STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: December 3, 4, 5, 6, 9, and 10, 2024. Facility number: 000100 Provider number: 155191 AIM number: 100266130 Census Bed Type: SNF/NF: 55 Residential: 78 Total: 133 Census Payor Type: Medicare: 10 Medicaid: 36 Other: 9 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 17, 2024.	F 0000	Please accept this letter as our formal request for a desk review of our annual state survey held at Westminster Village Kentuckiana on 12/10/24m, event ID 5WXH11. We have submitted our plan of correction with the date of compliance of 1/21/25. Your assistance in this matter is greatly appreciated. Respectfully, Kathy Dearing, Administrator The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of Correction is filed as evidence of the facilities desire to comply with the regulatory requirements and continue to provide quality care. Please accept this plan of correction as our credible allegation of compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to complete discharge Minimum Data Set (MDS) assessments for 2 of 19 MDS's reviewed. (Residents 14 and 25) Findings include: 1. The clinical record for Resident 14 was reviewed	F 0641	MDS re-educated on RAI schedule for Discharges for MDS discharge assessment, needs to be completed timely. The discharge assessments for residents 14(discharge date was 7/5/24 and not 7/1/24) and 25 were completed by MDS nurse on 12/10/24.	01/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Dearing	Administrator	12/30/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 12/09/24 at 10:23 A.M. The resident's census indicated they were admitted to the facility on 06/05/24 and discharged with no anticipated return on 07/01/24. The MDS listings lacked a completed discharge assessment. 2. The clinical record for Resident 25 was reviewed on 12/09/24 at 10:26 A.M. The resident's census indicated they were admitted to the facility on 06/14/24 and discharged with no anticipated return on 07/01/24. The MDS listings lacked a completed discharge assessment. During an interview on 12/09/24 at 10:52 A.M., the MDS Coordinator indicated if a resident discharged from the facility then a discharge assessment should be completed. The discharge assessments for residents 14 and 25 had been missed and should have been completed. The current facility policy titled, "Resident Assessment Instrument", with a revised date of September 2021, was provided by the Director of Nursing on 12/09/24 at 2:07 P.M. The policy indicated, "...The Assessment Coordinator is responsible for ensuring that the Interdisplinary Assessment Team conduct timely resident assessments..." 3.1-31(d)		2. Discharge MDS audit was conducted by Corporate Nurse from July 1, 2024 to present and no other resident identified. 3. MDS nurse(s) and nursing administration has been educated on RAI schedule for Discharges for MDS discharge assessment. This was completed: 12/30/2024. Any new MDS nurse will be educated RAI schedule for Discharges for MDS discharge assessment 4. MDS nurse/Designee will audit discharge assessments weekly for two months with audit reviewed by Director of Nurses (DON). Then MDS nurse/Designee will audit discharge assessments monthly for four months and DON will review. Data will be reported to QAPI who will make recommendations to assure compliance with plan and that plan is met 100%, if not, they will make recommendations to modify plan and or continue plan if necessary until met at 100% compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to prevent a skin	F 0684	1 Resident 3's skin treatments continue per Physician	01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	impairment for 1 of 17 residents reviewed for quality of care. (Resident 3) Findings include: During and observation on 12/06/24 at 1:47 P.M., Resident 3 was assisted with peri care. The resident had a bandage to the right bottom of the buttock. The dressing was clean and dry. The bandage was dated 12/06/24. The clinical record for Resident 3 was reviewed on 12/05/24 at 11:46 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/08/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, anemia, hemiplegia/hemiparesis, and depression. The resident was always incontinent of bowel and bladder. A Progress Note, dated 10/23/24 at 12:53 A.M., indicated a Certified Nurse Aide (CNA) had reported an open area to the resident's upper right posterior thigh from the brief. The area measured 2.5 centimeters (cm) X (by) 1.0 cm X 0.2 cm. The area was cleansed and covered with a foam dressing. Wound Care was notified, and they were awaiting orders. A Wound MD Note, dated 10/23/24, indicated the resident had a non-pressure wound to the right buttock from brief trauma. The wound measured 0.6 cm X 3 cm X 0.1 cm. A treatment order was initiated, daily. A Wound MD Note, dated 11/27/24, indicated the resident had a non-pressure wound to the right buttock. The wound measured 0.8 cm X 1 cm X 0.1 cm. The treatment remained the same.		orders. Nursing and C.N.A. staff have been educated on proper sizing and placement of briefs and pull-on briefs, completed 12/27/25. Resident 3's waist and hip size corresponds to the correct incontinence product as verified on audit. 