STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075252	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to notify responsible party timely of a change in condition. The findings include:Resident #1's diagnoses included dementia and restlessness/agitation. The Resident Care Plan (RCP) dated 11/11/2024 identified at risk of falls. Interventions directed transfer and ambulate per MD order, observe closely for side of medications, and to check often to ensure grippy socks are on at night/resident removes grippy socks. A physician order dated 1/31/2025 directed ambulation: independent. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen, indicative of severe cognitive impairment, and was independent with bed mobility, transfers, and ambulation without adaptive equipment. Further review identified RCP updated 3/15/2025 to include grippy socks on at all times. Review of aide care card/Kardex dated 3/18/2025 directed ensure that resident is wearing appropriate footwear when ambulating. Review of facility reportable event dated 3/19/2025 identified a Nurse Aide (NA) witnessed Resident #1 fall at 3:55 AM in the hallway. RN assessment identified Resident #1 was observed lying supine (face up) on the floor with blood and a laceration noted on the head. A call was made to 911, resident remained on the floor until EMS arrival and Resident #1 was transferred to the hospital. Further, the reportable event identified the APRN and family were notified. Review of facility Change of Condition Evaluation dated 3/19/2025 indicated Resident #1 had a fall with a change in level of consciousness and a laceration to the back of the head. Further, the Evaluation form identified the provider was notified at 5:15 AM and family/resident representative notification was via voicemail on 3/19/2025 at 9 AM. Although clinical record review identified RN #1 left a voice mail message for the responsible party at 9 AM, additional record review failed to identify any additional attempts were made to contact the responsible party. Interview, clinical record review, and facility documentation review with RN #1 (RN supervisor) on 12/1/2025 at 11:47 AM identified he worked on 3/19/2025 from 12 AM (midnight) to 8 AM. RN #1 stated he notified Resident #1's responsible party by leaving a voice mail message at about 9 AM. Further, RN #1 stated he believed he notified the family around 5 AM but he did not document a call was made at 5 AM. RN #1 stated if he made a call at 5 AM, he would have written a nursing note, and his usual routine is to write a note whenever he makes a call. Interview on 12/1/2025 at 1:00 PM with LPN #3 identified she was the charge nurse working on the 7 AM to 3 PM shift on 3/19/2025, she did not place any calls to the responsible party to notify them that Resident #1 was transferred to the hospital after a fall. LPN #3 stated she did not make any calls because Resident #2 was no longer in the facility. Interview on 12/1/2025 at 1:27 PM with LPN #4 identified she was the charge nurse on 3/19/2025 on the 11 PM to 7 AM shift (ending at 7 AM on 3/19/2025) when Resident #1 fell. LPN #4 stated she did not call the family/responsible party to notify of Resident #1's fall or transfer to the hospital as the RN supervisor (RN #1) had stated he would notify them. LPN #4 stated a follow up call should have been made after the voice mail message was left, and it should have been documented in the medical record if it was done. Interview and record review with the Administrator and RN #2 (Regional Clinical Director) on 12/1/2025 at 2:10 PM identified a resident's responsible party should be notified timely of a change in condition, especially when a serious injury has occurred. If a responsible party is not reached, additional attempts should be made, as well as documentation of all attempts, including the initial attempt in the nursing notes. Although interview identified additional attempts to notify the responsible party should have been made after the voice mail message was left, interview failed to identify why additional attempts were not made. Additional interview with RN #1 on 12/3/2025 at 10:26 AM identified his usual routine is to follow up with the responsible party if he did not reach them (left a voice mail message), however he was unsure if he had placed any additional calls, and was unable to provide documentation of additional calls beyond the voicemail message at 9 AM. Review of facility Physician Notification - Change of Condition Policy directed in part, the responsible party will be notified of a change in condition. The nurse will document in the nurse's notes regarding responsible party notification. Review of facility Fall Management Program Policy directed in part, notify the family/responsible party (of a fall).