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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westridge Health Care Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure a resident's change in condition after a fall was assessed and treated which resulted in harm of a resident who had delayed treatment for a fractured right femur (thigh bone) that required surgery for 1 of 4 residents reviewed for accidents (Resident 8). Findings include:During an interview, on 3/15/26 at 1:33 p.m., Resident 8 indicated she had constant pain and recently had a fall and was hurt. Resident 8's record was reviewed on 3/17/26 at 11:56 a.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia, moderate, with mood disorder (fixed, false beliefs strongly held despite clear evidence to the contrary, often stemming from mental health, neurological, or substance-related conditions), major depressive disorder (serious mental health condition characterized by persistent sadness, hopelessness, and a loss of interest in activities lasting at least two weeks), right femur fracture (severe break in the right thighbone), and pain, unspecified (a patient experiences pain that cannot be traced to a specific injury, disease or anatomical cause). Facility census information indicated the resident admitted to the facility on [DATE]. A physician order, dated 1/24/24, indicated to assess resident's pain level and notify medical provider if new onset or worsening pain. A care plan, dated 5/20/25, indicated the resident had multiple risk factors for falls including impaired mobility, cognitive deficits, range of motion deficits, and dementia. Interventions included, but were not limited to, ensure pathways are clutter free, keep frequently used items within reach, and notify resident representative and physician if fall occurs. A progress note, dated 11/30/25 at 7:10 a.m., indicated Resident 8 was on the floor beside her bed when staff was called to her room. No injuries noted and no complaints of pain. A Hoyer lift (mechanical device used to safely transfer individuals with limited mobility between a bed, chair, or other surfaces) was used to get the resident back into bed. A progress note, dated 11/30/25 at 9:40 a.m., indicated the facility notified the Nurse Practitioner (NP) of the fall without injuries. Review of neurological check flowsheet indicated Resident 8 complained of pain to her knees on 12/1/25 at 11:00 p.m., 12/2/25 at 11:00 p.m., 12/3/25 at 3:00 a.m., and pain to knee/legs on 12/3/25 at 7:00 a.m. A progress note, dated 12/3/25 at 5:19 a.m., indicated Resident 8 was complaining of right knee pain and had her leg up prompt on pillows. The record lacked documentation that a physician was notified of increased pain after the fall. A progress note, dated 12/6/25 at 11:32 a.m., indicated Resident 8 had recent complaints of leg pain. The nurse assessed and noted bruising to bilateral knees and they were swollen. The nurse notified the NP and received an order for x-rays. The record lacked documentation that the x-rays were completed. A late entry progress note, dated 12/18/25 at 12:08 a.m., indicated that on 12/1/25 at 12:30 a.m. Resident 8 complained of increased pain in legs and all over with movement during care. An as needed pain medication was administered, and no bruising was noted to her legs or knees at that time. The record lacked documentation that a physician was notified of increased pain after the fall. A late entry progress note, dated 12/18/25 at 12:11 a.m., indicated that on 12/2/25 at 12:55 a.m. Resident 8 was given as needed pain medication for complaints of pain in knees and legs, no bruising noted at this time. The record lacked documentation that a physician was notified of increased pain after the fall. Review of November 2025 Medication Administration Record (MAR) indicated had (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 0684 Level of Harm - Actual harm Residents Affected - Few	complained of 3 out of 10 pain once in the month and all other complaints were 0 to 2 out of 10. Review of November 2025 MAR indicated the resident did not receive any as needed pain medication for the month. Review of December 2025 MAR indicated the resident complained of 10 out of 10 pain on 12/1/25 during the dayshift. On 12/2/25 during the night shift the resident complained of 6 out of 10 pain. On 12/5/25 during the night shift the resident complained of 7 out of 10 pain.Review of December 2025 MAR indicated the resident received as needed pain medication on 12/1/25 at 12:38 a.m. for 7 out of 10 all over pain. The resident received as needed pain medication on 12/2/25 at 12:58 a.m. for 6 out of 10 pain. A progress note, dated 12/7/25 at 5:00 p.m. indicated Resident 8 was sent to hospital for uncontrolled pain. A progress note, dated 12/7/25 at 5:32 p.m., EMS (Emergency Medical Services) arrived at the facility to transport the resident to the hospital. The facility census information indicated