STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155484	A. BUILDING 00 B. WING	06/05/2024

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SOUTHWOOD HEALTHCARE CENTER	2222 MARGARET AVE TERRE HAUTE, IN 47802

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435352 and IN00435829. Complaint IN00435352 - Federal/State deficiencies related to the allegations are cited at F744. Complaint IN00435829 - No deficiencies related to the allegations are cited. Survey dates: June 3, 4, and 5, 2024 Facility number: 000564 Provider number: 155484 AIM number: 100285610 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare: 2 Medicaid: 82 Other: 20 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 13, 2024.	F 0000		
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on record review and interview, the facility failed to supervise, monitor, and initiate	F 0744	We respectively request a desk review, and thank you for your time.	07/05/2024

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

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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	interventions for a dementia resident with a known history of intrusive wandering behaviors, Resident B, which resulted in her being hit by another resident, for 1 of 3 residents reviewed for abuse (Residents B and C). Findings include: An Indiana State Department of Health (ISDH) Survey System report, dated 5/27/24 at 9:40 a.m., submitted by the facility indicated Resident B went into Resident C's room. Resident C made contact with Resident B's right side of her face. Resident B sustained a reddened area on her right temple measuring 2 centimeters (cm) by 3 cm. Resident B was one-on-one observation with staff at the time of the incident and staff had tried to redirect the resident. Resident C was trying to get Resident B out of his personal space with no intent to harm. Resident B was transferred to an inpatient psychiatric facility. The physician, the police department, and responsible parties were notified of the incident. On 6/3/24 at 10:21 a.m., Licensed Practical Nurse (LPN) 7 indicated Resident B had been one-on-one with staff at the time of the incident, on 5/27/24, until she was sent to the psychiatric facility on 5/28/24. Resident B had behaviors of pacing and fighting with staff. Resident C did not normally have any behaviors. He had dementia and sometimes got confused and lost as to where he was. On 6/3/24 at 11:07 a.m., Registered Nurse (RN) 6 indicated, on 5/27/24, Certified Nursing Aide (CNA) 4 notified RN 6 that Resident B had entered Resident C's room and Resident C had slapped Resident B. RN 6 completed skin, pain, and change of condition assessments for both		**F 744** **Corrective Action accomplished for those residents found to be affected by the alleged deficit practice:** Staff immediately intervened and separated residents. Resident B was assessed for injury and skin grid non-pressure was completed. Resident B remained in 1:1 care until transferred to inpatient psych. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents housed on the dementia unit who have intrusive wandering behaviors have the potential to be affected. The facility will complete interviews with those residents and families to identify appropriate interventions to deter behaviors and update care plans and Kardex as needed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The facility will complete in-servicing referencing the Dementia Care Resident Rights and Privileges Policy with emphasis on implementing personalized interventions and updating the plan of care and Kardex. **How the corrective measures will be monitored to ensure the alleged deficient practice does**	

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	residents. Resident B had a red mark, 2 cm by 3 cm, above her temple next to her right eye. RN 6 notified the Director of Nursing (DON), the physician, and the residents' families of the event. On 6/3/24 at 11:15 a.m., the Social Services Director (SSD) indicated Resident B was at an inpatient psychiatric facility, because of a resident-to-resident incident of Resident B's and Resident C's altercation in Resident C's room, where Resident C slapped Resident B. Resident B had been one-on-one with staff for couple of weeks, due to dementia with accelerated mania. Resident C did not normally have behaviors, but Resident B must have gotten in his face to cause him to slap her. On 6/4/24 at 10:45 a.m., CNA 4 indicated she had worked in the memory care unit for about a year and had been one-on-one with Resident B for about a month or two. Resident B had behaviors. She irritated the other memory care residents by taking their food in the memory unit dining room during mealtimes and was very emotional. Resident B would touch other residents and did not understand personal space, especially with the male residents. Resident B would touch their shoulders or stroke their head and did not understand that she should not overstep the boundaries of personal space. On 5/26/24 and 5/27/24, CNA 4 was assigned one-on-one with Resident B from 10:00 p.m. to approximately 10:00 a.m. Resident B and CNA 4 walked the memory care unit hall often and the resident enjoyed snacks. Resident B enjoyed classical music, talking and interacting with the other residents with hands on attention. There was no documentation of the resident's specific interventions, like classical music, but staff had gotten to know the resident and found out that		**not recur:** The DON/ designee will conduct observations and review documentation on the dementia care unit five times a week for four weeks then three times a week for four weeks, then weekly for 4 weeks to ensure residents personalized interventions are implemented when behaviors occur. If corrected action is needed the DON/ Designee will complete 1:1 education immediately. **The results of the audit observation will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for future recommendations.**	

