| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155234 | A. Building<br>B. Wing | 09/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westridge Health Care Center | 125 W Margaret Ave<br>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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>(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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, interview, and record review, the facility failed to assure staff provided safe and accurate administration of medication for 4 of 4 residents reviewed for pharmaceutical services (Residents D, E, F, and G). Findings include:1. During a random observation on 9/18/25 at 3:32 p.m., LPN 4 was observed seated at the 100 hall nurses' station. The desk had multiple cards of medications and plastic medication cups, with initials marked on the outer surface. LPN 4 was dispensing pills from the medication cards into her bare hands and placing the pills in the medication cups. She dropped a pill onto the desk surface, picked it up with her bare hands, and placed it into the medication cup. During the observation, LPN 4 indicated she was setting up her medications for administration later in her shift. There were nine filled medication cups, stacked one on top of the other, on the desk. She indicated these were for the east hall. The cups were labeled with initials in marker. The following was observed, with the Director of Nursing (DON), Nurse Consultant, and LPN 4 present: Resident E's cup contained two pills: one yellow, oblong; and one orange, round, and small. The Nurse Consultant later identified these as oxycarbazepin (to control seizures) 600 mg (milligram) and docusate sodium (to treat constipation) 100 mg, both medications were due to be administered between 6:00 p.m. and 10:30 p.m. A review of the resident's electronic Medication Administration Record (eMAR) indicated clonidine (to treat high blood pressure) 0.1 mg was due to be administered between 2:30 p.m. and 10:30 p.m. and had not yet been administered. The resident's medication cup, that had been prepared with the two other medications, lacked the clonidine tablet. Resident F's cup contained four pills: two white, oblong; one tan, oblong; and 1 small round. The Nurse Consultant later identified these as Vascepa (medication to lower triglycerides) 1 gram, due 6:00 p.m. to 10:00 p.m., metformin (to lower blood sugar levels) 500 mg, due 6:30 p.m. to 10:30 p.m., and rosuvastin 5 mg, due 6:00 p.m. to 10:00 p.m. A review of the resident's eMAR indicated magnesium oxide (a dietary supplement) 400 mg was due 6:00 p.m. to 10:30 p.m., primidon (to treat seizures or tremors) 50 mg was due 6:00 p.m. to 10:00 p.m., and sertraline (to treat depression) 100 mg was due 6:00 p.m. to 10:00 p.m. The resident's medication cup, that had been prepared with the three other medications, lacked the magnesium oxide, primidon, and sertraline tablets. Resident G's cup contained four pills: two yellow, oblong; one small, round; and one large, orange, oblong. The Nurse Consultant later identified these as oxycarbazepine 600 mg, furosemide (to treat edema) 20 mg, and calcium 600 with vitamin D3 (supplement). A review of the resident's eMAR indicated atorvastatin (to lower cholesterol) 40 mg was due 6:00 p.m. to 10:00 p.m, buspirone (to treat anxiety) 15 mg was due 6:00 p.m. to 10:00 p.m., gabapentin (to treat nerve pain) 100 mg (2 capsules for 200 mg dose) was due 6:00 p.m. to 10:30 p.m., pramipexol (to treat restless leg syndrome) 0.25 mg was due 6:00 p.m. to 10:00 p.m., sertraline 100 mg was due 6:00 p.m. to 10:00 p.m., and tizanidine (to treat muscle spasticity) 4 mg was due 6:00 p.m. to 10:30 p.m. The resident's medication cup, that had been prepared with the three other medications, lacked the atorvastatin, buspirone, two gabapentin, pramipexol, sertraline, and tizanidine medications. Resident G had an order for Xarelto 15 mg to be administered at 5:00 p.m. which was due to be administered prior to the 6:00 p.m. medications. During an interview on 9/19/25 at 3:48 p.m. the Nurse Consultant indicated at no time should medications be handled with bare hands. She indicated she believed staff were able to pre-set medications for one medication pass. The facility policy had referenced pre-pour, which she believed indicated prepare in advance. During an interview on 9/19/25 at 2:32 p.m., the DON indicated she believed pre-pour meant prepare in the facility policy. 2. During an interview on 9/18/25 at 2:55 p.m., Resident D indicated LPN 4 had tried to give him the wrong medications on two separate occasions while he was in the dining room for dinner. She would set a cup of medications down in front of him and walk away. He got her attention when she returned to give another resident their medication cup and told her the medications in his cup were not the ones he takes in the evenings. She indicated to him that they were not his medications, and she would return with his medications. On another occasion his sister was present at the dining table when LPN 4 set his medication cup down for him to take. He told his sister that these were not his medications, and his sister went to find LPN 4 to get his correct medications. The clinical record for Resident D was reviewed on 9/18/25 at 10:48 a.m. Diagnoses included hemiplegia/hemiparesis following a stroke affecting his right side, chronic respiratory failure, major depressive disorder, and anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 8/5/25, indicated the resident was cognitively intact, had no delusions or hallucinations, no behaviors, and no rejection of care. During an interview on 9/19/25 at 1:21 p.m., Resident D's sister indicated she had visited Resident D for |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation and interview, the facility failed to assure nursing staff were using proper hygiene and infection control when preparing to administer medications for 1 of 2 observations for medication pass. Findings include:During a random observation on 9/18/25 at 3:32 p.m., LPN 4 was observed seated at the 100 hall nurses' station. The desk had multiple cards of medications and plastic medication cups, with initials marked on the outer surface. LPN 4 was dispensing pills from the medication cards into her bare hands and placing the pills in the medication cups. She dropped a pill onto the desk surface, picked it up with her bare hands, and placed it into the medication cup. She indicated she had not realized it was an issue after washing her hands. During an interview on 9/19/25 at 3:48 p.m. the Nurse Consultant indicated at no time should medications be handled with bare hands. A current facility policy, revised 4/2017, titled, Medication Administration, provided by the DON on 9/18/25 at 3:35 p.m., included the following: Purpose: To safely administer medications as per physicians' orders .Infection control: .3. Never touch medications with hands Guidelines for Medication Administration: 13. Never touch medications with your hands. This citation relates to Intake 1396147. 3.1-18(b)(1) |