Resident 8 re-admitted to the facility on [DATE].Review of nurse practitioner progress note, dated 12/12/25, indicated Resident 8 had a right femur fracture and L(lumbar)1-L4 compression deformities and L5 TP (a break in the bony protrusion on the side of the lowest lumbar vertebra often caused by high-impact, blunt trauma or sever muscle contraction) fracture. The resident had experienced a fall at the facility the week prior. The resident underwent surgical fixation of right femur fracture on 12/8/25. A significant change in status Minimum Data Set (MDS) assessment, dated 1/19/26, indicated the resident had moderate cognitive impairment and was on a pain medication regimen. During an interview, on 3/19/25 at 10:42 a.m., the Clinical Consultant indicated she was aware of Resident 8's fall on 11/30/25 and at the time of the fall it was reported that there were no complaints of pain and no injuries. The consultant indicated the resident had chronic pain and when the resident started to complain of knee/leg pain after the fall they thought it was from her chronic pain. She did not know why the staff did not notify the physician when the resident started to complain of worsening pain. On 3/19/26 at 11:56 a.m., the Clinical Consultant provided a document dated 10/14, titled, Notification of Change, and indicated it was the current policy being used by the facility. The policy indicated, .To keep resident, legal representative (or interested family member), and physician (when applicable) aware of changes which directly affect the care and welfare of the resident.Facility personnel shall immediately inform resident, consult with resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:.an accident involving the resident that results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status. 410 Indiana Administration Code (IAC) 16.2-3.1-37(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and their representatives participated in care plan meetings (a documented meeting where a resident, their family, and a team of health professionals meet to discuss the resident's goals, preferences, and necessary care services), for 4 of 16 residents reviewed for care plan meetings (Residents 41, 40, 1, and 8). Findings include:1. During an interview, on 3/15/26 at 12:53 p.m., Resident 41's brother indicated he was the resident Power of Attorney (POA-a legal document that allows someone else to act on another individual's behalf) and responsible party. He indicated he attended a care plan meeting right after the resident was admitted but had not known about or attended a meeting since that time. At the same time, the resident indicated she could not remember having a meeting since that time as well. Resident 41's record was reviewed on 3/18/26 at 8:43 a.m. The census indicated that the resident had been admitted to the facility on [DATE], for diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (one-sided weakness or paralysis on the right side of the body caused by a stroke in the left side of the brain). A quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident had no cognitive deficit. Review of the care conference meeting history indicated the following: A care conference meeting was held on 8/1/25. The conference note lacked documentation that the resident and/or her brother/POA had been invited or were in attendance, and why they had not attended the meeting. An Interdisciplinary Care Plan Conference Record form, dated 9/3/25, indicated that a meeting had been held on this date. The form indicated a care plan letter had been mailed on 8/25/25. The resident's brother/POA had attended. The form lacked documentation that the resident had been invited, had attended, and, if she did not attend, a reason why. An Interdisciplinary Care Plan Conference Record form, dated 10/1/25, indicated that a meeting had been held on this date. The conference note lacked documentation that the resident and/or her brother/POA had been invited, were in attendance, and why they had not attended the meeting. An Interdisciplinary Care Plan Conference Record form, dated 12/31/25, indicated that a meeting had been held on this date. The form indicated that the resident and her brother/POA had not attended the meeting. The conference note lacked documentation that the resident and/or her brother/POA had been invited and why they had not attended the meeting. During an interview, on 3/18/26 at 9:50 a.m., the Social Services Director (SSD) indicated she was not sure why the resident's brother/POA had not attended any of the care plan meetings. She had sent him letters to notify him of the meetings. She was unsure why there was not any documentation to indicate why the resident and/or her brother/POA had not attended any of the meetings. She kept a log of all the facility residents meetings, and those who were invited, but had no other documentation to explain if the resident or their representatives had attended