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	she responded to the music, it calmed and relaxed the resident. Resident B had not slept the night of 5/26/24 and was not acting herself, being restless, eating snacks, playing music, and putting her in bed did not work. Resident B was aggressive and combative with CNA 4. CNA 4 kept a safe space between herself and the resident, but close enough to be right with the resident. Resident B was so restless and tired that the mania was overcoming her. We were walking the unit, and the resident was manic, then all of a sudden, Resident B walked into Resident C's room. CNA 4 tried to redirect Resident B to get a snack. Resident B was right in Resident C's face, and he smacked her with an opened hand, not a fist. Resident B was distraught and started to cry. CNA 4 was then able to escort Resident B out of Resident C's room. CNA 4 notified LPN 6 of the incident. Resident B would often dart into the male residents' rooms. Resident B did not understand that she could not go into the other residents' rooms. The staff did not get interventions for the residents who resided on the memory care unit. If a new staff worked the memory unit, the other staff would verbally fill them in on the residents' likes and dislikes. The male residents on the memory unit, did not like Resident B around them, with her constantly touching them and taking their food and drinks. She had been like this for at least a couple of years. CNA 4 indicated once the 5/27/24 event between Resident B and Resident C had happened, the facility assigned the CNA 4 to another unit. The Residents' electronic record told the staff about all the residents' activities of daily living (ADL) and showers. It would be nice to have something that showed the residents' likes, dislikes, and interventions to help care for the residents in the memory care unit. The next day after Resident B was hit by Resident C, she was			

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	sent to the psychiatric facility. Resident B had not slept during the CNA's one-on-one shift with the resident, not even a nap. Resident B was consistently manically running up and down the memory care unit hallway. On 6/4/24 at 11:35 a.m., the Administrator (ADM) indicated, to her knowledge, Resident B had not hit any other residents, just the staff. Resident B's clinical record was reviewed on 6/3/24 at 1:30 p.m. Diagnoses included but were not limited to, Alzheimer's dementia disease (type of dementia that affected memory, thinking, and behavior), schizoaffective disorder (illness characterized by hallucinations, delusions and disintegration of the personality), bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels), and other manic episodes (mood: abnormally upbeat, jumpy, or wired with a heightened, often frenzied emotional state). A quarterly Minimum Data Set (MDS) assessment and a state optional assessment, both assessments, dated 4/18/24, indicated Resident B had a severe cognitive impairment, had rejection of care and wandering behaviors for 4 to 6 days of the 7-day assessment period, was an extensive assistance of one-person for bed mobility, supervision of one-person physical assist for transfers, supervision of one-person physical assist for eating, and was an extensive assistance of two-persons physical assistance for toilet use. A care plan, initiated on 10/7/20 and revised on 12/17/21, indicated Resident B had a mood problem related to the diagnoses of bipolar, mania, schizophrenia, panic disorder, obsessive compulsive disorder, and disease process			