2 An audit was conducted of resident waist and hip size which corresponds to the correct incontinence supply sizing on 1/13/25 by Director of Nursing (DON)/Designee. No other resident was found to be affected by the identified issue. 3 Nursing and C.N.A. staff were educated on proper sizing and placement of briefs and pull-on briefs, completed 1/13/25. Education also added to C.N.A. and nursing orientation. Central Supply has been educated to inform Nursing Management (DON/Designee) when there is change in brand or sizing of incontinence supplies on 1/13/25. New nursing staff will be educated on proper sizing and placement of briefs. Measuring resident's waist/hips will be completed upon admission, annually and as needed. 4 DON will audit admitting residents for sizing and skin check twice a week for two weeks, then weekly for 2 weeks, then monthly for 4 months. Data will be reported to QAPI who will make recommendations to assure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Care Plan, with a start date of 10/24/24, indicated the resident had a non-pressure injury to her right buttock that included the following interventions that started on 10/24/24: - administer medications per the physician's order, - contact the physician as needed, - encourage 100% of meal and fluid consumption, - encourage and assist with turning and repositioning every two hours as needed, - observe for signs and symptoms of infection, - treatments per the physician's order, and - weekly skin assessments. During an interview on 12/09/24 at 9:32 A.M., CNA 7 indicated the resident required total staff assistance with all care. She was incontinent of bowel and bladder and had a wound on the back side of her right leg. During an interview on 12/09/24 at 9:42 A.M., the Infection Preventionist/Wound Nurse, indicated the wound MD had classified the wound to the resident as trauma from the brief. She believes it was a trauma from friction of the brief not being placed properly or the resident was wearing the wrong size brief that day. The staff were not in-serviced on any brief placement or correct brief sizing. During an interview on 12/09/24 at 9:47 A.M., CNA 8 indicated the resident required a mechanical lift for transfers, was a total assist with care, was incontinent. The resident had a wound		compliance with plan and that plan is met 100%, if not, they will make recommendations to modify plan and or continue plan if necessary until met at 100% compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	under her right buttock. She thought the wound was from the resident's brief not being positioned right. She was unsure if there was education on correct brief placements. During an interview on 12/09/24 at 10:04 A.M., the Director of Nursing (DON) indicated she believed the residents wound was from how the staff were applying the resident's brief. The resident was followed by the Wound MD. She was unsure if any staff were in-service related to brief placement, and she would not have updated the care plan with any interventions related to the brief placement or size. During an interview on 12/09/24 at 10:09 A.M., CNA 9 indicated if she needed to get residents more briefs because they were out in their room, she would look to see what size they had on. She had never had to get a resident more briefs because the night shift always put them in the resident's closets. During an interview on 12/09/24 at 10:13 A.M., the Facility Central Supply indicated if a resident ran out of briefs in their room, then the staff would go by what size the resident had on them. There was not a list saying what size brief residents wore for the staff working the floor. When a resident came to the facility the CNAs would measure them and let her know what size brief they needed and then she would order them. If a resident changed sizes, then she would be updated by the CNAs. She was never aware that Resident 3 needed new brief sizes and had not order her a different size in the last 6 months. The current facility policy titled, "Urinary Continence and Incontinence-Assessment and Management", with a revised date of September			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2021, was provided by the DON on 12/10/24 at 11:10 A.M. The policy indicated, "...The staff and practitioner will appropriately screen for, and manage individuals with urinary incontinence...A "check and change" strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin..." The current facility policy titled, "Perineal Care", with a revised date of February 2018, was provided by the DON on 12/10/24 at 11:10 A.M. The policy indicated, "...The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition..." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to ensure the proper dose was administered related to priming the needel for the insulin kwikpens and following the physician's order for 2 of 2 resident's observed for pharmacy services. (Residents 160 and 56) Findings include: 1. During an observation on 12/5/24 at 11:00 a.m., LPN (Licensed Practical Nurse) 10 obtained Resident 160's blood sugar by glucometer. The blood sugar reading was 263 mg/dL (milligrams per deciliter). The LPN applied the needle to the Humalog kwikpen and dialed the pen to 3 units. She did not prime (dial the kwikpen to 2 units and	F 0755	1 Residents 160 and 56 have had no adverse reactions from receiving doses from unprimed insulin pens, evaluated by Director of Nursing (DON) on 12/5/24. Medical Director was informed about insulin pens not being primed by DON on 12/5/24. Nurse10 was immediately educated on policy and procedures and following manufacturer's guidelines of priming insulin pens on 12/5/24 by DON. 2 Audit completed by DON/Designee on 12/27/24	01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	press to remove air) the needle prior to administering 3 units of Humalog into the resident's right upper arm. During an interview on 12/5/24 at 11:15 a.m., LPN 10 indicated she had administered 4 units, then corrected herself and confirmed she had only administered 3 units of insulin to the resident. The LPN planned to administer another unit. During an observation on 12/5/24 at 11:20 a.m., LPN 10 applied the needle to the Humalog kwikpen. The LPN administered 1 more unit into Resident 160's right upper arm. She did not prime the needle prior to administering 1 unit of Humalog. The physician's order, dated 11/20/24, indicated staff were to administer the resident's Humalog kwikpen per sliding scale: If the resident's blood sugar level was 150 to 199 mg/dL give 2 units; 200 to 249 mg/dL give 3 units; 250 to 299 mg/dL give 4 units; 300-349 mg/dL give 5 units; 350 to 400 mg/dL give 6 units; 400 mg/dL plus give 7 units, subcutaneously before meals and at bedtime related to diabetes mellitus. 2. During an observation on 12/5/24 at 11:27 a.m., LPN 10 entered Resident 56's room. The resident indicated he had self obtained a high blood sugar reading. The LPN indicated she would have to obtain the blood sugar reading herself by glucometer. The blood sugar reading was 518 mg/dL when the LPN obtained the reading. The LPN indicated she would administer a total of 12 units of insulin. The LPN obtained the resident's lispro kwikpen and attempted to dial the 12 units. There was only 5 units left. She injected the 5 units of lispro into the resident's left upper arm, without priming the kwikpen needle.		regarding use of insulin pens and no other resident was found to be affected by this practice. 3 Nurses and QMA staff have been educated on policy and procedures, the need to follow manufacturer guidelines, and to prime insulin pens. New Nurses and QMAs will be educated on policy and procedures, the need to follow manufacturer guidelines, and to prime insulin pens. 4 DON/Designee to monitor medication orders for any new insulin pen orders or newly identified diabetic diagnosis for potential of insulin pen orders. Insulin pen administration will be observed by DON/Designee two times per week for two weeks, then weekly for two weeks and then monthly for four months. Data will be reported to QAPI who will make recommendations to assure compliance with plan and that plan is met 100%, if not, they will make recommendations to modify plan and or continue plan if necessary until met at 100% compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 12/5/24 at 11:45 a.m., LPN 10 obtained Resident 56's lispro kwikpen from the refrigerator. She applied the needle to the kwikpen and dialed the remaining 7 units. The LPN did not prime the needle prior to administering the lispro into the resident's left upper arm. The physician's order, dated 10/14/24, indicated staff were to administer 7 units of the resident's lispro kwikpen subcutaneously before meals related to type 1 diabetes mellitus. The physicians' order, dated 11/2/24, indicated staff were to administer the resident's lispro kwikpen per sliding scale: If the resident's blood sugar was 150 to 225 mg/dL give 1 unit; 226 to 301 mg/dL give 2 units; 302 to 377 mg/dL give 3 units; 378-453 mg/dL give 4 units; 454 to 529 mg/dL give 5 units, subcutaneously before meals and at bedtime related to type 1 diabetes mellitus. During an interview on 12/5/24 at 11:51 a.m., LPN 10 indicated she did not prime the needle prior to administration. She should prime the needle with 5 units to make sure the resident received all of their insulin, in case there was air in the needle. During an interview on 12/5/24 at 1:58 p.m., the DON (Director of Nursing) indicated the staff should follow the physician's orders when administering insulin. She felt the insulin kwikpens did not require priming, as that was already built in. The Instructions For Use Humalog Kwikpen injection, for subcutaneous use 3 mL [milliliters] single-patient-use pen (100 units per mL), last copyrighted in 2023, included, but was not limited			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to, " ... Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units ..." The Insulin Administration policy, revised September 2014, included, but was not limited to, " ... 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order ... Steps in the Procedure (Insulin Injections via Syringe) ... 8. Check the order for amount of insulin ... 12. Double check the order for the amount of insulin ..." 3.1-25(b)(9)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to follow guidelines related to dishwasher temperatures for 2 of 2 kitchen observations, infection control during dining for 1of 3 dining observations, and to maintain a resident snack refrigerator in a sanitary manner for 1 of 2 resident snack refrigerators observed. This deficient practice had the potential to affect 55 of 55 residents who received food from the kitchen. Findings include: 1. During an observation and interview of the dishwasher on 12/03/24 at 9:30 A.M., the Dietary	F 0812	1 Dishes that were processed when dishwasher not at temperature were rewashed assuring temperature was between 180 and 194 on 12/4/24. Staff trained prior to use of dishwasher to assure main power on EST Conveyor and Nitto booster switch is turned on and gauge is checked for rinse temperature to be between 180 and 194 and retrained after 12/10/24. Education with CNA 11 was completed on 12/10/2024 on proper handwashing and	01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Manager indicated there was a wash and rinse valve to monitor for the temperatures on the dishwasher. The valve indicated the rinse temperature was at 140 degrees. The Dietary Manager indicated the dishwasher temperature for the rinse cycle should be 180 degrees. She was going to have the staff stop washing the dishes and have the Maintenance Director look at it. The Dish Machine daily Temperature Record Logs for November 2024 indicated from 11/01/24 through 11/27/24 for breakfast, lunch, and dinner the rinse temperature was less than 180 degrees. During an observation and interview on 12/04/24 at 9:25 A.M., the dishwasher had the following rinse temperatures: - 140 degrees, - 160 degrees, and - 175 degrees. The Dietary Manager indicated she had in-serviced staff on reading the final rinse gauge as it was a different one then the one she had showed the day before. She was unsure why the temperature was not reaching 180 degrees. She told the staff to stop washing dishes until the maintenance director looked at it again. Her staff would rewash the dishes once the machine reached the appropriate temperature. The current facility policy titled, "Dishwashing Machine Use", with a revision date of March 2010, was provided by the Administrator on 12/04/24 at 11:06 A.M. The policy indicated, "...Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use		frequencies and Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices. Residents 51 and 38 did not have any adverse reactions. The snack refrigerator for 100 hall was cleared of outdated food(s) and cleaned by DON/Designee on 12/9/24. Nursing and C.N.A. staff have been re-educated on policy for refrigerator and freezer and foods brought in by family/visitors, completed 1/13/25. 2 No other resident was identified to have been affected by this practice of failing to follow the policy “Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices.” No residents affected as dishes were rewashed. Residents at risk of being affected were 55. No residents were affected by the practice of failing to follow policies, refrigerators and freezers and foods brought by family/visitors. Residents at risk of being affected numbered 43. 3 Maintenance adjusted booster heater flow to remain on during entire wash/rinse cycle on 12/4/24. Pipes from booster heater to dish machine have been insulated to retain heat on 12/5/24. Department Heads educated on rinse temperature	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and sanitation...Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degrees, or less than: 180 degrees..." 