

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Westridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 125 W Margaret Ave Terre Haute, IN 47802	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</p> <p>Based on observation, record review, and interview, the facility failed to update care plans with post fall interventions for 4 of 6 residents reviewed for falls (Residents B, C, H, and K).</p> <p>Findings include:</p> <p>1. On 6/6/24 at 2:30 p.m., observed Resident A sitting up in wheel chair she was propelling herself in the hall. She had both shoes and socks on. She had difficulty communicating related to aphasia. Bed alarm was on the bed under an incontinent pad. Chair alarm was not visible on the wheelchair.</p> <p>On 6/7/24 at 11:57 a.m., observed Resident A, sitting in wheelchair in the main dining room. A call alarm was on the wheelchair with the alarm device on the back of the chair.</p> <p>On 6/6/24 at 10:49 a.m., the medical record for Resident A was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, hemiplegia, unspecified affecting right dominant side (a loss of strength in the arm, leg, and sometimes face on one side of the body), unsteadiness on feet, muscle weakness (generalized), vascular dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body), and hemiparesis (a relatively mild loss of strength) following cerebral infarction affecting right dominant side, aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension) following cerebral infarction (stroke), and expressive language disorder.</p> <p>On 5/18/24 the resident fell , sustained a laceration to her head and was sent to the emergency room (ER) for sutures. Additional falls occurred on 4/8/24, 4/3/24, and 5/20/24 with no injuries reported from these falls.</p> <p>A quarterly Minimum Data Set (MDS) assessment indicated the cognition level of the resident was poor. The MDS lacked documentation of level of assistance required for transfers and mobility.</p> <p>A care plan, dated 12/5/23, indicated the resident was at risk for falls. A care plan, dated 1/25/24, indicated falls. The record lacked evidence of post fall immediate interventions.</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A care plan, dated 4/10/24, indicated falls with injury. The record lacked evidence of post fall immediate interventions.</p> <p>A care plan, updated 6/8/22, indicated she was an assist of one for Activities of Daily Living (ADL) and transfers and indicated the resident had a fall risk assessment dated [DATE]. An undated intervention indicated staff moved the resident's room closer to the nurses' station.</p> <p>On 5/18/24 an intervention indicated the resident sustained an injury requiring an ER visit.</p> <p>An intervention, dated 5/18/24, indicated monitor for attempts safe transfer remind to ask for assistance and use call light. The care plan did not indicate what the attempts were, and the record lacked documentation of monitoring.</p> <p>An intervention, dated 5/20/24, indicated to change alarm.</p> <p>An intervention was entered on 5/30/24 indicating a chair alarm. An intervention, dated 5/30/24, indicated position change alarm. The care plan lacked evidence of interventions for prevention of falls corresponding to a care plan root cause.</p> <p>2. On 6/6/24 at 2:00 p.m. the medical record for Resident C was reviewed. Documentation indicated on 11/13/23 at 7:00 p.m., Resident C, fell out of wheelchair. The record lacked evidence of post fall immediate interventions.</p> <p>A care plan, dated 11/8/23, indicated falls.</p> <p>A care plan, dated 2/7/24, indicated falls with injury. The record lacked evidence of post fall care plan with immediate interventions.</p> <p>On 6/27/19 an intervention for anti-rollbacks to wheelchair was entered.</p> <p>An intervention dated 4/16/24 indicated frequent reminders to not sit back, hand on wheelchair and request assistance as needed.</p> <p>The record lacked documentation of interventions related to the root causes for the 11/8/23 fall, 2/7/24 fall with injury, and 4/16/24.</p> <p>3. On 6/6/24 at 3:00 p.m., the medical record of Resident H was reviewed. Director of Nursing indicated the resident had fallen in the last 60 days. The record lacked documentation of a fall. A care plan, dated 2/14/19, indicated the resident was at risk for falls. An intervention, dated 2/21/20, indicated Dycem per Medical Doctor (MD) order. An intervention, dated 5/30/24, indicated a Broda Chair when up out of bed for comfort and safety. The record lacked documentation of post fall immediate interventions for the fall within the last 60 days.</p> <p>4. On 6/7/24 at 11:30 a.m., during routine observation of Resident K, observed resident sitting on edge of bed. Call light was within reach and wheelchair sitting next to bed. The resident indicated he was not trying to get up he was just resting. He was alert and oriented indicated he had three falls while at the facility but no injuries from the falls. He knew to ask the staff for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/6/24 at 3:30 p.m., the medical record of Resident K reviewed. A care plan, dated 5/16/24, indicated the resident was at risk for falls. An intervention, dated 5/17/24, indicated to ensure door to room was open when leaving room for safety unless resident requested otherwise. The record lacked documentation post fall immediate interventions.</p> <p>On 6/6/24 at 1:57 p.m., during an interview Qualified Medication Aide (QMA) 4, indicated the care plans were on the paper chart. She was not sure who updated the care plans.</p> <p>On 6/6/24 at 2:02 p.m., during an interview with the Regional Nurse Consultant, she indicated the CNAs and nurses received report and discussed falls and interventions at that time. The interdisciplinary team (IDT) team updated the care plan after every fall with interventions initiated.</p> <p>On 6/7/24 at 9:30 a.m., the Regional Nurse Consultant provided a document, titled, Care Plan Development and Review, dated 9/17, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure .7. The comprehensive care plan shall be reviewed and revised by the interdisciplinary team after each assessment, including both comprehensive and quarterly review assessments .9. Care plans shall be re-written as needed to maintain an up-to-date legible document .Communication to personnel .2. Care plan interventions specific to direct care personnel will be included on the direct caregiver's assignment sheet, or similar tool in use</p> <p>This citation relates to Complaint IN00435269</p> <p>3.1-35(c)(1)</p>		