or declined the invitation to attend. She acknowledged there was no consistency with any progress notes about the meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 3/18/26 at 11:10 a.m., the resident's brother/POA indicated he could not remember that he ever received a letter from the facility about care plan meetings. During an interview, on 3/18/26 at 9:20 a.m., the Corporate Social Services Consultant indicated the SSD would send letters out to invite resident representatives and residents to the care conference meetings. They did not have time to follow up to determine if the letter was received and/or if they were planning to attend or not. She believed that if the resident and their representatives had been invited, there was no need to document if and why they did not attend. At the same time, she acknowledged there was no consistency with documentation on who was invited and who attended the care plan meetings. 2. On 3/15/2026 at 10:39 a.m., during initial observation and interview Resident 40 indicated she had not been invited to any care plan meetings. She indicated she was bed bound and the staff were welcome to meet in her room to discuss her needs. On 3/18/26 the medical record of Resident 40 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), chronic pain (pain that lasts or recurs for more than 3 to 6 months), and atherosclerotic heart disease (a condition where arteries supplying the heart become narrowed or blocked due to a buildup of plaque). A quarterly Minimum data Set assessment (MDS), dated [DATE], indicated the resident was cognitively intact and required maximum assistance from the staff for daily care needs. Review of the medical record indicated the date of a care plan date had been entered. The record lacked documentation regarding the care plan meeting or if the resident was in attendance. On 3/18/26 at 9:47 a.m., during an interview the Social Service Director indicated the review team went to the room of Resident 40 for care plan meetings and she kept a written log of care plan invitations. The resident was always invited to attend. She indicated care plan meetings were completed quarterly and when the resident had a significant change in condition. She wrote invitation letters and sent them to family or responsible party. If the resident was their own person she hand delivered the letter to the resident. She indicated she did not have documentation for the actual care plan meetings of Resident 40. 3. During an interview on 3/15/26 at 12:49 p.m., Resident 1 indicated she did not remember having care plan meetings consistently. Resident 1's record was reviewed on 3/16/26 at 10:18 a.m. The profile indicated the resident's diagnoses included, but were not limited to, depression unspecified (clinically significant depressive symptoms that cause distress but do not meet the full criteria for specific disorders like Major Depressive Disorder), schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia (hallucinations [seeing things that aren't there], delusion, disorganized thinking) with a mood disorder such as depression or bipolar disorder), and fibromyalgia (a chronic multi system disorder characterized by widespread musculoskeletal pain, profound fatigue, and cognitive difficulties). Facility census information indicated the resident admitted to the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care conference note, dated 5/7/25, indicated a quarterly review was conducted on this day for Resident 1, but the record lacked documentation if the resident or resident representative was invited or attended the meeting. A care conference note, dated 7/7/25, indicated a quarterly review was conducted on this day for Resident 1, but the record lacked documentation if the resident or resident representative was invited or attended the meeting. A care conference note, dated 9/18/25, indicated a quarterly review was conducted on this day for Resident 1, but the record lacked documentation if the resident or resident representative was invited or attended the meeting. A care conference note, dated 12/17/25, indicated a care plan meeting was conducted on this day for Resident 1. The documentation indicated the resident was in attendance. A quarterly Minimum Data Set (MDS) assessment, dated 12/19/26, indicated the resident had moderate cognitive impairment. 4. During an interview on 3/15/26 at 1:30 p.m., Resident 8 indicated she did not remember having care plan meetings regularly. She was unsure when the last one was. Resident 8's record was reviewed on 3/17/26 at 11:56 a.