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	04/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/01/25 Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410 At this Emergency Preparedness survey, Westridge Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 66 certified beds. At the time of the survey, the census was 45. Quality Review completed on 04/04/25	E 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for this survey. Due to the low scope and severity of the survey finding and the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the providers allegation of compliance. Thus, the provider respectfully requests the granting of paper compliance in lieu of a post survey re-visit. Should additional information be necessary please contact the provider directly.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or facts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Bloesing	Administrator	04/15/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Survey Date: 04/01/25 Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410 At this Life Safety Code survey, Westridge Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a detached laundry, and a single detached shed used for storage that are not sprinklered. The facility has a capacity of 66 and had a census of 45 at the time of this survey. All areas where the residents have customary access are sprinklered. All areas providing facility services were sprinklered except a detached laundry and a maintenance storage area. Quality Review completed on 04/04/25		alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for this survey. Due to the low scope and severity of the survey finding and the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the providers allegation of compliance. Thus, the provider respectfully requests the granting of paper compliance in lieu of a post survey re-visit. Should additional information be necessary please contact the provider directly.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in accordance with NFPA 13, Standard for the	K 0351	**K351** ***What Corrective action(s) will be accomplished for those***	04/04/2025

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	155234	A. BUILDING 01 B. WING	04/01/2025

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	Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect 15 residents, staff and visitors in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 04/01/25 during a tour of the facility at 1:13 p.m., the escutcheon did not completely cover the hole around the sprinkler in the water softener room near physical therapy. Additionally, observation at 2:10 p.m. revealed the escutcheon did not completely cover the hole around the sprinkler in the housekeeping supply room next to resident room 317 exposing the attic. Based on interview at 1:14 p.m. and 2:11 p.m, the Maintenance Director agreed the attic space was exposed around the aforementioned sprinklers. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		***residents found to have been affected by the deficient practice?*** The noted 15 residents, staff and visitors were not negatively affected by alleged deficient practice. The escutcheon plates that did not cover the hold around the sprinkler in housekeeping supply room and next to resident room 317 were corrected at the time of survey. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient practice; however, all residents, staff and visitors had the potential to be affected. An audit of all sprinkler escutcheon plates was completed. Any noted discrepancies were 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 sprinkler policy has been reviewed and no changes are indicated. All maintenance and facility staff has been in-serviced to ensure any holes or missing escutcheon plates noted are reported immediately to maintenance supervisor or facility administrator. A monitoring tool	

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			has been implemented. ***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 maintenance director or designee will be responsible for completing the monitoring tool to ensure that all sprinklers have no visible holes or space around them and are adequately cover with escutcheon plates. All sprinklers will be audited 3 times week for 4 weeks, then weekly for 4 weeks, then monthly thereafter. Should any concern be found, immediate corrective action will be immediately taken. The plan will be adjusted by increasing or decreasing the monitoring practices if needed. ***Date of completion: April 4, 2025***	
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility failed to protect 5 of over 40 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a	K 0930	There is no plan of correction (POC) required for this K930 due to the low SS tag (A).	04/18/2025

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	minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect 7 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 04/01/25, one liquid oxygen container was stored and in use in the following resident sleeping Rooms: at 1:13 p.m. in room 111, 1:40 p.m. in room 205, 1:45 p.m. in room 212, 2:04 p.m. in room 307 and 2:05 p.m. in room 309. Each of the five resident sleeping rooms were not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor doors to the rooms were not self-closing or automatic closing and each door was not equipped with a fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Director agreed liquid oxygen containers were stored and in use in the rooms and each room was not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.			