STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155484				VILDING NG	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/24/2024	
	ROVIDER OR SUPPLIER			2222 M	ADDRESS, CITY, STATE, ZIP COD ARGARET AVE HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
F 0000							DATE
F 0000 Bldg. 00	Complaint IN00421 the allegations are c Complaint IN00421 the allegations are c Complaint IN00421 the allegations are c Complaint IN00421 related to the allegar F755. Survey dates: Janua Facility number: 00 Provider number: 1: AIM number: 10026 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 1 Medicaid: 82 Other: 10 Total: 93	517 - No deficiencies related to ited. 680 - Federal/state deficiencies tions are cited at F684 and ry 23 and 24, 2024 0564 55484 85610	F 00	000			
	accordance with 410	0 IAC 16.2-3.1.					
	Quality review com	pleted on February 1, 2024.					
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of	of care					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Brenda Hatfield Administrator 02/12/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1F1I11 Facility ID: 000564 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND P	LAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155484	B. WI	NG		01/24/	/2024
NAME	OF PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD	_	
					IARGARET AVE		
SOU	THWOOD HEALTHCA	RE CENTER		IERRE	HAUTE, IN 47802		
(X4) II		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFI	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		a fundamental principle that					
	1 1	tment and care provided to					
	facility residents.						
	-	ssessment of a resident, the					
	_	re that residents receive					
		re in accordance with					
	7	dards of practice, the					
		erson-centered care plan,					
	and the residents	'choices.					00/04/222
			F 06	584	Facility respectfully requests		02/21/2024
	Based on observation, interview and record				desk review for paper complia	ance.	
	review, the facility failed to ensure 1 of 3 residents						
	received care and services related to skin				F 684		
	impairment (Reside	ent D).			Corrective Actions accomplis		
					for those residents found to b		
	Findings include:				affected by the alleged deficit		
	<u></u>	1/22/24 + 1.27			practice: Resident D was not		
	_	v on 1/23/24 at 1:37 p.m.,			harmed by the alleged deficie		
		ed she had gaulding (chafing or			practice. On 1/23/2024 Resid		
	· · · · · · · · · · · · · · · · · · ·	ninal folds. She asked the staff			D's orders were reviewed and		
		ply medication. She asked the			verified with NP and the facili	ty	
		des (CNA) to tell the nurse she			wound nurse completed an	_	
		atment applied and they did not			assessment of the wound and	-	
		r pain medication yesterday			completed the treatment per	NID	
		a long time to get it. She called for medicine and had to wait			orders. Identification of other residen	to.	
	_	her pain medication. She had			having the potential to be affected		
		The was out when they did			by the same alleged deficient		
		y she was out when they did h. The resident indicated the			practice and corrective action		
	•	ninal folds had not been			taken: All resident with Topic Medication Administration ord		
		veral days. The resident			have the potential to be affect		
		een seen by the Nurse			The wound nurse conducted		
		3/24 and was given an order for			audit of all residents treatmer		
		worsening gaulding of the			1/23/24 to ensure no other	ແວ UII	
	abdominal folds.	worsening gautuing of the			treatments were incomplete.		
	audominiai ioids.				Measures put in place and		
	On 1/23/24 at 2:04	p.m., observation of treatment			systemic changes made to er	neura	
		atin powder was not in the			the alleged deficient practice		
		ing an interview Licensed			not recur. The facility educate		
	i u caunciii caii. 17111	me an increic w citchiacu			T IOCIECUL LUC MUNIVEUNISIE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F1I11

