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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00456945, IN00455170, IN00455371, and IN00456227. Complaint IN00456945 - Federal/state deficiencies related to the allegations are cited at F760. Complaint IN00455170 - Federal/state deficiencies related to the allegations are cited at F880. Complaint IN00455371 - No deficiencies related to the allegations are cited. Complaint IN00456227 - No deficiencies related to the allegations are cited. Survey dates: April 9 and 10, 2025 Facility number: 000564 Provider number: 155484 AIM number: 100285610 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 9 Medicaid: 80 Other: 2 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 17, 2025.	F 0000	/b> ="" b=""> ="" b=""> ="" b="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Preston Meng	RDCO	04/30/2025

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.

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
F 0760 SS=E Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on observation, record review, and interview, the facility failed to ensure medications were administered and documented according to physician orders for administration of insulin for 4 of 4 residents reviewed for medication administration (Residents, D, F, B, and E). Findings include: 1. On 4/9/25 at 10:00 a.m., during an initial observation and interview of Residents D and E. The residents indicated they had received their insulin. They were not sure of times of administration and indicated it was administered at breakfast. On 4/9/25 at 1:40 p.m., observed Licensed Practical Nurse (LPN) 7, at the medication administration cart. The LPN indicated she was not usually late administering insulin. On 4/9/25 at 1:05 p.m. during interview with Resident D. She indicated she received her insulin around 12:30 p.m., She indicated she did not eat breakfast that a.m. but she did receive insulin. She did not know what time it was administered. She indicated she usually got her insulin before she ate but it did vary. On 4/9/25 at 2:10 p.m., during interview with Resident E, the resident indicated she thought her insulin was administered before meals, but she did not know the times it was administered. On 4/10/25 at 7:00 a.m., observed Registered Nurse (RN) 9, administering medications to	F 0760	=”” b=””> =”” b=””> **1 Corrective actions accomplished for those residents founds to be affected by the alleged practice:** Residents D, F, B and E were not found to be harmed by the alleged practice. Education was provided to all nursing staff to ensure insulin is administered and documented according to physician orders. Resident blood glucose levels checked, and no concerns noted. MD notified of findings. **2 Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents with orders for insulin have the potential to be affected. Education was provided to all nursing staff utilizing the Medication Administration policy to ensure insulin is administered and documented according to physician orders. Facility completed an audit on all residents with insulin orders to ensure residents have documentation of timely administration of insulin. There	05/16/2025

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	residents. The employee indicated she had not administered insulin to residents and would administer insulins with their breakfast. On 4/10/25 at 10:40 a.m., the medical record of Resident D was reviewed. The resident was admitted to the facility on 10/9/24. Admitting diagnosis included, but were not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes). A care plan, dated 10/7/20, indicated the resident had diabetes mellitus and was at risk for complications. Interventions included but were not limited to, diabetes medication as ordered by doctor. A Minimum Data Set (MDS) assessment, dated 3/31/25, indicated the resident was cognitively intact and received insulin injections during the look back period. A physician order, dated 3/3/25 and 3/19/25, indicated to administer insulin, Aspart Flex Pen 100 unit/ml solution pen-injector, inject 10 unit subcutaneously (under the skin) before meals for diabetes mellitus. Administration times were 7:30 a.m., 11:30 a.m., and 4:30 p.m. A physician order, dated 3/3/25, indicated to administer insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml (Glargine), inject 30 unit subcutaneously one time a day for diabetes. Administration time was indicated as AM. A physician order, dated 3/19/25, indicated to administer Lantus SoloStar 100 unit/ml Solution		were no other residents harmed by the alleged practice. **3 Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with all nursing staff utilizing the Medication Administration policy with emphasis on ensuring insulin is administered and documented according to physician orders. 