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia, moderate, with mood disorder (fixed, false beliefs strongly held despite clear evidence to the contrary, often stemming from mental health, neurological, or substance-related conditions), major depressive disorder (serious mental health condition characterized by persistent sadness, hopelessness, and a loss of interest in activities lasting at least two weeks), and right femur fracture (severe break in the right thighbone). Facility census information indicated the resident admitted to the facility on [DATE]. A care conference note, dated 6/11/25, indicated a quarterly review was conducted on this day for Resident 8, but the record lacked documentation if the resident or resident representative was invited or attended the meeting. A care conference note, dated 8/27/25, indicated a quarterly review was conducted on this day for Resident 8. The documentation indicated that the daughter and resident were in attendance. A care conference note, dated 11/5/25, indicated an annual review was conducted on this day for Resident 8, but the record lacked documentation if the resident or resident representative was invited or attended the meeting. A care conference note, dated 12/3/25, indicated an annual review was conducted on this day for Resident 8. The documentation indicated the resident was in attendance. A significant change in status Minimum Data Set (MDS) assessment, dated 1/19/26, indicated the resident had moderate cognitive impairment. A care conference note, dated 1/19/26, indicated a significant change review was conducted on this day for Resident 8, but the record lacked documentation if the resident or resident representative was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	invited or attended the meeting. During an interview on 3/18/26 at 2:00 p.m., the Social Service Director (SSD) indicated she was unable to provide documentation that the resident and/or resident representatives had attended quarterly care plan meetings. There were times she was unable to get the documentation completed on the computer or on paper. On 3/19/26 at 10:02 a.m., the SSD consultant provided a document, dated 10/07, titled, Care Plan Notification Log, and indicated it was the current policy being used by the facility. The policy indicated, .1. Social Service Director and/or appointed designee will be responsible to ensure the residents, family and responsible parties have been notified of all care plan meetings. 2. Social Service will utilize the Care Plan Notification Log to indicate date of notification, date of care plan meeting, who was notified and how they are notified. 410 Indiana Administrative Code (IAC) 16.2-3.1-35(2)(C)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure psychotropic medication consents were obtained for the initiation of or increase of psychotropic medications for 2 of 5 residents reviewed for unnecessary medications (Residents 1 and 30). Findings include: 1. Resident 1's record was reviewed on 3/16/26 at 10:18 a.m. The profile indicated the resident's diagnoses included, but were not limited to, depression, schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia with a mood disorder such as depression or bipolar disorder), and fibromyalgia (a chronic multi system disorder characterized by widespread musculoskeletal pain, profound fatigue, and cognitive difficulties). Facility census information indicated the resident admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 12/19/26, indicated the resident had moderate cognitive impairment and received anti-psychotic and anti-depressant medications during the look back period. A physician order, dated 2/9/26, indicated to administer duloxetine (anti-depressant medication) 20 milligrams (mg), 1 capsule by mouth once a day. The electronic health record lacked documentation of a psychotropic informed consent was obtained for the use of the duloxetine medication. During an interview on 3/17/26 at 10:42 a.m., the Clinical Consultant indicated she had misinformed about psychotropic consents and when they needed to be obtained. She was unable to find documentation of the consent being obtained for when the duloxetine medication was initiated for Resident 1. She was now aware of the error and had started an audit tool regarding the psychotropic consents. 2. Resident 30's record was reviewed on 3/16/26 at 10:28 a.m. The profile indicated the resident's diagnoses included, but were not limited to, major depressive disorder, recurrent (a mental health condition characterized by experiencing two or more major depressive episodes, separated by periods of improvement or remission) and generalized anxiety disorder (a mental health condition defined by chronic, excessive, and uncontrollable worry about everyday things for at least 6 months). A significant change Minimum Data Set (MDS) assessment, dated 2/10/26, indicated the resident had no cognitive deficits and received antidepressant medication (medication used to treat symptoms of depression). A care plan, dated 2/24/26, indicated the resident was at risk for side effects related to the use of psychotropic medications. A historical review of the resident's physician's orders for sertraline (antidepressant medication) indicated the following: a. A physician order, dated 10/1/24 and discontinued on 7/1/25, indicated to administer a 100 milligram (mg) tablet of sertraline, one time daily for anxiety and depression. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A physician order, dated 5/6/25 and discontinued on 7/1/25, indicated to administer a 25 mg tablet of sertraline, one time daily for anxiety and depression. c. A physician order, dated 7/1/25 and discontinued on 11/19/25, indicated to administer one and a half-100 mg tablets of sertraline (150 mg), one time daily for anxiety and depression. The record lacked documentation of a consent form for the increase of the sertraline medication, ordered on 7/1/25. A Psychiatry progress note, dated 7/1/25, indicated the Psychiatrist had discussed the resident's increased depression and anxiety with the Interdisciplinary Team (IDT). The IDT agreed that the resident's depression had increased. The decision was made to increase the resident's sertraline from 125 mg daily to 150 mg daily. During an interview, on 3/17/26 at 9:57 a.m., the Regional Clinical Consultant indicated she was unable to locate a consent form for the sertraline medication increase, dated 7/1/25. On 3/17/26 at 12:55 p.m., the Regional Clinical Consultant provided a document, dated 4/2025, titled, Psychotropic Medication Consent, Use and Gradual Dose Reduction, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures.16. Residents receiving an order for a new psychotropic medication, or dosage increase to existing orders, shall have consent obtained from the resident or their representative. 410 Indiana Administrative Code (IAC) 16.2-3.1-3(l)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Registered Dietitian (RD) recommendations were addressed by the physician and ordered interventions were implemented to prevent weight loss for 1 of 2 residents reviewed for weight loss (Resident 11). Findings include:On 3/15/26 at 10:30 a.m., during an initial observation, observed Resident 11 sitting up in bed drinking water from a two handle cup. The resident was alert with slow verbal response. Noted while drinking she was coughing frequently. Liquid was noted to be thin consistency. On 3/15/26 at 1:44 p.m., the medical record of Resident 11 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but not limited to, 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), hypertension (high blood pressure) and anorexia (a serious, potentially fatal eating disorder characterized by an intense fear of gaining weight). A care plan, dated 10/7/25, indicated resident had incurred weight loss. Interventions included, but were not limited to, determine potential causal factor of decreased consumption/weight loss and involve appropriate disciplines to provide intervention, food preferences, depression/isolation, need for increased assistance, dining seating/atmosphere. Monitor consumption and encourage resident to consume 100% of meals, snacks, and supplements. Notify physician and dietician of continued weight loss. A physician order, dated 10/22/25, indicated diet: mechanical soft with diet condiment send sugar free cookies for bedtime (HS) snack per resident request every shift. A physician order, dated 10/22/25, indicated to send thrive ice cream at lunch and dinner twice a day. On 11/26/25 at 10:32 a.m., a Registered Dietitian (RD) note indicated the resident's November weight on 11/04/25 was 239.8 lb equaling 0.1% loss in 30 days, 2.6% loss in 90 days, and 7.9% loss in 180 days. There was no significant weight changes; however, weights had trended downward. Resident had been wanting to lose weight in the past; however, this trend likely was due to decreased intakes. Resident's diet changed on10/22/25 to mechanical soft with diet condiments. Send sugar free cookies for an HS snack per resident's request. Current intake at meals was 26 to 100% for breakfast and lunch and 26 to 75% for dinner. Resident also started to receive a thrive ice cream with lunch/dinner; however, uncertain of percentage consumed. Do recommend to supplement diet with Active liquid protein 60 ml twice daily, send a Boost Breeze (or Ensure Clear) with breakfast, and weekly weights continue. Continue with all other current interventions. A quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was cognitively impaired and required maximum assistance for daily care needs. The MDS indicated, no weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. Review of the Medication Administration Record (MAR) indicated from November 2025 to March 2026 the resident received thrive ice cream twice daily. The record lacked documentation of a physician order to administer, active liquid protein BID (twice daily), or administration of Boost Breeze (or Ensure Clear) with breakfast per Registered Dietitian (RD) recommendation. Review of the weight history indicated significant weight loss. Six month weight record on 10/7/25 weight was 240 pounds (lb). On 3/4/26 weighed 190.8 lb., equaling a 20.5 percent (%) loss in 6 