Facility ID: 000564 If continuation sheet Page 2 of 12

INDIFICATION STATES AND MAKE THE MAKE THE STATES AND PROVIDER OR SLIPPLER SOUTHWOOD HEALTHCARE CENTER SIMMARY STATEMENT OF DEFICIENCE WHITE AND SEMMARY STATEMENT OF DEFICIENCE BRITER (LACII DEFICIENCY MUST BE PRECEDED BY TULL TAG. Practical Nurse (LPN) 6 acknowledged the medication cart for the 400/500 halls and the treatment had not been completed. During an interview, on 1/23/24 at 3:15 p.m., LPN Sindicated the resident was almost out of Nystatin powder on 1/20/24. She was not able to locate the medication towals or the medication towals. During an interview on 1/23/24 at 3:55 p.m., the wound nurse 1 PN 8 indicated the resident was out of the nystatin powder and would give it a nurse to be used for a resident. She did not do the textament on 1/23/24 for Resident D. LPN 8 acknowledged she gave the rurse an unused bottle of Nystatin powder and would give it a nurse to be used for a resident. She did not do the textament on 1/23/24 for Resident D. LPN 8 acknowledged she gave the nurse an unused bottle of Nystatin powder on 1/5/23. She acknowledged she gave the nurse an unused bottle of Nystatin powder on the legs back to the heart), chronic epancrealitis (inflammation of the pancreas that can cause swelling, pain, and changes in bow an organ or tissues work), type 2 diabetes mellitus (a disease that occurs when your Hood glacoce, also called blood sugar, is too high), neuroposity (when nerve durange leads to pain, weakness, numbress or inging in one or more past of your body), cellulitis (a common bacterial skin infection that causes seedings, swelling, and pain in the infected area of the skin), and congestive heart failure (a condition in which the verified the resident property of the states of the same and the past of the pancreas that can cause swelling, and pain in the infected area of the skin), and congestive heart failure (a condition that develops when your heart of the skin), and congestive heart failure (a condition that develops when your heart of the pancreas that can cause swelling and pa	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F1I11

Facility ID: 000564

If continuation sheet Page 3 of 12

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155484	B. W	ING		01/24	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARGARET AVE		
SOUTHV	VOOD HEALTHCAI	RE CENTER			HAUTE, IN 47802		
	· · · · · · · · · · · · · · · · · · ·			LININE			1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		gh blood for your body's					
	needs).						
	D1 · · · 1 · ·	1 1 11 7 7 7 7 1					
		ncluded but were not limited					
	_	nilligrams (mg) capsule give 1					
	capsule by mouth the	lone-acetaminophen 10-325 mg					
		up to four times a day as					
	_	d Nystatin Powder apply to					
		d under breasts topically every					
		ift for fungal infection.					
		tot tungut mitotiom					
	A care plan, dated 1	11/7/23, indicated resident had					
	_	rity and was at risk for further					
	-	y. Approaches included but					
	_	administer medications as					
	ordered, and admin	ister treatments as ordered by					
	the medical provide						
	A care plan dated 1	/9/23 indicated, resident					
	presented with a M	ASD (moisture associated skin					
	· ·	olds on back. Approaches					
		not limited to, treatment as					
	ordered, wash and o	dry skin folds daily.					
		R (treatment administration					
	· · · · · · · · · · · · · · · · · · ·	ths of December 2023 and					
	1	d administration documentation					
	several times of the	treatment administration.					1
	On 1/24/24 -+ 0.32	om the DON massided -					
		a.m., the DON provided a					
	document, titled, "I	ed 08-2020, and indicated it					
		ently being used by the					
		indicated, " Policy					
		•					
	Medications will be administered in a safe and effective mannerProcedures22. Note						
		ne treatment by recording					
		me in the appropriate area on					
	the MAR or TAR						

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Event ID:

1F1I11

Facility ID: 000564

If continuation sheet Page 4 of 12

PRINTED: 02/20/2024 FORM APPROVED

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155484	B. WING 01/24/2024				
NAME OF I	AND CAMPED OR CAMPAGE		STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIE	R		2222 M	ARGARET AVE		
SOUTHV	VOOD HEALTHCA	RE CENTER		TERRE	HAUTE, IN 47802		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	undated document, administration", an currently being use indicated, " PolicGeneral Procedur "borrow" medication administer medicat missingeeNaragivenggmedic withheld or not givDocumentation medication will be administrationb.	a.m., the DON provided an titled, "Medication d indicated it was the policy d by the facility. The policy yMedication Administration resyDo not share or ons from otherszDo not ion if the label is not legible or cotics will be signed out when ations that are refused or en will be documentedIV .a. Documentation of current for medication Documentation of medications d standards of nursing practice					
		s to Complaint IN00421680.					
	3.1-37						
F 0755 SS=D Bldg. 00	§483.45 Pharmac The facility must pemergency drugs residents, or obtated described in §483 permit unlicensed drugs if State law general supervision §483.45(a) Proceprovide pharmaceprocedures that a acquiring, receiving	s/Pharmacist/Records					

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meet the needs of each resident.

Event ID:

1F1I11

Facility ID: 000564

If continuation sheet

Page 5 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155484	B. WI	NG		01/24/	/2024
			1	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			ARGARET AVE		
SOUTHV	VOOD HEALTHCA	RE CENTER			HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	must employ or o licensed pharmad §483.45(b)(1) Pro	ce Consultation. The facility btain the services of a cist who- ovides consultation on all ovision of pharmacy services					
	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and						
	periodically recor	iciled.					00/01/22
	Based on interview facility failed to im and reconcile narcorresidents reviewed ensure medications administered in acc for 1 of 3 residents (Resident D). Findings include: 1. During an interview Resident D indicate medication on 1/22 to wait for a long to times to ask for medication to receive the control of the contr	y, and document review, the aplement a system to monitor of the medications for 1 of 3 for medications, and failed to swere available and cordance with physician orders reviewed medications riew on 1/23/24 at 1:37 p.m., ed, she asked for pain 2/24 around 10:00 a.m. and had time to get it. She called several edications and had to wait for e pain medication. p.m., Licensed Practical Nurse	F 07	755	Facility respectfully requests a desk review for paper complial F 755 Corrective Actions accomplish for those residents found to be affected by the alleged deficit practice: Resident D was not harmed the alleged deficient practice. On 1/23/2024 Resid D's orders were reviewed and verified with NP. 1/24/2024 Facility ensured resident medications were available at Resident D received all control substances per order and documentation was complete facility reordered nystatin pow for delivery to facility for Resid D. An audit was completed for	ent d olled . The	02/21/2024
		4, indicated, if they did not have			Resident D's medications and		
	a medication, they	got it out of the emergency			other medications was found	to be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155484		IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 01/24/2024
	PROVIDER OR SUPPLIEI		2222 N	ADDRESS, CITY, STATE, ZIP COD MARGARET AVE E HAUTE, IN 47802	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	drug kit (EDK). If a	not available in the EDK, they		missing.	
	call the pharmacy and order the medication.			Identification of other residents	
				having the potential to be affect	ted
	On 1/23/24 at 3:45	pm during interview with the		by the same alleged deficient	
	DON. The DON in	dicated if medication was not		practice and corrective action	
	available the nurse	would obtain the medications		taken: All residents with an ord	er
	from the EDK, if m	nedications were not in the EDK		for medications have the poten	tial
	the nurse would no	tify the physician, contact		to be affected. 1/24/2024 the	
	pharmacy, and orde	er medications.		facility conducted an audit to	
				ensure medication were available	ole,
	On 1/23/24 at 3:50	p.m., during phone interview		and documentation was comple	ete.
	with Registered Nu	arse 9, the nurse indicated she		Any medication not found as	
	administered Perco	cet to the resident and signed		available was re-ordered.	
	the medication out on the narcotic record but not			Measures put in place and	
	the medication adn	ninistration record (MAR).		systemic changes made to ens	ure
				the alleged deficient practice do	oes
		w of the medical record of		not recur: The facility educated	all
		ed, diagnosis included but were		licensed staff on the Controlled	
		onic respiratory failure, venous		Substances Policy #8.5 and	
		ndition in which the veins have		Medication Administration polic	у
		blood from the legs back to the		with emphasis on medication	
		creatitis (inflammation of the		availability, re-ordering and	
	1 -	ause swelling, pain, and		documentation. Education was	;
		organ or tissues work), type 2		completed on 1/24/2024.	
		disease that occurs when your		How the corrective measure wi	
	1 -	called blood sugar, is too		monitored to ensure the alleged	
		when nerve damage leads to		deficient practice does not recu	r:
	1 *	mbness or tingling in one or		The DON/ designee will audit	
		body), cellulitis (a common		residents with medication order	
		tion that causes redness,		to ensure orders were available	<i>'</i>
		in the infected area of the skin),		and documentation was comple	ete
	_	rt failure (a condition that		for 5 residents per week for 4	-1-
		r heart doesn't pump enough		weeks, then 3 residents per we	ек
	blood for your body	y s needs).		for 4 weeks, then 1 resident a	
	Dlavaiaia!	in alredad host strong to at 1500 let d		week for 4 months.	
	1 '	included but were not limited		The results of the audit	
		etaminophen 10-325 mg tablet		observation will be reported,	
		up to four times a day as		reviewed and trended for	Pr.
	needed for pain and	d tramadol 100 mg administer	1	compliance thru the facility Qua	lity