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	dementia with psychosis. Interventions on the care plan included but were not limited to, to assist with the development and provide resident with a program of activities that were meaningful and of interest, snacks, taking walks outside or off unit, one-on-one conversation, date initiated 10/7/20; assist the resident, family, and caregivers to identify strengths, positive coping skills and reinforce these, date initiated 10/7/20 and revised on 3/21/22. The care plan goal target, dated 7/23/24, of the resident will have improved mood state as evidenced by happier and a calmer appearance through the review date. The care plan lacked resident specific person-centered interventions. A care plan, initiated on 10/7/20, indicated the resident had the behavior of she tended to notice failings of others, but did not recognize her own behaviors. She had a history of exhibiting behaviors of being intrusive, seeking out staff, going into other's rooms if she hears talking and assumed others were talking about her, however, did not like when someone else entered her room. The resident did not adjust well to change, worried when not having a roommate, worried when receiving a new roommate until getting used to that person in her environment. The resident would seek attention repeatedly through the day and would become short with others if she did not hear the response she was looking for. She attempted to be helpful, wanted to push wheelchairs or help with someone else's walker but did not want others to help her. The resident needed frequent reassurance, asked to call son multiple times daily. She had a diagnosis of Alzheimer's with very poor short-term recall, with interventions, dated 10/7/20, of staff to observe the resident's whereabouts and redirect to her own room if entering other resident's room,			

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	encourage her to walk slowly up and down hall to relax, offer positive reinforcement and hugs if accepting frequently through shift, suggest walking outdoors when the weather was nice, invite resident to walk with staff when delivering carts back to the kitchen or similar to help the resident feel useful and wanted, offer her the opportunity for helping within activities such as passing out supplies such as paper or songbooks, with the target goal, dated 7/23/24, of the resident will demonstrate happiness with daily routine and will not create emotional distress for herself or others related to intruding on their space through the next review period. The care plan lacked resident specific person-centered interventions. A care plan, initiated on 2/1/22 and revised on 5/13/22, indicated Resident B required a secured unit for behaviors, elopement risk, and poor cognition with interventions included but not limited to, educate the resident and resident's representative of the need for a secured unit to maintain the resident's safety. The target goal, dated 7/23/24, of the resident will exhibit a decrease in behaviors due to the benefits of a secured environment and Resident B would remain without injury related to placement on a secured unit through target date. The care plan lacked resident specific person-centered interventions. A care plan, initiated on 9/26/22 and revised on 6/2/23, indicated the resident had a behavior problem related to dementia diagnosis. The resident would get flirtatious, sit close and attempted to kiss male residents and staff, placing hands and rubbing hand on others, tearfulness, excessive sleeping, sad expression, and negative statements. Interventions on the care plan, included but were not limited to, one-on-one,			

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	dated 4/23/24; engage resident in conversation one-on-one, take a walk outdoors, offer praise for accomplishments, offer a hug if accepting every shift for behaviors, dated 6/2/23, with the goal target, dated 7/23/24, of the resident will have fewer episodes of behaviors through the next review date. The care plan lacked resident specific person-centered interventions. A care plan, initiated on 3/20/23, indicated the resident was at risk for disruption of psychosocial well-being related to a resident to resident incident with care plan interventions, dated 12/27/23, included but not limited to, observe the resident for signs and symptoms of new onset of psychosocial issues and initiated resident specific interventions with the goal target, dated 7/23/24, of the resident would feel safe, comfortable, and well cared for and the resident would report decreased feelings of social isolation by next review date. The care plan lacked resident specific person-centered interventions. A care plan, initiated on 1/11/24, indicated the resident was at risk for impaired psychosocial wellbeing, related to personal health practices, beliefs/values, cultural needs/preferences, and/or linguistic needs/preferences. Interventions on the care plan included, but were not limited to, to approach the provision of care and services for those residents with cultural differences with dignity and respect, honor specific preferences, and promote effective communication between staff and the resident, with the goal target dated 7/23/24. The care plan lacked resident specific person-centered interventions and resident specific preferences. A physician's order, dated 1/11/24, indicated Resident B resided on the memory care unit.			

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A physician's order, dated 1/11/24, indicated to monitor Resident B for behaviors of 1. Accelerated thought and movement, 2. Paranoia, 3. Panic Attack, 4. Aggression, 5. Invaded others personal space. She was a person that liked to touch others for comfort. Non-Pharmacological Interventions were: 1. Reassure with hugs if accepting, 2. Validate her feelings, 3. Suggest she take slow walks up and down the hallway to dissipate energy, 4. Introduce to new residents on the unit to aid with friendships, 5. Staff to intervene and redirect every shift.