2. During a continuous observation on 12/03/24 from 11:28 A.M. through 11:48 A.M., the following was observed: - At 11:28 A.M., the food cart was delivered to the 100 Hallway. At 11:29 A.M., CNA 11 pushed the cart down the hall, opened the cart and took a tray into Resident 51's room. At 11:42 A.M., CNA 11 was in the hallway at the food cart. She adjusted her pants with both hands, retrieved a milk from the tub with her right hand, replaced the milk in the tub, retrieved a coffee cup with her right hand, and put coffee creamer in the cup. She squatted down and placed her right hand on her right knee, retrieved a sugar packet with her left hand, and used both hands to put the sugar in the coffee cup. She poured coffee into the cup and served the tray to a resident. At 11:44 A.M., CNA 11 retrieved a towel and cleaned spilled coffee off the floor in the hallway with her bare hands, placed the towel in a bag, and took the bag to the soiled utility room. She fixed her glasses with her right hand, fixed her shirt with both hands, touched a couple of meal tray cards in the meal cart, removed a tray from the cart, and served it to Resident 38. At 11:48 A.M., the CNA 11 retrieved an over the bed table out of a quiet room and placed it in front of Resident 54 and served her a meal tray. The CNA never washed or sanitized her hands during the meal service. During an interview on 12/09/24 at 1:52 P.M., CNA 12 indicated when serving resident's their meal trays she would wash her hands before started. If she had touched anything on herself or cleaning up spills then she would wash or sanitize her		required on dishwasher. Staff trained prior to use of dishwasher to assure main power on EST Conveyor and Nitto booster switch is turned on and gauge is checked for rinse temperature to be between 180 and 194 and retrained after 12/10/24. When first turning on in morning pipes are primed before a cycle is run to assure temp is between 180 and 194. Education to Administration, Nurses , CNAS and QMAS on preventing foodborne illness-employee hygiene and sanitary practices completed on 12/30/2024. New employees will be educated on preventing foodborne illness-employee hygiene and sanitary practices . Nursing and C.N.A. staff and Administrative staff have been re-educated on policy for refrigerator and freezer and foods brought in by family/visitors, completed 1/13/25. Refrigerators has been checked for following policies refrigerator and freezer and foods brought in by family/visitors and found in compliance by DON/Designee on 12/27/2024. 4 Maintenance to check dish machine daily for one week to assure rinse is between180 or 194 and main power and manual power are both turned on, check to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hands. The current facility policy titled, "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, with a revision date of October 2017, was provided by the Director of Nursing on 12/10/24 at 10:17 A.M. The policy indicated, "...All employee who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing forborne illness...Employee must wash their hands...After personal body functions (i.e., toileting, blowing/wiping nose, coughing, sneezing, etc...After engaging in other activities that contaminate the hands..." 3. During an observation on 12/09/24 at 2:01 P.M., the resident snack refrigerator on the 100 Hallway contained the following items: - a plastic container that contained food that belonged to Room 103 with no date on it, - two undated, plastic food containers with food in them that belonged to Room 112, - 1/2 pumpkin pie with a use by date of 12/02/24, - 1/2 pecan pie with a use by date of 12/02/24, - left over dinner plate on the bottom shelf that belonged to Resident 52, that was dated 12/05/24, - a Styrofoam container labled for Resident 53 that was dated 11/28, - a plastic circle food container that contained food for Resident 53 that was dated 11/28, and - three rectangular plastic food containers that contained food for Resident 53 that were in a plastic bag, dated 11/28. During an interview on 11/09/24 at 2:03 P.M., RN 5 indicated food should be thrown out after three days. The night shift staff were to clean the refrigerators on Mondays, Wednesdays, and Fridays. There was a sign on the refrigerator to		done during meal clean up. Dietary Manager/Designee to check for one week prior to run of first cycle to assure main power switch and manual power switch are turned on and machine rinse gauge reads between 180 and 194 for one week. Then This audit will be completed by Maintenance and Dietary Manager/Designee 3 times per week for 2 weeks, then 1 time per week for 2 weeks, then monthly for 4 months. DON or designee will observe staff serving meal trays two times a week for 2 weeks on random halls, then weekly for 2 weeks on random halls , then monthly for 4 months. Refrigerators are checked 2 times per week for 2 weeks for compliance with policies refrigerator and freezer and foods brought in by family/visitors by DON/Designee, then weekly for 2 weeks and then monthly for 4 months. Data will be reported to QAPI who will make recommendations to assure compliance with plan and that plan is