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three times a day for chronic pain.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155484	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/24/2024
	PROVIDER OR SUPPLIER		2222 N	ADDRESS, CITY, STATE, ZIP COD IARGARET AVE E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
	had complaints of a cirrhosis of liver, m and thyroid, arthriti risk for complication resident will be able through target date. non-pharmacologic diversion activities, music therapy, relax complete pain assess admission/re-admis change, and as need per orders, monitor side effects, and evaluation. On 1/23/24 at 3:15 administration reconcount record both roof medication admin 1/22/24. The narcott the date and time a bottle or medication was on 1/22/24 at 8 sheet documentation tablets remaining. The December 2023 and administration documentation administration documentation to the date and time a came into the narcotic record on 1 on 1/24/24 at 9:32 document, titled, "Condicated it was the	al interventions (repositioning, snacks and fluids, ice / heat, kation techniques, imagery), sment on sion, quarterly, significant led (PRN), provide medication for signs and symptoms of aluate effectiveness of p.m., review of the medication rd (MAR) and the narcotic records lacked documentation mistration at any time on ic count sheet (which records narcotic is removed from the a card) indicated the last entry 130 a.m. The narcotic count in indicated there were 20 The MAR for the months of all January 2024 lacked mentation several times of se		minimum of six monthly the randomly thereafter for furth recommendation.	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
		155484	B. WING	<u> </u>		01/24/	2024
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD ARGARET AVE		
SOUTHV	VOOD HEALTHCA	RE CENTER		TERRE	HAUTE, IN 47802		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION sified as controlled substances		TAG	DEFICIENCE		DATE
		ement Administration (DEA)					
		al handling, storage, disposal,					
		in the facility in accordance					
	with state and feder	ral laws and regulations					
		eccurate inventory of all					
		ons is maintained at all times.					
		substance is administered, the					
		rsonnel administering the					
		ately enters the following accountability record and the					
		stration record (MAR)a. Date					
		strationb. Amount					
		untability Record)c.					
	·	(Accountability Record)"					
	-	iew on 1/23/24 at 1:37 p.m.,					
		ed, she had gaulding (chafing					
	· ·	ominal folds. She asked the					
		ad apply medication. She asked Aides (CNA) to tell the nurse					
		treatment applied and they					
		ad no nystatin powder. It					
		she did not understand why					
		hey did not use it very much.					
	The resident indicat	ted the treatment to abdominal					
	folds had not been a	administered for several days.					
	On 1/23/24 at 2:04	p.m., observation of treatment					
	· ·	tin powder was not in the					
	-	ng an interview Licensed					
		(N) 6 acknowledged the					
	·	on the cart or the medication					
	cart for the 400/500	halls and the treatment had					
	not been completed						
	During an interview	v, on 1/23/24 at 3:15 p.m., LPN 5					
		nt was almost out of Nystatin					
		She was not able to locate the					
	medication today.						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	
		155484	B. WIN	NG	_	01/24	/2024