A May 2024 Medication Administration Record (MAR) for Resident B, indicated a physician's order, initiated on 1/11/24, indicated staff were to monitor for target behaviors, related to behaviors of accelerated thought and movement, paranoia, panic attack, aggression, and invasion of others' personal space. Resident B liked to touch others for comfort. Non-pharmacological interventions included to reassure Resident B with hugs if accepting, validate the resident's feelings, suggest the resident to take slow walks up and down the hallway to dissipate energy, introduce the resident to new residents on the unit to aid with friendships, and staff to intervene and redirect Resident B every shift. The May 2024 MAR was checked off by staff as completed but lacked documentation of the resident's specific behaviors, interventions implemented, and lacked documentation of efficacy of interventions.

The May 2024, titled, "Documentation Survey Report v2," created on 5/22/24, was provided by the Administrator, on 6/4/24 at 2:24 p.m. The report indicated staff were to document behavior monitoring and interventions every shift and indicated the resident had behaviors on: the day

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	shift (6:00 a.m. to 2:00 p.m.) on May 3, 4, 5, 6, 8, 9, 13, 14, 15, 23, 24, and 27, 2024; the evening shift (2:00 p.m. to 10:00 p.m.) on May 1, 2, 3, 4, 6, 7, 8, 9, 11, 15, 16, 21, 22, 23, and 27, 2024; the night shift (10:00 p.m. to 6:00 a.m.) on May 27, 2024. The report lacked documentation of the interventions implemented and lacked documentation of efficacy of the interventions. A nursing behavior progress note, dated 4/24/24 at 10:25 p.m., indicated Resident B became very agitated this evening and hit the aide who was with her multiple times and attempted several times to hit other residents. The resident was one-on-one staff supervision and staff continued to monitor for behaviors. A nurse practitioner's (NP) progress note, dated 4/25/24 at 1:00 a.m., indicated Resident B was seen by the NP for physical aggression towards the nursing staff. Resident B resided in the memory care unit and had a full-time staff member with her 24/7 (24 hours/7 days a week) for staff and resident safety. The resident had displayed increased nervousness, anxiety and mumbling. She walked and wandered during the waking hours and staff reported during night hours as well. A physician's order, dated 4/29/24, indicated one-on-one staff supervision for every shift. An NP's progress note, dated 4/30/24 at 1:00 a.m., indicated at the time of the assessment Resident B was with her dedicated staff and was anxious but not agitated. She had been physically aggressive and combative with staff. The resident required a dedicated staff to stay with her 24/7 for intense redirection. When told to speak slowly, the resident could answer questions appropriately			

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	and coherently. The resident continued to pace and wander into other resident's rooms but followed commands when instructed to come out of the room. An aggressive behavior was observed today with the resident becoming agitated when staff would not let her go out one of the doors. Resident B grabbed and pulled on the CNA and would not let go of their clothing. Other staff had assisted with getting the resident to let go of the CNA's clothing. A nursing behavior progress note, dated 4/30/24 at 7:52 p.m., indicated Resident B had been very agitated and was hitting, pinching, smacking, and kicking anyone within arm's reach. A nursing behavior progress note, dated 5/1/24 at 4:54 p.m., indicated Resident B had been pacing, scratching, pinching, hitting, and scratching staff that had been near her. The resident was also attempting to make contact with other residents. Resident B was already one-on-one staff supervision. A psychologist report, dated 5/1/24, indicated Resident B was still so manic that she was completely on the go for days until she simply crashed. A nursing behavior progress note, dated 5/2/24 at 1:21 p.m., indicated Resident B had been smacking, kicking, punching, and attempting to pull staffs' hair. Contact was made by the resident several times with staff. A nursing behavior progress note, dated 5/2/24 at 9:57 p.m., indicated Resident B had been smacking, punching, pinching, scratching, and kicking staff. Resident B was one-on-one with staff supervision, continued to be monitored, and			