met 100%, if not, they will make recommendations to modify plan and or continue plan if necessary until met at 100% compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	remind them. The undated sign from the refrigerator was provided by the Director of Nursing on 12/10/24 at 9:50 A.M. The sign indicated, "...All items in the refrigerator must have a name and date on them. Any item not dated, or the date exceeds 3 day[s] will be thrown away. Per state law. 3RD SHIFT CNA'S You are to clean out the refrigerators on Monday, Wednesday, and Friday..." The current facility policy titled, "Food Brought by Family/Visitors" with a revised date of October 2017, was provided by the Director of Nursing on 12/10/24 at 9:50 A.M. The policy indicated, "...The nursing staff will discard perishable foods on or before the "use by" date..." 3.1-21(i)(3)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure the equipment in resident rooms were kept clean for 6 of 26 rooms reviewed for environment. (Rooms 105, 107, 111, 114, 115, and 120) Findings include: During a tour of the facility on 12/4/24 at 11:00 a.m., the 100 and 200 Halls had several rooms observed to have a black spotty substance covering most of the slats on the following heater vents: - Room 105 had a black substance covering the heater vents. - Room 107 had a black substance covering the	F 0921	1 Maintenance Tech re-trained on 12/17/24 by Maintenance Director on manufacturer guidelines for routine maintenance of the heaters (ptac covers). As noted in the manufactures recommendations. Clean the front cover when needed. Use mild detergent. Wash and rinse with warm water. Allow them to dry thoroughly before reinstalling them in chassis. The soiled vent heaters in rooms 105, 107, 111, 114, 115 and 120 were cleaned on 12/5/24 by Maintenance Tech. 1.All residents assessed by	01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	heater vents. - Room 111 had a black substance covering the heater vents. - Room 114 had a black substance covering the heater vents. - Room 115 had a black substance covering the heater vents. - Room 120 had a black substance covering the heater vents. During an interview on 12/4/24 at 9:46 a.m., Resident 47 indicated she had black mold on her heater vents. When she woke up in the mornings the first thing she did was to start sneezing. During an observation on 12/5/24 at 10:00 a.m., in Room 114 with the Maintenance Supervisor, he indicated the black substance on the heater vent was not black mold and it was dirt buildup. He did not have a cleaning schedule for when the vents needed cleaned. The staff would let him know when the vents were dirty and maintenance would clean them. During an interview on 12/5/24 at 1:22 p.m., CNA (Certified Nursing Aide) 4 indicated the nursing staff did not clean the heater vents. They would inform maintenance if they needed clean. She was not aware of any vents that needed cleaned. During an interview on 12/6/24 at 11:00 a.m., RN 5 indicated staff could clean the heater vents if they observed them dirty. They would also let the maintenance department know when they needed cleaned. She was not aware the vents were dirty. The Maintenance Director Job Description, dated 2023, included, but was not limited to, "...To assist to maintain the physical plant, grounds, and all equipment in good working order to ensure a safe,		DON including those residing in 105, 107, 111, 114, 115 and 120 by DON for illness related to this practice of soiled front covers; no ill effects noted audit completed 12/17/24. 1.The front cover of heater units (ptac covers) was checked in each resident room and cleaned if needed on 12/5/24 by the Maintenance Technician. Maintenance staff were educated by the Maintenance Director on manufacturer guidelines for routine maintenance of the ptac. As noted in manufacturer guidelines for routine maintenance of the heaters (ptac covers). Clean the front cover when needed. Use mild detergent. Wash and rinse with warm water. Allow them to dry thoroughly before reinstalling them in chassis. Department heads were educated on the need for clean front cover of ptac and to put in a work order when they view one that is soiled and in need of cleaning. Preventive Measure placed in Tels system to clean ptac covers quarterly. 1.10 ptac covers will be audited for cleanliness each week for 2 weeks by Administrator/Maintenance Director/Designee and if needed cleaning will be completed. Then 5 ptac covers will be audited for cleanliness each week for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attractive, and enjoyable living environment for the resident of the facility and in accordance with current Federal, State, and local standards governing the facility..." 