STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING -- B. WING	12/19/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/19/24 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130 At this Emergency Preparedness survey, Westminster Village Kentuckiana was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 55. Quality Review completed on 12/27/24	E 0000	January 13, 2025 To: Indiana State Department of Health (Life Safety) From: Westminster Village Kentuckiana RE: Request for desk review for event ID 5WXH21 Please accept this letter as our formal request for a desk review for event ID 5WXH21 for annual life safety survey at Westminster Village Kentuckiana on 12/19/24. We have submitted our plan of correction with a completion date of February 3, 2025. Your assistance with 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.	
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies	E 0025	1 Action taken for those residents identified:	02/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Dearing	Administrator	01/13/2025

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	and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Policies and Procedures Plan and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 10:40 am and 1:45 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review but the agreements were several years old, dating back to 2008. Based on an interview during records review, the Administrator stated she had been trying to update the transfer agreements. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference.		No individual resident was identified. Transfer agreements between Westminster and three entities have been drafted to be in place by completion date. 2 How other residents are identified: All residents have the potential to be affected. 3 Systems in place: Emergency Preparedness manual updated to include the signed transfer agreements. Staff have been educated on the requirement of transfer agreements and where they are located in the Emergency Preparedness Manual. 4 How the facility will monitor and quality assurance program. Administrator/Designee will audit the Emergency Preparedness manual for current letters of transfer weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meeting will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	January 13, 2025	

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/19/24 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130 At this Life Safety Code survey, Westminster Village Kentuckiana was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 55 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 12/27/24		To: Indiana State Department of Health (Life Safety) From: Westminster Village Kentuckiana RE: Request for desk review for event ID 5WXH21 Please accept this letter as our formal request for a desk review for event ID 5WXH21 for annual life safety survey at Westminster Village Kentuckiana on 12/19/24. We have submitted our plan of correction with a completion date of February 3, 2025. Your assistance with 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.	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Based on observation and interview, the facility failed to ensure 3 of over 20 alcohol-based hand	K 0325	1 Action taken for those residents identified: No individual	02/03/2025

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	sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 20 residents in two smoke compartment. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 1:45 p.m. and 3:45 p.m., alcohol-based hand sanitizer dispensers were installed on the wall directly above electrical outlets in the corridor near resident rooms 118,122 and 203. Based on interview at the time of observation, the MD confirmed the alcohol-based hand sanitizer dispensers were installed on the wall directly above electrical outlets in the corridor by rooms 118,122 and 203. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference. 3.1-19(b)		resident was identified. The identified hand sanitizing dispensers , were relocated over near rooms 118, 122 and 203 were moved 4 feet in horizontal spacing from an electric outlet. 2 How other residents are identified: All residents have the potential to be affected. 3 Systems in place: Audit of all hand sanitizing dispensers was completed by Maintenance Director on 12/19/24. Two additional sanitizers were identified, near room 103 and 105 each has been relocated at least 4 feet horizontal spacing from electric outlet. Staff have been educated that hand sanitizers must be located at least 4 feet horizontal spacing from electric outlets, if one is noted too close it is to be reported immediately to the Maintenance Director/Administrator for immediate corrective action. 4 How the facility will monitor and quality assurance program. Administrator/Designee will audit hand sanitizers are located at least 4 feet horizontal spacing from electric outlets weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meeting will	

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			continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 4 staff and 25 residents. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 1:45 p.m. and 3:45 p.m.; A) 1 of 6 Sprinkler Heads in the dining area was protruding down from the ceiling approximately 4-5 inches creating space around the sprinkler head which would allow smoke to escape into the area above the ceiling. B) The Soiled Utility Closet near RR# 111 was missing an escutcheon and did not completely cover the hole around the sprinkler. Based on interview at the time of observation, the MD agreed the aforementioned area was missing the escutcheon. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference.	K 0351	1 Action taken for those residents identified: No individual resident was identified. The two sprinkler heads one which was adjusted on 1/7/25 by Maintenance Technicians so there is no gap around it and the missing escutcheon has been replaced in w36 which is located near room 111. This was completed on 12/19/24 by Maintenance Technician. . 2 How other residents are identified. All residents have the potential to be affected by this deficient practice. 3 Systems in place: Audit completed by Maintenance Director on 12/19/24 shows no other issues detected involving sprinkler head or missing escutcheons. Staff educated that no gaps can be present around sprinkler heads and all must have an escutcheon, when one is missing or a gap exist, a work order is to be completed. 4 How the facility will monitor	02/03/2025

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	3.1-19(b)		and quality assurance program. Administrator/Designee will audit a section of Healthcare building weekly to assure each has no gaps noted in sprinkler heads and each sprinkler head has an escutcheon for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meetings will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2	K 0353	1 Action taken for those residents identified: No individual resident was identified. Sprinkler inspection completed by Integrity Fire Safety Services on 12/26/24. 2 How other residents are identified: All residents have the potential to be affected. 3 Systems in place: Have sprinkler systems certified/inspected every 3 months scheduled by to be scheduled and perform quarterly inspection of	02/03/2025