4 **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct audits of 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, and then 4 residents per month for 4 months to ensure residents with insulin orders have been administered and documented as ordered. Any discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	pen-injector, inject 30 unit subcutaneously at bedtime for Diabetes Mellitus. Administration time was indicated as HS (hour of sleep). The medical record lacked documentation of administration Lantus insulin on 3/26/25. A physician order, dated 3/21/25 at 10:15 p.m., indicated to administer insulin lispro subcutaneous solution pen injector 100 unit/ml (Insulin Lispro), inject 15 unit subcutaneously STAT (immediately) for hyperglycemia (high blood sugar). The medical record lacked documentation of administration of insulin. A physician order, dated 3/22/25, indicated to administer insulin lispro, injection solution 100 unit/ml (Insulin Lispro) inject subcutaneously before meals and at bedtime for diabetes mellitus as per sliding scale. (Sliding scale insulin is units of insulin that is administered according to the range of the residents blood sugar reading): For blood sugar of 100 - 150 = 0 units; blood sugar of 151 - 200 = 2 units; blood sugar of 201 - 250 = 4 units; blood sugar of 251 - 300 = 6 units; blood sugar of 301 - 350 = 8 units; blood sugar of 351 - 400 = 10 units; and blood sugar of 401 - 999 = 12 units. Administration times were 7:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. From 3/3/25 to 3/11/25, Glargine insulin was scheduled to be administered at 7:00 a.m., the record indicated the insulin was administered at the following times: 3/3/25 - 9:32 a.m. 3/4/25 - 11:48 a.m. 3/6/25 - 9:40 a.m. 3/8/25 - 9:25 a.m. 3/9/25 - 9:38 a.m. 3/10/25 - 9:28 a.m. 3/11/25 - 11:01 a.m.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	From 3/1/25 to 3/31/25, Aspart insulin was to be administered at 7:30 a.m. the MAR indicated the insulin was administered at the following times. 3/4/25 - 11:47 a.m. 3/6/25 - 9:40 a.m. 3/7/25 - 11:13 a.m. 3/8/25 - 9:30 a.m. 3/9/25 - 9:42 a.m. 3/10/25 - 9:24 a.m. 3/11/25 - 10:48 a.m. 3/20/25 - 9:01 a.m. 3/21/25 - 9:32 a.m. 3/22/25 - 10:17 a.m. 3/24/25 - 10:32 a.m. 3/26/25 - 9:38 a.m. 3/29/25 - 11:32 a.m. 3:30/25 - 9:35 a.m. 3/31/25 - 9:39 a.m. From 3/1/25 to 3/31/25, Aspart insulin was to be administered at 11:30 a.m. the MAR indicated the insulin was administered at the following times. 3/8/25 - 2:03 p.m. 3/10/25- 1:50 p.m. 3/20/25 - 1:12 p.m. 3/23/25 - 1:26 p.m. 3/25/25 - 7:10 p.m. 3/26/25 - 2:08 p.m. From 3/1/25 to 3/31/25, Aspart insulin was to be administered at 4:30 p.m., the MAR indicated the insulin was administered at the following times. 3/3/25 - 8:48 p.m. 3/6/25 -10:25 p.m. 3/10/25 - 11:29 p.m. From 3/21/25 to 3/31/25, Aspart insulin was to be administered at 5:30 p.m., the MAR indicated the insulin was administered at the following times.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	3/21/25 - 10:37 p.m. 3/23/25 - 10:21 p.m. 3/24/25 - 9:56 p.m. 3/30/25 - 8:00 p.m. 3/31/25 - 8:21 p.m. On 3/22/25, 3/23/25, 3/24/25, 3/25/25, 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/30/25, 3/32/25 and 4/1/25. Lispro insulin sliding scale, was not documented as administered. From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 7:30 a.m., the MAR indicated the insulin was administered at the following times. 4/3/25 - 10:47 a.m. 4/4/25 - 3:23 p.m. 4/7/25 - 9:24 a.m. 4/9/25 - 9:56 a.m. From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 11:30 a.m., the MAR indicated the insulin was administered at the following times. 