3.1-11		weeks by Administrator/Maintenance Director/Designee and if needed cleaning will be completed. Then 5 ptac covers will be audited weekly for 4 months by Administrator/Maintenance Director/Designee and if needed cleaning will be completed. Audits completed until 100 % compliance. QAPI will review the results and determine if further steps are needed.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Residential Complaint IN00448413. Complaint IN00448413: No deficiencies related to the allegations are cited. Survey dates: December 3, 4, 5, 6, 9 , and 10, 2024. Facility number: 000100 Residential Census: 78 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on December 17, 2024.	R 0000	Please accept this letter as our formal request for a desk review of our annual state survey held at Westminster Village Kentuckiana on 12/10/24m, event ID 5WXH11. We have submitted our plan of correction with the date of compliance of 1/21/25. Your assistance in this matter is greatly appreciated. Respectfully, Kathy Dearing, Administrator The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of Correction is filed as evidence of the facilities desire to comply with the regulatory requirements and continue to provide quality care. Please accept this plan of correction as our credible allegation of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed follow guidelines related to dishwasher temperatures for 2 of 2 kitchen observations. This deficient practice had the potential to affect 78 of 78 residents who received food from the kitchen. Findings include: Findings include: During an observation and interview of the dishwasher on 12/03/24 at 9:30 A.M., the Dietary Manager indicated there was a wash and rinse valve to monitor for the temperatures on the dishwasher. The valve indicated the rinse temperature was at 140 degrees. The Dietary Manager indicated the dishwasher temperature for the rinse cycle should be 180 degrees. She was going to have the staff stop washing the dishes and have the Maintenance Director look at it. The Dish Machine daily Temperature Record Logs for November 2024 indicated from 11/01/24 through 11/27/24 for breakfast, lunch, and dinner the rinse temperature was less than 180 degrees. During an observation and interview on 12/04/24 at 9:25 A.M., the dishwasher had the following rinse temperatures: - 140 degrees, - 160 degrees, and - 175 degrees. The Dietary Manager indicated she had in-serviced staff on reading the final rinse gauge	R 0273	1.Dishes that were processed when dishwasher not at temperature were rewashed assuring temperature was between 180 and 194 on 12/4/24. Staff trained prior to use of dishwasher to assure main power on EST Conveyor and Nitto booster switch is turned on and gauge is checked for rinse temperature to be between 180 and 194 and retrained after 12/10/24. 1.No residents affected as dishes were rewashed. Residents at risk of being affected were 77 in the Assisted Living. 1.Maintenance adjusted booster heater flow to remain on during entire wash/rinse cycle on 12/4/24. Pipes from booster heater to dish machine have been insulated to retain heat on 12/5/24. Department Heads educated on rinse temperature required on dishwasher. Staff trained prior to use of dishwasher to assure main power on EST Conveyor and Nitto booster switch is turned on and gauge is checked for rinse temperature to be between 180 and 194. When first turning on in morning pipes are primed before a cycle is run to assure temp is between 180 and	01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	as it was a different one then the one she had showed the day before. She was unsure why the temperature was not reaching 180 degrees. She told the staff to stop washing dishes until the maintenance director looked at it again. Her staff would rewash the dishes once the machine reached the appropriate temperature. The current facility policy titled, "Dishwashing Machine Use", with a revision date of March 2010, was provided by the Administrator on 12/04/24 at 11:06 A.M. The policy indicated, "...Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation...Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 degrees, or less than: 180 degrees..."		194. 1.Maintenance to check dish machine daily for one week to assure rinse is between180 or 194 and main power and manual power are both turned on, check to be done during meal clean up. Dietary Manager/Designee to check for one week prior to run of first cycle to assure main power switch and manual power switch are turned on and machine rinse gauge reads between 180 and 194 for one week. Then This audit will be completed by Maintenance and Dietary Manager/Designee 3 times per week for 2 weeks, then 1 time per week for 2 weeks, then monthly for 4 months. QAPI will review data and make recommendations to assure compliance with plan and that plan is met 100%, if not, they will make recommendations to modify plan and or continue plan if necessary until 4 months met at 100% compliance.	