months. Weight on 2/3/26 was 202.4, on 3/4/26 weight was 190.8, equaling a 5.73% loss in 30 days. The record lacked documentation of physician notification of continued weight loss.An evaluation completed by the RD was completed on 3/16/26. The evaluation indicated Current p.o. (by mouth) intakes are not adequate to meet estimated needs. Recommend 1) appetite stimulant per MD preference.The record lacked documentation of notification to the physician of the recommendation. On 3/19/26 at 1:15 p.m., during an interview the RD acknowledged she had made recommendations for the resident to receive additional protein liquid and an appetite stimulant. She was unsure of why the recommendations had not been implemented or followed. On 3/19/26 at 2:00 p.m., during an interview the Regional Nurse Consultant indicated the facility had posted the recommendation for the physician to review on the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	next scheduled visit. She acknowledged the recommendations had not been implemented and physician had not been notified. On 3/19/26 at 3:00 p.m., the Clinical Nurse Consultant provided a document, titled, Dietitian Recommendations, dated 10/2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures.6. Administrative staff shall be responsible to ensure said communications are communicated to the resident's physician as son as possible, but no later than three (3) days from receiving said recommendation. Physician response shall be documented and implemented accordingly. 410 Indiana Administrative Code (IAC) 16.2-3.1-46

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	155234	A. Building B. Wing	03/19/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure a physician's order for an assessment of a resident's dialysis access site (surgically prepared area on the body that allows easy, high-volume access to the bloodstream for filtering blood during hemodialysis [a medical treatment that acts as an artificial kidney for people with kidney failure] was accurate, for 1 of 1 resident reviewed for dialysis (resident 2). Findings include:Resident 2's record was reviewed on 3/16/26 at 11:17 a.m. The profile indicated the resident's diagnoses included, but were not limited to, end stage renal disease (the final stage of kidney failure, where kidneys lose roughly 90% of their function, or are no longer able to work well enough to sustain life) and dependence on renal dialysis. A quarterly Minimum Data Set (MDS) assessment, dated 1/22/26, indicated the resident had no cognitive deficit. A care plan, dated 2/11/25, indicated the resident had diagnoses of end stage renal disease and required hemodialysis. Interventions included, but were not limited to, monitor shunt for bruit and thrill every shift. Review of the nurse's notes indicated the resident had a dialysis port in her upper right chest. The notes lacked documentation that the resident had an AV Fistula site (an abnormal connection between an artery and a vein, allowing blood to flow directly between them). A physician's order, dated 7/17/25, indicated to monitor the resident's AV Fistula site for bleeding, redness, swelling and warmth. Notify the medical provider of complications every shift. A physician's order, dated 7/17/25, indicated to monitor the resident's AV Fistula site for bruit and thrill (A bruit is an audible whooshing or blowing sound heard with a stethoscope, indicating turbulent blood flow in an artery or vein. A thrill is a palpable, gentle buzzing sensation or vibration felt with the hand over the same area). If bruit of thrill is negative notify medical provider and document findings every shift. The record lacked documentation of an order to assess the resident dialysis port to her right upper chest. During an interview, on 3/17/26 at 1025 a.m., Registered Nurse (RN) 4 indicated that she knew that the resident did not have an AV Fistula. She was aware that the orders indicated assessments for an AV Fistula. During an interview, on 3/17/26 at 10:40 a.m., the Regional Clinical Consultant indicated the incorrect order had been overlooked by several staff who had responsibility to review the resident orders. She was unsure as to why the order had not been caught sooner. During an interview, on 3/18/26 at 8:30 a.m., the Regional Clinical Consultant indicated it had been brought to her attention that the resident did have an AV Fistula, but it was not accessible. She had a dialysis port in her right upper chest that was used for her dialysis treatments. A new order to assess the residents' port was added to the orders on 3/17/26. During an interview, on 3/18/25 at 9:40 a.m., the resident indicated she had the AV Fistula prior to coming to the facility. It had never worked, so they put the port in for her dialysis last fall. She had an appointment to get the A V Fistula removed, but she was not able to attend to get the procedure done. Nothing had ever been said about it since. On 3/17/26 at 