

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

PRINTED: 10/17/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155167</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/15/2024</b>	
NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER VILLAGE NORTH</b>				STREET ADDRESS, CITY, STATE, ZIP CODE  <b>11050 PRESBYTERIAN DR</b> <b>INDIANAPOLIS, IN 46236</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00439975, IN00440139, IN00444191, IN00445069, and IN00445085.</p> <p>Complaint IN00439975 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00440139 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00444191 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00445069 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00445085 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 15, 2024</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Census Bed Type: SNF/NF: 119 Total: 119</p> <p>Census Payor Type: Medicare: 13 Medicaid: 66 Other: 40 Total: 119</p> <p>Westminster Village North was found to be in compliance with 42 CFR Part 483, Subpart B and</p>			F 000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 410 IAC 16.2-3.1 in regards to the Investigation of Complaints IN00439975, IN00440139, IN00444191, IN00445069, and IN00445085.  Quality review completed on October 16, 2024.	F 000			