STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN 47802

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00435269. Complaint IN00435269 - Federal/state deficiencies related to the allegations are cited at F657. Survey dates: June 5 and 6, 2024 Facility number: 000139 Provider number: 155234 AIM number: 100266410 Census Bed Type: SNF/NF: 3 SNF: 3 NF: 38 Total: 44 Census Payor Type: Medicare: 3 Medicaid: 38 Other: 3 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 13, 2024.	F 0000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance. Please find enclosed this Plan of Correction for this survey. Due to the low scope and severity of the survey findings, the Facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that			

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

Lisa Gustus | MSN, RN Consultant | 06/26/2024

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	includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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). Findings include: 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. On 6/7/24 at 11:57 a.m., observed Resident A,	F 0657	F 0657 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** The noted residents were not negatively affected by the alleged deficient practice. Resident A, B,C, H and K's care plans have been updated to indicate each fall that has occurred and updated to reflect the post fall immediate interventions. ***How other residents having the potential to be affected by the***	07/03/2024

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	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. 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 6/8/22. 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. 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. 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. 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.		***same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents negatively affected by the alleged deficient practice; however, all residents with falls or risk for falls have the potential to be affected. All residents' care plans will be reviewed to ensure that comprehensive person-centered care plans regarding falls and or risk for falls is updated and reflects their post fall immediate interventions, and that all of the interventions are current. All noted discrepancies will be immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Care Plan Development and Review" has been reviewed and no changes are indicated at this time. All nursing staff and members of the IDT will be re-educated on the facility policies regarding comprehensive care plan development and review. The in-service will focus on development and implementation of comprehensive person-centered care plans and care plan updating to reflect changes and post fall immediate interventions. A monitoring tool has been implemented.	

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	A care plan, dated 4/10/24, indicated falls with injury. The record lacked evidence of post fall immediate interventions. 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 6/8/22. An undated intervention indicated staff moved the resident's room closer to the nurses' station. On 5/18/24 an intervention indicated the resident sustained an injury requiring an ER visit. 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. An intervention, dated 5/20/24, indicated to change alarm. 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. 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. A care plan, dated 11/8/23, indicated falls. A care plan, dated 2/7/24, indicated falls with injury. The record lacked evidence of post fall care plan with immediate interventions. On 6/27/19 an intervention for anti-rollbacks to wheelchair was entered. An intervention dated 4/16/24 indicated frequent reminders to not sit back, hand on wheelchair and request assistance as needed.		***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that all residents with falls and or fall risk have comprehensive person-centered care plans implemented and that care plans display evidence of post fall immediate interventions. Care Plans will be reviewed on all residents will falls for post fall interventions as follows: All residents with falls will be reviewed weekly for four weeks, and then reviewed every other week for 4 weeks, and then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved. .	

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	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. 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. 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. 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. 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.			

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	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. 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 ...." This citation relates to Complaint IN00435269 3.1-35(c)(1)			