleaned. | | |
| | | spots, appearing to be mildew, | | | The milk was removed and de | bris | |
| | to the vents in the o | ceiling outside the dry storage, | | | under racks in the walk-in | | |
| | in front of the reacl | n in fridge, and above the steam | | | refrigerator were cleaned up. | | |
| | table. | | | | The ceiling vents outside of th | e dry | |
| | | | | | storage room, in front of the | | |
| | | vas coated in a layer of brown | | | reach-in refrigerator and above | | |
| | _ | which was streaking down the | | | steam table were wiped down | | |
| | steam table base. | | | | The steam table and base we | re | |
| | | | | | cleaned. | | |
| | | y buildup of grime along the | | | The baseboards, corners and | | |
| | baseboards and in the corners and along the walls | | | | walls in the kitchen were clear | ned. | |
| | throughout the kite | hen. | | | | | |
| | | | | | II How other residen | ts | |
| | _ | up tour of the kitchen, on | | | are identified: | | |
| | | m., the following concerns | | | No residents identified or affect | cted. | |
| | remained: | | | | | | |
| | l | | | | III System in place: | | |
| | | y buildup of white under the | | | The dietary staff were provide | d | |
| | dishwasher and dir | ty dish counter. | | | with cleaning schedules and | | |
| | | 1 61 | | | training regarding kitchen | | |
| | _ | guard of the stove had a | | | sanitation that was completed | on | |
| | moderate buildup o | of brown and black grease to it. | | | 11/10/2023. | | |
| | There 11 1 | amata ammanuis-t-li '11 | | | The Dietary Manager and/or | | |
| | | spots, appearing to be mildew, | | | Designee will be responsible f | or | |
| | | ceiling outside the dry storage, in in fridge, and above the steam | | | the coordination of cleaning | | |
| | | n in iridge, and above the steam | | | schedules and completion of | | |
| | table. | | | | tasks. | | |
| | There was a bear | y buildup of grease on the | | | | 11 | |
| | | ldle. Dietary Cook 4 indicated | | | IV How the facility wil | | |
| | _ | lean right after you left, I didn't | | | monitor and quality assurand program: The | ∪ U | |
| | | aintenance to get under there." | | | Administrator/Designee will be | 2 | |
| | Set ander I need Inc | annonance to get under there. | | | responsible for monitoring by | • | |
| | - There was a mode | erate buildup of grease and | | | completing a kitchen sanitation | n | |
| | | of the Vulcan oven as well as | | | tour/audit twice weekly. Shou | | |
| | - | d the floor underneath of it. | | | concerns be identified, immed | | |
| | and main defining, and | a mo moor andernoun of it. | | | corrective action shall be take | | |
| | | | 1 | | Someonive action stialine take | | |

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

PRINTED: 11/30/2023 FORM APPROVED OMB NO. 0938-039

| 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 10/30/2023 | | | | |
|---|---|--|---|--|----------------------|--|--|--|
| 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 REGULATORY OF | 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) | (X5) COMPLETION DATE | | | |
| | - There was a heavy be swaying, hangin the walk-in freezer - In the walk-in frid grapes, a puddle of which was growing approximately 1 to milk on the floor ur - The steam table w and white buildup, steam table base. - There was a heavy baseboards and in the throughout the kitel and the above concered and interview Dietary Aide 5 indiffered and in the steam of the could. The white been there for years they had the time to staffing issues and everything like they people now. During an interview 10/27/23 at 9:50 a.r. looked a lot better they now had a warm of the warm of the sway of the hard they now had a warm of the walk-in free to staffing issues and everything like they people now. | y coating of dust observed to g on the wall, fan and hose in and fridge. ge there were two molded an unidentifiable substance white fuzzy mold 2 inches tall, and a gallon of oder the metal rack. as coated in a layer of brown which was streaking down the y buildup of grime along the ne corners and along the walls nen. up tour, on 10/27/23 at 9:00 a.m., rns as observed on 10/26/23 | | The results of these audits ar any necessary corrective activill be discussed during the monthly QAPI meetings with additional education or revision the plan made on the basis of findings. Monthly meetings with continue for a minimum of 6 months. | on of f the | | | |

