STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westridge Health Care Center	125 W Margaret Ave Terre Haute, IN 47802

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49068 Based on observation, record review, and interview, the facility failed to ensure a call light device was in reach for 1 of 16 residents reviewed for call light placement (Resident 34). Findings include: On 2/26/24 at 2:52 p.m., Resident 34's call light was observed to be draped on the outlet against the wall and out of reach. The resident indicated that staff stopped giving one to her recently, so she needed to ask for things when they came in. The resident indicated that she could not move her arms or legs very much and could not turn herself in bed without assistance. The resident was observed to be laying on her left side and the bed was positioned diagonally away from the call light device. On 2/27/24 at 11:57 a.m., Resident 34's call light was observed to be draped on the outlet against the wall and out of reach from the resident. On 2/28/24 at 11:04 a.m., Resident 34 requested help getting assistance from staff, her call light was observed to be draped on the outlet against the wall and out of reach from the resident. Resident 34's record was reviewed on 2/27/24 at 11:49 a.m. The profile indicated that the resident's diagnoses included, but were not limited to, right knee contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), left knee contracture, muscle weakness, stiffness of left hand, and gastrostomy status (the placement of a feeding tube through the skin and the stomach wall). An annual Minimum Data Set (MDS) assessment, dated 1/1/24, indicated Resident 34 was cognitively intact and had functional limitation in range of motion in the upper extremity (shoulder, elbow, wrist, hand) on both sides and in the lower extremity (hip, knee, ankle, foot) on both sides. She was dependent and required assistance for turning and repositioning in bed, and her vision was moderately impaired. During an interview with the Director of Nursing (DON) on 2/28/24 at 2:44 p.m., she indicated that Resident 34 did not use her call light very often and she was not ordered to have a soft touch call light. Resident 34's call light was observed with the DON. The call light was draped on the outlet against the wall and out of reach of the resident. The DON indicated that it should not be on the wall and then placed it within reach of 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/1/24 at 10:12 a.m., the Regional Nurse Consultant (RNS) provided and identified a document as a current facility policy, titled, Call Light dated 10/2014. The policy indicated, .Purpose: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met . Procedure . 8. Call lights must remain functional and within reach of each resident. Call lights must not be disabled. Call lights must not be removed from resident's reach 3.1-3(v)(1)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 35317 Based on interview and record review, the facility failed to ensure pressure ulcer treatments were completed by qualified staff and staff followed proper standards of practice for 1 of 1 residents reviewed for pressure ulcer care (Resident 29). Findings include: During an interview, on 2/26/24 at 10:54 a.m., Resident 29 indicated he had an open area to his bottom, and it had been there for a few months. He indicated it was a facility acquired pressure ulcer. During an interview, on 2/28/24 at 10:20 a.m., the Qualified Medication Aide (QMA) 6 indicated she had already completed Resident 29's dressing change to his open area in the morning and it was a dayshift dressing change daily. During an interview, on 2/29/24 at 9:11 a.m., Registered Nurse (RN) 14 indicated a QMA would need to let the nurse know that a dressing change needed to be completed because QMAs were not licensed to perform a pressure ulcer dressing change. During an interview, on 2/29/24 at 10:13 a.m., Resident 29 indicated there were two QMAs who normally completed the pressure ulcer dressing change to his bottom, and they were QMA 5 and QMA 6. During an interview, on 2/29/24 at 10:25, the Regional Nurse Consultant indicated it was against the company's policy for a QMA to complete a dressing change on a pressure ulcer that was greater than a stage I (pressure related alteration of intact skin with non-blanchable redness over a bony prominence) pressure ulcer. Resident 29's record was reviewed on 2/28/24 at 10:43 a.m. The profile indicated the resident diagnoses included, but were not limited to, Type 2 diabetes mellitus without complications (a chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems), and pressure ulcer of sacral region (pressure injuries occur when a bony prominence, such as sacrum, is subjected to prolonged pressure and can result in soft tissue injury). An annual Minimum Data Set (MDS) assessment, dated 2/7/24, indicated the resident was cognitively intact and had a stage III (full thickness tissue loss where subcutaneous fat may be visible) pressure ulcer. A care plan, dated 11/22/23, indicated the resident was at risk for the development of pressure ulcers related to the history of stage IV (severe full thickness tissue loss where muscles, bones, and/or tendons may be visible) pressure ulcer on sacrum. Interventions included, but were not limited to, low air loss mattress, pressure reducing cushion to chair, and staff to observe skin condition while providing care. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of initial pressure ulcer assessment sheet, dated 12/12/23, indicated a stage III pressure ulcer to left coccyx. The wound measured 3 centimeters (cm) by (x) 1.5 cm with a depth of 1.8 cm. A physician order, dated 12/12/23 with an end date of 12/28/23, indicated wet to dry dressing to sacral wound, change daily and as needed for soilage. A physician order, dated 12/28/23 with an end date of 2/22/24, indicated cleans open area with normal saline, may use wound cleanser, pat dry. Apply skin prep to peri-wound (tissue surrounding wound). Apply wet to dry gauze, cover with Mepilex, once a day. Review of December 2023, MAR's (Medication Administration Record) indicated QMA 6 documented as completing the dressing change to Resident 29's stage III pressure ulcer 7 out of 19 days. QMA 11 documented completing the dressing change 5 out of 19 days. QMA 16 documented completing the dressing change 4 out of 19 days. A care plan, dated 1/11/24, indicated the resident had a pressure ulcer. Interventions included but not limited to, dressing change daily per medical doctor order, notify physician of any signs and symptoms of infection, and pressure relieving devices in place. Review of January 2024, MARs indicated QMA 5 documented completing the dressing change to Resident 29's stage 3 pressure ulcer 1 out of 28 days. QMA 6 documented completing the dressing change 11 out of 28 days. QMA 16 documented completing the dressing change 6 out of 28 days. Review of weekly skin assessment, dated 2/23/24, indicated the current wound measured 3 cm x 1.4 cm with a depth of 0.9 cm. A physician order, dated 2/22/24, indicated cleanse open area with normal saline, may use wound cleanser, pat dry, and apply skin prep to peri-wound. Cut Puracol wound dressing into rope and fit into wound bed. Cover with Mepilex, once a day. Review of February 2024, MARs indicated QMA 6 documented as completing the dressing change to Resident 29's stage III pressure ulcer 19 out of 28 days. QMA 16 documented completing the dressing change 1 out of 28 days. During an interview, on 3/1/24 at 9:26 a.m., QMA 16 indicated she had not performed any dressing changes on a wound greater than stage I because it was not allowed with her license. During an interview, on 3/1/24 at 9:28 a.m., QMA 11 indicated she would not perform any dressing changes that were not allowed under her license as a QMA. During an interview, on 3/1/24 at 9:38 a.m., the Director of Nursing (DON) indicated a QMA may only complete a dressing change on a wound that was a stage I or less. She was aware that the QMA's were signing off on the MAR that they were completing the dressing change to Resident 29's wound and that they would be educated on not signing off things that were beyond their scope of practice. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/24 at 11:01 a.m., the Regional Nurse Consultant provided an undated document titled, Qualified Medication Aide, Scope of Practice, and indicated it was the current policy being used by the facility. The policy indicated, .The following tasks shall NOT be included in the QMA scope of practice .(6) Administer a treatment that involves advanced skin conditions, including stage II, stage III, stage IV decubitus ulcers On 2/29/24 at 11:01 a.m., the Regional Nurse Consultant provided a document, with a year of 2023 titled, Job Description, Qualified Medication Aide, and indicated it was the current policy being used by the facility. The policy indicated, .6. Administer medications/treatments as taught per Indiana QMA curriculum 3.1-35(g)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review, observation, and interview, the facility failed to provide treatment to prevent further decrease in range of motion for 1 of 2 sampled residents reviewed for range of motion (Resident 32). Findings include: On 2/26/24 at 11:10 a.m., during a routine observation, Resident 32 was sitting in a wheelchair. The left hand was contracted in a fist position, nails were long and touching the inside of the palm of the hand. No anti-contractual device was in Resident 32's hand. During an observation on 2/28/24 at 11:00 a.m., Resident 32 was sitting in a wheelchair in the activity lounge area. The left hand was contracted in a fist position, no anti-contracture device was in the left hand. During an interview, on 2/27/24 at 2:44 p.m., the Director of Nursing (DON) indicated if a resident had a contracture of the limbs, therapy evaluated the resident, and the therapist would decide if the resident needed an anti-contracture device. During an interview on 2/28/24 at 11:13 a.m., the Certified Occupational Therapy Assistant (COTA) indicated when a resident needed to be assessed the evaluation request was given to the therapist. Before the evaluation was completed and the therapist obtained an order from the physician to evaluate and treat the resident. The evaluation was completed by the therapist or the COTA. The information was placed in the hard copy chart. The COTA acknowledged the resident was to be evaluated on 2/28/24 for the contracture of the left hand. She received a referral to evaluate the resident last week, but she had not gotten to it yet. During an interview on 2/28/24 at 11:24 a.m., Certified Nurse Aide (CNA) 13 indicated the resident did not have an anti-contracture device in her left hand. She indicated the resident would probably not allow them to place anything in her hand. During an interview on 2/28/23 at 1:47 p.m., the Regional Nurse Consultant indicated she spoke to the COTA last week about the resident's contracture of her left hand. She thought an order was obtained for an evaluation. She acknowledged the contracture was not recent and an evaluation with treatment order by the physician had not been obtained. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/24 at 10:51 a.m., Resident 32's medical record was reviewed. Resident 32 was admitted on [DATE]. Diagnoses, dated 5/5/23, include, but are not limited to, 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 nontraumatic subarachnoid hemorrhage (subarachnoid hemorrhage is bleeding in the area between the brain and the thin tissues that cover the brain) affecting left non-dominant side, muscle weakness (generalized), hypertension (high blood pressure), chronic obstructive pulmonary (a group of diseases that cause airflow blockage and breathing-related problems), unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), not due to a substance or known physiological. Resident had a diagnosis, dated 6/1/23, of dysphagia (difficulty swallowing), oropharyngeal phase (the middle part of the throat, behind the mouth). The record lacked documentation of orders to complete range of motion (ROM), or prevention of contractures. A quarterly Minimum Data Set, (MDS), dated [DATE], indicated the resident was cognitively impaired and had mobility impairment to the left upper side. A care plan, dated 5/5/23, indicated the resident was at risk for complications related to hemiplegia/hemiparesis related to impaired physical mobility. Interventions included, but were not limited to, range of motion to be performed and repositioning of affected limb(s) by nursing staff due to impaired physical mobility. Documentation lacked evidence that range of motion had been provided by the nursing staff. On 3/1/2024 at 10:30 a.m., the Director of Nursing (DON) provided a document titled, Joint Mobility Screen, dated 10/2014, and indicated it was the policy currently being used by the facility. The policy indicated, . Purpose .To identify those residents who may be at risk for contractures/decreased range of motion . Procedure .2. Possible interventions included but were not limited to active or passive range of motion at least twice daily, O.T./P.T. (occupational therapy/physical therapy) screening and or treatments .assessment of contractures on a regular basis .3. Applicable recommendations will be made to the attending physician and orders obtained accordingly per their discretion .4. Interventions will be addressed on the individual care plan .5. The joint mobility screen shall be re-evaluated/completed .as necessary relative to .significant change in condition affecting range of motion, etc 3.1-42(a)(1) 3.1-42(a)(2) 3.1-42(a)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34525 Based on observation, interview, and record review, the facility failed to ensure the wash temperature of the chemical sanitizing dish machine (a dishwashing machine that applies potable water and a chemical sanitizing solution to the surfaces of wares to achieve sanitization), met the required temperature for 1 of 2 kitchen observations. Findings include: During the initial kitchen tour, on 2/26/24 at 9:59 a.m., the dish machine temperature dial indicated a top temperature of 80 degrees Fahrenheit (a scale for measuring temperature, in which water freezes at 32 degrees and boils at 212 degrees), during the wash cycle. Four separate wash cycles were attempted. None reached a wash temperature higher than 80 degrees Fahrenheit. On 2/26/24 at 10:01 a.m., the Dietary Manager used a manual thermometer to measure the dish machine wash temperature. The thermometer registered a top temperature of 80 degrees Fahrenheit. At the same time, the Dietary Manager indicated he believed the minimum temperature should be between 100 and 120 degrees Fahrenheit. On 2/28/24 at 8:50 a.m., the Dietary Manager provided the dish machine temperature logs, dated February 2024, and indicated they were the logs of the temperatures that had been taken during the wash cycles for the dish machine. The logs documented the dish machine temperature had been measured at 100 degrees Fahrenheit for all days during the month. On 2/28/24 at 8:50 a.m., the Dietary Manager provided an undated document, titled, CMA Dish Machines, and indicated it was the manufacturer's guidelines for the dish machine currently in use by the facility. The document indicated, .CMA Dish Machine Model AH Details .Water Temperature 120-140 degrees Fahrenheit 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49068 Based on observation and interview, the facility failed to ensure clean linen was carried away from the body and failed to ensure soiled linen was in a container while transporting in the hallway during 5 of 5 random observations for linen handling. Findings include: During a random observation on 2/28/24 at 10:01 a.m., Certified Nursing Assistant (CNA) 21 retrieved a stack of linens from the clean linen closet located in the 100 hall, she then held the linens against her body while transporting them to a resident's room. During a random observation on 2/28/24 at 11:00 a.m., CNA 21 retrieved a stack of linens from the clean linen closet located in the 100 hall, she held the linens against her body while transporting. During a random observation on 2/29/24 at 9:50 a.m., Employee 3 was observed coming out of a resident's room on the 200 hallway wearing gloves and holding soiled linens that were unbagged against her body. She left the resident's room and indicated she needed to take the linens to the hopper. During a random observation on 2/29/24 at 2:48 p.m., CNA 20 retrieved a stack of linen from the clean linen closet located in the 100 hall, transported the linens against her body while entering a resident's room, walked out of the room still holding the linens against her body and transported them to a shower room. During a random observation on 3/01/24 at 8:45 a.m., CNA 21 retrieved a stack of linen from the clean linen closet located in the 100 hall and transported the linens against her body. During an interview on 2/28/24 at 3:01 p.m., Employee 8 indicated that staff were not to carry linens against their body and soiled linens were supposed to be transported in a plastic bag. During an interview on 3/1/24 at 9:55 a.m., CNA 22 indicated when they remove dirty linen it was to be put in a bag and then taken to the hopper room and placed in the linen barrel. When they remove linen from the clean linen closet, they were supposed to hold the items away from their body, never against their body. On 3/1/24 at 10:12 a.m., the Regional Nurse Consultant (RNS) provided and identified a document as a current facility policy titled, Linen, Handling, dated 12/2015. The policy indicated, . The facility shall handle linen in a manner to prevent the spread of infection . Procedure .2. Linen will not be carried against the body . 7. Soiled linen will be placed in a container (i.e., linen barrel, plastic bag, etc.) prior to taking it into the hallway 3.1-18(b)(1)