12:55 p.m., the Regional Clinical Consultant provided a document, with a revised date of 9/2017, titled, Dialysis Coordination/Facility Services, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy.Review physician's orders for the resident receiving dialysis to confirm: Type of access site and location, Orders for care access site. 410 Indiana Administrative Code (IAC) 16.2-3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure insulins stored in the medication carts were labeled with the open date for 1 of 2 medication carts reviewed and 3 of 3 residents with insulins stored in the medication cart (Residents 37, 12, and 34). Findings include:On 3/17/26 at 1:25 p.m., observed the North hall medication cart with RN 6. The following insulin pens (a portable, easy-to-use medical device for injecting insulin to manage diabetes) were observed: Resident 37, Novolog - Insulin Pen. The medication label indicated the prescription had been filled on 2/13/26. No date opened was recorded on the label or the pen. Resident 37, Basaglar insulin pen. The medication label indicated the prescription had been filled on 7/2/25. No date opened was recorded on the label or the pen. Resident 37, Novolog insulin pen. The medication label indicated the prescription had been filled on 12/10/25. No date opened was recorded on the label or the pen. Resident 12, Glargine insulin pen. The medication label indicated the prescription had been filled on 2/13/26. No date opened was recorded on the label or the pen. Resident (34), Lantus insulin pen. The prescription label did not indicate a refill date. No date opened was recorded on the label or the pen. On 3/17/26 at 1:30 p.m., during an interview RN 6 acknowledged insulin pens must be dated once opened to ensure they were not administered after the expiration date. 1. The electronic medical record of Resident 37 indicated a diagnosis of diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A physician order indicated to administer Novolog FlexPen U-100 Insulin (insulin aspart u-100) insulin pen; 100 unit/mL (milliliter) administer 13 units; subcutaneous (under the skin) with meals. The current physician orders, dated 3/1/26, lacked an order for Basaglar insulin for Resident 37. 2. The electronic medical record of Resident 12 indicated a diagnosis of diabetes. A current physician order indicated to administer glargine insulin 100 unit/mL (3 mL) administer 13 units; subcutaneous at bedtime. 3. The electronic medical record of Resident 34 indicated a diagnosis of diabetes. A current physician order indicated to administer Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL) administer 30 units; subcutaneous twice a day. On 3/19/26 at 9:12 a.m., the Director of Nursing provided a document titled, Medication expiration, dated 10/2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.1.d. Multiple dose injections such as insulin will expire 28 days after opening unless otherwise noted by manufacturer.2. Facility staff shall date the label of any multi-use vial when the vial is first accessed. 410 Indiana Administrative Code (IAC) 16.2-3.1-25(j)410 Indiana Administrative Code (IAC) 16.2-3.1-25(m)410 Indiana Administrative Code (IAC) 16.2-3.1-25(n)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure lab services were completed as ordered, for 2 of 5 residents reviewed for unnecessary medications (Residents 30 and 3). Findings include: 1. Resident 30's record was reviewed on 3/16/26 at 10:28 a.m. The profile indicated the resident's diagnoses included, but were not limited to, other seizures (seizure types beyond common convulsions, characterized by temporary, abnormal brain activity causing sudden changes in movement, sensation, behavior, or awareness). A significant change Minimum Data Set (MDS) assessment, dated 2/10/26, indicated the resident had no cognitive deficit and received anticonvulsant medications (medications used to control seizures). A physician's order, dated 11/21/25, indicated to administer 1-500 milligram (mg) tablet of Keppra (anticonvulsant medication) two times a day. A Pharmacy recommendation, dated 2/3/26, indicated to consider checking the resident's Keppra level, if it had not been done lately. The physician agreed and signed and dated the document on 2/24/26. A physician's order, dated 2/24/26, indicated to obtain a Keppra level (a blood test that measures how much of the seizure medication is currently in a person's bloodstream). The record lacked documentation of the Keppra level had been obtained as ordered. A February 2026 lab order tracking form, indicated the resident had a physician's order, dated 2/24/26, to draw a Keppra level. The form indicated draws had been attempted on 3/4/26 (L hand) unsuccessful and a second attempt on 3/13/26 (L AC) and were unsuccessful. The form indicated the physician had not been notified of the failed attempts to draw the Keppra level until 3/17/26. The progress notes lacked documentation of