State Form Event ID: Q8V311 Facility ID: 000100 If continuation sheet Page 31 of 35

| STATEMENT OF DEFICIENCIES X1) PRO | | X1) PROVIDER/SUPPLIER/CLIA | lì í | | ONSTRUCTION | (X3) DATE SURVEY | | |
|-----------------------------------|--|---|------|--------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | | | COMPLETED | |
| 155191 | | B. WING 10/30/2023 | | | | | | |
| NAME OF F | PROVIDER OR SUPPLIE | R | _ | | ADDRESS, CITY, STATE, ZIP COD | | | |
| | | | | | REENTREE N | | | |
| WESTMI | NSTER 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 APPROPRIA | ATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | 1 - | e. Maintenance was supposed | | | | | | |
| | | ean the vents every week. She | | | | | | |
| | · · | ey had the mildew buildup. | | | | | | |
| | | ep cleaning the kitchen once a lad the staff. Staff should be | | | | | | |
| | · · | ping under and behind | | | | | | |
| | | ney were not deep cleaning it | | | | | | |
| | | tuff up under the equipment. | | | | | | |
| | | t up stock was supposed to | | | | | | |
| | | der the racks in the fridges and | | | | | | |
| | | ras to get the kitchen as clean | | | | | | |
| | _ | I to be, but it had been a | | | | | | |
| | | the first had to get staff in the | | | | | | |
| | building. They used to work the whole kitchen with 6 people. They did not have cleaning | | | | | | | |
| | | | | | | | | |
| | | d to use them, but staff were | | | | | | |
| | basically just check | king off tasks and not | | | | | | |
| | completing them as | nd she had quit using them. She | | | | | | |
| | could not provide a | any current cleaning checklists | | | | | | |
| | for the kitchen. | | | | | | | |
| | The most current D | Dietary Sanitation Practices | | | | | | |
| | | it was not limited to, " All | | | | | | |
| | 1 | will practice standard sanitary | | | | | | |
| | | ean equipment and work units | | | | | | |
| | _ | y, weekly and monthly cleaning | | | | | | |
| | | iding any additional specific | | | | | | |
| | | re designated by the food | | | | | | |
| | | 3. The kitchen, dining area and | | | | | | |
| | | ned following facility policy" | | | | | | |
| R 0145 | 440 140 40 0 5 4 | F/h) | | | | | | |
| 11.0143 | 410 IAC 16.2-5-1 | .5(ກ) afety Standards - Deficiency | | | | | | |
| Bldg. 00 | | all maintain equipment and | | | | | | |
| Diag. 00 | 1 ' ' | and operational condition | | | | | | |
| | | uantity to meet the needs of | | | | | | |
| | the residents. | Manuty to moot the needs of | | | | | | |
| | | on and interview, the facility | R 0 | 145 | The filing of this plan of | | 11/17/2023 | |
| | | | | 1 TJ | correction does not constitu | ıte | 11/1//2023 | |
| | failed to ensure adequate maintenance of essential kitchen equipment for 3 of 3 observations. This | | | | that the alleged deficiency d | | | |

State Form Event ID: Q8V311 Facility ID: 000100 If continuation sheet Page 32 of 35

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) D | | | (X3) DATE | 3) DATE SURVEY | |
|-----------------------------------|--|--|-----------------------------------|--------|--|-----------------|----------------|--|
| AND PLAN OF CORRECTION IDENTIFICA | | IDENTIFICATION NUMBER | | | | COMPL | ETED | |
| | | 155191 | B. WING 10/30/2023 | | | 2023 | | |
| | | | | CTREET | ADDRESS OF A TE ZID COD | | | |
| NAME OF I | PROVIDER OR SUPPLIEF | t | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| VA/EOTA | NOTEDIALLAGE | (ENTLICKIANIA | | | REENTREE N | | | |
| WESTMI | NSTER VILLAGE K | RENTUCKIANA | | CLARK | SVILLE, IN 47129 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DROWING BY AN OF CORRECTION | CONDUCTION (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 | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 16 | DATE | |
| | deficient practice ha | ad the potential to affect all 83 | | | in fact exist. This Plan of | | | |
| | _ | residing at the facility. | | | correction is filed as evidence | :e | | |
| | | | | | of the facility's desire to | | | |
| | Findings include: | | | | comply with the regulatory | | | |
| | | | | | requirements and continue to | | | |
| | During the initial to | our on 10/23/23 at 9:30 a.m., in | | | provide quality care. | | | |
| | the walk-in freezer | | | | l | | | |
| | accumulation of ice | on the floor spanning from | | | R0145 | | | |
| | wall to wall. Mainte | enance Assistant 6 was using a | | | The facility maintains all | | | |
| | long-handled dustp | an to break up and scoop up | | | mechanical, electrical, and pat | tient | | |
| | the ice before depos | siting it into a 13-gallon trash | | | care equipment in safe operati | | | |
| | can which was half | way full of ice. The broken ice | | | condition. | Ū | | |
| | remaining on the flo | oor was approximately | | | | | | |
| | one-quarter of an in | ich thick and appeared to have | | | I Action taken for | | | |
| | accumulated out ap | proximately 4 feet from the fan | | | those residents identified: | | | |
| | at the back of the fr | idge. There was a heavy | | | No residents were identified. | | | |
| | stream of water flow | wing from the condenser pipe | | | The ice was removed from the | floor | | |
| | and onto the floor. | Maintenance Assistant 6 | | | of the freezer. | | | |
| | indicated he wasn't | sure how long the ice had | | | The condensate drain line was | 6 | | |
| | been accumulating. | He had been notified on the | | | cleaned and ice plug removed | | | |
| | radio of the issue ju | st a few minutes prior to the | | | The ice formations were remove | ved | | |
| | observation. | | | | from the outside of the pipe ar | nd | | |
| | | | | | condenser hose under the fan | | | |
| | During an interview | v on 10/23/23 at 9:45 a.m., the | | | Pipe was cleaned and pipe wr | ар | | |
| | Dietary Manager in | dicated the ice had been an | | | replaced. Refrigeration vendor | - | | |
| | | e weeks. They had an issue in | | | called in to check systems. Un | iit | | |
| | the past and the fac | ility had replaced the | | | is working properly. | | | |
| | condenser. Since th | ey had done that, it was now | | | Frost was removed from the d | oor. | | |
| | | in. They had to chop up the ice | | | A new gasket system was plac | ced | | |
| | | Thursday. The ice that was in | | | on door. | | | |
| | | built up since the prior | | | | | | |
| | - | e over the weekend must have | | | II How other resident | ts | | |
| | | hey kept there to catch the | | | are identified: | | | |
| | _ | hat's why it was so bad. It | | | No residents were identified or | r | | |
| | - | em if someone didn't move the | | | affected. | | | |
| | bucket. | | | | | | | |
| | | | | | III System in place: | | | |
| | _ | v on 10/26/23 at 11:25 a.m., the | | | Maintenance provided a clean | • | | |
| | | tor indicated back in June they | | | schedule and education regard | - | | |
| | had to replace the c | had to replace the compressor because it was | | | equipment maintenance. It wa | s | | |