	PROVIDER OR SUPPLIER			2222 M	ADDRESS, CITY, STATE, ZIP COD ARGARET AVE HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	wound nurse LPN 8 of the nystatin power a bottle of nystatin phad died. The bottle opened. She indicat nystatin powder and used for a resident. on 1/23/24 for Residual she gave the nurse a powder on 1/15/23. On 1/23/24 at 3:30 g (LPN) 3 and LPN 4 medication, they go kit (EDK). If not averthe pharmacy and of the pharmacy and of the pharmacy and of the pharmacy and order medication were would notify the phand order medication nurse kept spare bot residents. She indicated not limited to: Chrominsufficiency (a comproblems sending beheart), chronic pance pancreas that can calchanges in how an ediabetes mellitus (a blood glucose, also	on 1/23/24 at 3:55 p.m., the 3 indicated the resident was out der, and she gave the resident powder from a resident who awas new and had not been sed she kept bottles of unused di would give it a nurse to be She did not do the treatment dent D. LPN 8 acknowledged an unused bottle of Nystatin p.m., Licensed Practical Nurse indicated if they did not have a set it out of the emergency drug railable in the EDK, they called ordered the medication. To on 1/23/24 at 3:45 p.m., the needication was not available the the medications from the EDK. In not in the EDK the nurse sysician, contact pharmacy, ons. She indicated the wound titles of Nystatin to use for atted the pharmacy sent them To of the medical chart of did diagnosis included but were onic respiratory failure, venous addition in which the veins have lood from the legs back to the creatitis (inflammation of the ause swelling, pain, and organ or tissues work), type 2 disease that occurs when your called blood sugar, is too when nerve damage leads to					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPI	LETED
		155484	B. W	ING		01/24	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ARGARET AVE		
SOUTHV	VOOD HEALTHCAI	RE CENTER			HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	BROWING N. IN OF CORRESSOR		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	A.T.C	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
	pain, weakness, nur	mbness or tingling in one or					
	more parts of your	body), cellulitis (a common					
	bacterial skin infect	tion that causes redness,					
	swelling, and pain i	in the infected area of the skin),					
	_	rt failure (a condition that					
		r heart doesn't pump enough					
	blood for your body	y's needs).					
	Physician's orders i	ncluded but were not limited					
		r apply to abdominal folds and					
		ally every day and evening					
	shift for fungal infe						
	5						
	A care plan, dated	11/7/23, indicated resident had					
	impaired skin integ	rity and was at risk for further					
	altered skin integrit	y. Approaches included but					
	were not limited to	administer medications as					
	ordered, administer	treatments as ordered by the					
	medical provider.						
	A gara plan datad 1	/9/23 indicated, resident					
	_	ASD (moisture associated skin					
	1 ~	folds on back. Approaches					
		not limited to, treatment as					
		dry skin folds daily.					
	Station, wash and	ary chin rotes unity.					
	The MAR and TAF	R (treatment administration					
		ths of December 2023 and					
	· ·	d administration documentation					
	1	treatment administration.					
	On 1/24/24 -+ 0.22	om the DON marrided					
		a.m., the DON provided a					
	document titled, "T	opical Medication ted 08-2020, and indicated it					
		ently being used by the					
		indicated, " Policy					
		inistrationGeneral Procedures					
		or 'borrow' medications from					
		administer medication if the					
	iabei is not legible	or missingeeNarcotics will			I		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155484			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/24/2024					
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2222 MARGARET AVE TERRE HAUTE, IN 47802					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	are refused or withh documentedIV Documentation of r medication adminis medications will fol nursing practice'	givenggmedications that held or not given will be Documentationa. nedication will be current for trationb. Documentation of llow accepted standards of to Complaint IN00421680.						

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