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	requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 10:40 am and 1:45 p.m., there was no quarterly sprinkler system inspection report available for the 3rd quarter of 2024. The most recent sprinkler report was dated 06/12/24, over 6 months old. A telephone call to the vender revealed that a sprinkler inspection for the third quarter of 2024 did not occur. During an interview at the time of record review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been inspected during the third quarter of 2024. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference. 3.1-19(b)		sprinkler system by Maintenance Director. Maintenance staff educated that vendor is expected months to perform and where to file inspections. Sprinkler inspection completed by Integrity Fire Safety Services on 12/26/24. 4 How the facility will monitor and quality assurance program. Administrator/Designee to audit Maintenance inspections weekly for 4 weeks, then biweekly for 4 weeks to ensure quarterly inspection of sprinkler system is complete. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meeting will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents and 4 staff. Findings include: A) Based on observation and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 1:45 p.m. and 3:45 p.m., the corridor door to Resident Room 217 was missing completely. Based on interview at the time of the observations, the MD agreed the corridor door was missing and the room would not have any resistance to the passage of smoke into the corridor if a smoke or fire event originated in the room. The MD stated that the room was going to become a common area open to the corridor during a plan to convert the hall into a memory care unit. However, now the room is going to be a double occupancy resident room, as it has been in the past. 2 beds were observed in the room however the curtain and track had been removed. Room #217 is currently not occupied by residents. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference. B) Based on observation and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 1:45 p.m. and 3:45 p.m., the corridor door to the ICF Break Room had a doorknob which was not installed properly and had a gap creating a hole through the door. The	K 0363	1 Action taken for those residents identified: No individual resident was identified. The door has been on order and will be installed no later than 1/21/24. The latch for the break room door was repaired on 12/19/24 by the Maintenance Director. 2. How other residents are identified: All residents have the potential to be affected. 3. Systems in place: Audit of all bedrooms to assure a door is present completed by Maintenance Director on 12/19/24. Education provided to staff that all resident rooms must have a door, when one is missing or damaged a work order is to be put in. Audit completed by Maintenance Director on 12/19/24 shows no issues with other door latches. Education completed with staff that any door latch with issues must have a work order put in to repair/replace it. 4. How the facility will monitor and quality assurance program. Administrator/Designee will audit resident rooms to assure each has a door weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of	02/03/2025

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	MD agrees the doorknob was loose and needed attention, was not functioning properly and had created a hole through the door. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference. 3.1-19(b)		the plan made based on audit findings. Monthly meeting will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits. Administrator/Designee will audit a ¼ section of Healthcare building weekly to assure door latches work correctly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meeting will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification.	K 0921	1 Action taken for those residents identified: No individual resident was identified. Policy and Procedure addressing patient related electrical appliances and equipment added to the Emergency Preparedness Binder. 2 How other residents were identified. All residents have the potential to be affected by this deficient practice. 3 Staff trained on the Policy and Procedure regarding testing of	02/03/2025

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	Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 10:40 am and 1:45 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The Administrator stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the Administrator and MD stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the MD at the time of discovery and again by the MD and		patient related electrical appliances and equipment and where to locate in book. Maintenance staff trained on testing of in house medical equipment. Electrical testing obtained equipment supplied by outside vendors who supply it; TCM. System in place to assure documentation when needed from Innovative pharmacy or other vendors. Facility owned equipment tested by Westminster Maintenance staff and documentation filed. 4 How the facility will monitor and quality assurance program. Administrator/Designee will audit That Policy and procedure addressing patient related electrical appliances and equipment are present in Emergency Preparedness Binder weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meeting will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	

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	Administrator at the exit conference. 3.1-19(b)			
K 9999 Bldg. 01	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. 3.1-19(k)(7) Except in private rooms, each bed must have ceiling suspended cubicle curtains or screens of flameproof or flame-retardant material, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide privacy curtains in 2 of over 10 resident sleeping rooms containing at least 2 residents. This deficient practice could affect 4 residents. Findings include: Based on observation and interview with the Maintenance Director (MD) and Administrator on 12/19/24 between 1:45 p.m. and 3:45 p.m., resident sleeping rooms 217 and 218 each with two beds for double occupancy were not equipped with privacy curtains or track for privacy curtains. Based on interview at the time of the	K 9999	1 Action taken for those residents identified: No individual resident was identified. Tracks for privacy curtain replaced on 12/27/24 by Maintenance Tech. Privacy curtains in place on 12/31/24 completed by Housekeeping staff. 2 How other residents are identified: All residents have the potential to be affected by this deficient practice. 3 Systems in place: Audit completed by Maintenance Director on 12/19/24 showed no other areas missing privacy curtain tracks or curtain(s). Education provided to staff that all areas must have privacy curtains and tracks for them, when a curtain or track is missing a work order is to be completed. 4 How the facility will monitor and quality assurance program. Administrator/Designee will audit resident rooms weekly to assure each has privacy curtain track(s) and curtain(s) for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly	02/03/2025

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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
	observations, the MD stated the curtains, and track had been removed anticipating using the two rooms as common areas open to the corridor but plans changed and they will once again be used as double occupancy rooms. The aforementioned rooms are currently not occupied. This finding was acknowledged by the MD at the time of discovery and again by the MD and Administrator at the exit conference. 3.1-19(a)		QAPI meetings with additional education or revision of the plan made based on audit findings. Monthly meeting will continue for a minimum of four months then will be stopped after two consecutive months with no findings or issues noted with the audits.	