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

PRINTED: 11/30/2023 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 10/30/2023 | | | |
|---|---|--|---|---|--|--|--|
| | 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 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 | | |
| | freezing up. They g been cleaning the co basis. It just so happ survey it was plugg every shift to check trash can there as a up. When they clear looked like mud. The monthly. As it got h should be monitorin been notified before Whatever had happ were not notified by get clogged, the wa and when it would of He had not reached drain. He had talked had to get a budget any contracts for se going in every Wed equipment and latel daily. During an observati walk-in freezer was can under the pipe of There were multiple condenser hose with about 4 inches long form on the door of During an observati the walk-in freezer however there was were multiple, new same ones from the hose with multiple; the door was heavie | ot that done and then they had ondensate line on a regular pened on the first day of ed. He had someone going in the freezer. They kept the precaution in case it backed ned the condensate line it ney had been cleaning it out notter it got worse. Dietary ng it as well. He should have the ice got as bad as it did. ened over the weekend, they y dietary staff. The line would ter would build up and freeze, defrost it had nowhere to go. out to anyone to service the dit oupper management, but he approved. They did not have rvicing. He had someone linesday checking all the y had to have them come in some on 10/26/23 at 9:15 a.m., the to observed to still have a trash with ice accumulating in it. e., new ice formations on the han icicle forming which was . There was frost beginning to | | completed 11/10/2023. The Maintenance Supervisor and/or Dietary Manager will be responsible for the coordinatic cleaning schedules and completion of tasks. IV How the facility with monitor and quality assurant program: The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taked. The results of these audits are any necessary corrective action will be discussed during the monthly QAPI meetings with additional education or revision the plan made on the basis of findings. Monthly meetings with continue for a minimum of 6 months. | e on of II ce e on uld diate en. uld ons | | |

State Form Event ID: Q8V311 Facility ID: 000100 If continuation sheet Page 34 of 35

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

PRINTED: 11/30/2023 FORM APPROVED OMB NO. 0938-039

| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, Z | | 00 | COD (X3) DATE SURVEY COMPLETED 10/30/2023 | |
|---------------------------------|---|---|---|--------|--|---|------------|
| WESTMINSTER VILLAGE KENTUCKIANA | | | 2210 GREENTREE N CLARKSVILLE, IN 47129 | | | | |
| (X4) ID | SUMMARY S | 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 | ATE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | policy, included, bu | t was not limited to, " All | | | | | |
| | malfunctions and ne | eed for repairs are reported to | | | | | |
| | the dietary manager | and maintenance department. | | | | | |
| | Procedure: 1. When | a piece of equipment | | | | | |
| | malfunctions, the di | etary manager is notified. 2. | | | | | |
| | The dietary manage | r notifies the maintenance | | | | | |
| | department by phon | e or in writing if needed, | | | | | |
| | letting them know h | ow quickly that piece of | | | | | |
| | equipment is needed | d. 3. If repairs require outside | | | | | |
| | help or the purchase of parts, this must be | | | | | | |
| | communicated with | the facility administrator" | | | | | |
| | | | | | | | |

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