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	kept away from the other residents due to her attempting to make contact with the other residents. A psychologist report, dated 5/22/24, indicated Resident B continued to struggle with being quite manic. A restorative progress note, dated 5/23/24 at 2:38 p.m., indicated Resident B was receiving active range of motion (AROM) and dressing/grooming in the restorative program. The staff played upbeat music during AROM to try and keep the resident's attention. She was not able to follow any verbal cues due to her confusion. The staff provided maximum assistance. When dressing, Resident B was a two person assist. One staff would cue the resident, while the other staff dressed her. She was not able to follow cues due to her confusion. A nursing progress note, dated 5/24/24 at 3:37 p.m., indicated Resident B had made contact with another resident's walker, when she was exiting her room into the hallway on the memory care unit. The residents were immediately separated. Both received a head-to-toe assessment including pain and skin. Staff were to keep Resident B at arm's length with other residents. The resident's family and the physician were notified. A nursing progress note, dated 5/25/24 at 1:25 p.m., indicated Resident B continued with physical aggression towards staff, but at this time the resident was resting in bed comfortably. She remained with one-on-one staff observation. A nursing progress note, dated 5/27/24 at 10:29 a.m., indicated Resident B had gone into another resident's room in the memory care unit. The other			

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	resident made contact with this resident leaving a mark on the right temple resulting in a 2 cm by 3 cm reddened area. Both residents were immediately separated and received a head-to-toe assessment including skin and pain. Resident B was found to be without pain and the reddened area was fading. Staff continued to monitor the resident for concerns or needs. Resident B remained on one-on-one staff supervision observation. The physician and family were notified. An e-interact summary for providers progress note, dated 5/27/24 at 10:51 a.m., indicated Resident B had a change in condition of behavioral symptoms of agitation and psychosis with nursing observations of the resident was more agitated and anxious than usual and fast pacing up and down the hall and darting in other residents' rooms. The primary care provider feedback with a recommendation of continue to observe the resident and without any new testing orders nor any new interventions orders. A psychologist report, dated 5/28/24, indicated the resident's mania had continued to be pronounced enough and distressing enough that a possible psychiatric facility placement was considered to try and stabilize the resident. A Social Service Director (SSD) progress note, dated 5/28/24 at 10:50 p.m., indicated SSD had spoken with Resident B's family regarding Resident B's increased behaviors and discussed possible inpatient psychiatric stay needed and family agreed. Resident B remained one-on-one observation with staff. An Internal Disciplinary Team (IDT) incident follow up nursing progress note, dated 5/28/24 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING 00 B. WING	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	11:03 a.m., indicated the date of incident and reviewed, on 5/27/24, for a resident-to-resident altercation, when Resident B entered another resident's room. The one-on-one staff supervision was unable to redirect Resident B. The other resident was upset and made contact with Resident B. The root cause of the incident was Resident B was wandering with an intervention put into place, due to the increased wandering, behaviors and invasiveness, of psychiatric services recommended and staff reached out to neuropsychic services for an evaluation of Resident B. The resident's care plan was updated. An SSD progress note, dated 5/28/24 at 1:32 p.m., indicated Resident B was accepted and transported to a psychiatric facility. On 6/4/24 at 10:45 a.m., the Corporate Registered Nurse Consultant (RN) 3, indicated all residents should have resident specific person-centered care plan interventions. RN 3 provided and identified an undated document as a current facility policy titled, "Subject: Dementia Care Resident Rights and Privileges." The policy indicated, "...It is the policy of this facility to provide resident centered care that meets the psychological, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors...II. Assessments...a. Initial and period reviews of the resident will be conducted for the purpose of continued placement on a locked unit, initial placement on a locked unit, medication regime changes and other therapeutic modes of care...c. Individual goals will be addressed on the care plan that meet the needs of the resident for quality of life and quality of care including safety and maximize independence and functioning...."			

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	This citation relates to Complaint IN00435352. 3.1-37			