the failed attempts to draw the Keppra level on 3/4/26 and 3/13/26 and lacked documentation that the physician had been notified of the failed attempts and notified on 3/17/26. During an interview, on 3/17/26 at 2:15 p.m., the Assistant Director of Nursing (ADON) indicated the facility had received an order to obtain the Keppra level on 2/24/26. The resident's veins were so bad, due to his cancer treatments, that it was difficult to get the labs drawn. The resident did not have a port (a small, soft-topped medical appliance surgically placed under the skin—usually in the upper chest) to draw from. They had tried a couple of times to get the blood, but they could not. During an interview, on 3/17/26 at 3:01 p.m., Registered Nurse (RN) 6 indicated the resident did have a port but it was not accessible for the nurses at the facility. She believed it was due to the policy of the facility. 2. Resident 3's record was reviewed on 3/16/26 at 3:14 p.m. The profile indicated the resident's diagnoses included, but were not limited to, osteomyelitis (a serious infection of the bone), dementia (a decline in mental ability severe enough to interfere with daily life), and personal history of pulmonary embolism (sudden life-threatening blockage in one or more pulmonary arteries in the lungs). (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) assessment, dated 2/7/26, indicated the resident had severe cognitive impairment and was dependent on staff for showers and toileting. A physician order, dated 10/8/25, indicated to administer Rexulti (anti-psychotic medication) 0.25mg (milligrams) by mouth once a day. A pharmacy recommendation, dated 1/5/26, indicated to consider checking a fasting lipid panel (a blood test, requiring 8-12 hours of fasting that measures total cholesterol and good and bad triglycerides), A1C (a blood test that measures your average blood sugar levels over the past 2 to 3 months), and b12 (measures the level of cobalamin [water soluble vitamin] in the blood) level to monitor for safety and/or effectiveness of mediations. The physician signed and dated the recommendation for 1/6/26 and indicated the resident was in the hospital. Facility census information indicated Resident 3 re-admitted to the facility on [DATE] from the hospital. The record lacked documentation that the labs had been ordered or obtained as recommended by the pharmacy. A second pharmacy recommendation, dated 2/3/26, indicated to consider checking a fasting lipid panel, A1C, and b12 level to monitor for safety and/or effectiveness of medications. The physician agreed and signed the recommendation on 2/24/26. A physician order, dated 2/24/26, indicated to obtain a fasting lipid panel, A1C, and b12 level. The record lacked documentation of the labs being obtained as ordered. A February 2026 lab order tracking form, indicated the resident had a physician order, dated 2/24/26, to draw the lipid panel, A1C, and b12 level. The form indicated the resident refused the labs on 3/4/26 and were unable to attempt on 3/10/26 because Resident 3 had already ate. The form indicated a failed attempt in the left hand and left ac (shallow triangular depression located on the inside of the elbow) on 3/13/26. The form indicated the physician had not been notified of the failed attempts or refusal. During an interview on 3/17/26 at 8:56 a.m., the Clinical Consultant indicated she had attempted to draw labs on Resident 3 twice and was unable to obtain the labs. The physician had not been notified that the facility was unable to draw the labs as ordered. The consultant indicated the facility had lost the lab contract with a previous company at the beginning of November 2025. Since that time they have not had a consistent phlebotomist (a person who does lab draws), the facility also had to drive the labs to the hospital to be processed once obtained. The facility did not have a nurse available who was able to draw labs in a timely manner. During an interview, on 3/17/26 at 1:10 p.m., the Clinical Consultant indicated the facility had offered a phlebotomist a position and she was hopeful they would be starting soon. She was aware they had an issue with lab services and there was a system failure, and the facility would be working on getting it corrected. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/26 at 1:46 p.m., the Clinical Consultant provided a document, dated 10/14, titled, Laboratory Orders, Timely Draws, and indicated it was the current policy being used by the facility. The policy indicated, .Laboratory testing shall be conducted in a timely manner per physician orders.This facility shall ensure that physician's orders requesting laboratory services to be rendered are followed as specified in the order.3. If not specified to be drawn now .or in a given time frame.any laboratory blood ordered to be drawn shall be drawn on the next regularly scheduled facility lab day. 410 Indiana Administrative Code (IAC) 16.2-3.1-49(a)