4/4/25 - 3:24 p.m. 4/9/25 - 1:44 p.m. From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 4:00 p.m., the MAR indicated the insulin was administered at the following times. 4/7/25 - 7:25 p.m. 4/8/25 - 6:49 p.m. From 4/1/25 to 4/10/25, Aspart insulin was to be administered at 5:30 p.m., the MAR indicated the insulin was administered at the following times. 4/1/25 - 9:53 p.m. 4/7/25 - 7:25 p.m. 4/9/25 - 7:12 p.m. From 4/1/25 to 4/10/25 Lispro insulin was to be administered at 7:00 a.m., the MAR indicated the			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	insulin was administered at the following times. 4/2/25 - 8:42 a.m. 4/3/25 - 10:47 a.m. 4/4/25 - 9:22 a.m. 4/7/25 - 9:24 a.m. 4/9/25 - 9:51 a.m. From 4/1/25 to 4/10/25 Lispro insulin was to be administered at 11:30 a.m., the MAR indicated the insulin was administered at the following times. 4/4/25 - 3:24 p.m. From 4/1/25 to 4/10/25 Lispro insulin was to be administered at 4:00 p.m., the MAR indicated the insulin was administered at the following times. 4/7/25 - 7:25 p.m. 4/8/25 - 6:49 p.m. On 4/10/25 at 7:10 a.m., during an interview RN 8, indicated, if the medication was late being administered the Medication Administration Record (MAR) would indicate it was late. The MAR was green when it was ready to be administered, it turned yellow when it was close to the end of the administration time and red when it was past the administration time. She indicated she documented medications at the time she administered them. On 4/10/25 at 1:05 p.m., during interview the Nurse Consultant indicated the staff did not administer Lispro insulin according to the physician order, dated 3/22/25, from 3/22/25 to 4/1/25. She indicated the order had not been confirmed by the nurse in the medical record and was not entered into the EMAR (electronic medical record) until 4/2/25. She indicated the nurse did administer the STAT order on 3/21/25 however the nurse indicated she did not document the administration of the medication.2. Resident F's record was			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	reviewed on 4/10/25 at 11:00 a.m. The profile indicated the resident's diagnosis included but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when a person with diabetes has persistently high blood sugar levels [hyperglycemia] due to insulin resistance and/or insufficient insulin production). A quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the resident had moderate cognitive deficit and was on insulin injections. A care plan, initiated on 2/2/24 and revised on 2/24/24, indicated the resident had diabetes and was at risk of complications. Interventions included but were not limited to, administer medication per provider's orders and observe for side effects and effectiveness. A physician order, dated 4/17/24, indicated to administer Lispro (insulin medication) subcutaneous (under the skin) solution pen injector 100 unit/ml (milliliter), inject 10 units subcutaneously before meals for type 2 diabetes mellitus at 7:30 a.m., 11:30 a.m., and 4:30 p.m. Review of March 2025 MAR indicated the Lispro insulin medication was documented as administered at the following times: a. On 3/1/25 the 7:30 am. dose was documented as administered at 6:37 p.m. b. On 3/1/25 the 11:30 a.m. dose was documented as administered at 3:11 p.m. c. On 3/1/25 the 4:30 p.m. dose was documented as administered at 9:48 p.m.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	d. On 3/2/25 the 7:30 a.m. dose was documented as administered at 2:07 p.m. e. On 3/2/25 the 11:30 a.m. dose was documented as administered at 2:07 p.m. f. On 3/3/25 the 4:30 p.m. dose was documented as administered at 8:36 p.m. g. On 3/6/25 the 7:30 a.m. dose was documented as administered at 9:23 a.m. h. On 3/6/25 the 4:30 p.m. dose was documented as administered at 9:30 p.m. i. On 3/7/25 the 7:30 a.m. dose was documented as administered at 10:24 a.m. j. On 3/7/25 the 11:30 a.m. dose was documented as administered at 1:18 p.m. k. On 3/8/25 the 11:30 a.m. dose was documented as administered at 1:08 p.m. l. On 3/9/25 the 7:30 a.m. dose was documented as administered at 11:39 a.m. m. On 3/10/25 the 7:30 a.m. dose was documented as administered at 11:29 a.m. n. On 3/10/25 the 4:30 p.m. dose was documented as administered at 11:15 p.m. o. On 3/11/25 the 7:30 a.m. dose was documented as administered at 9:42 a.m. p. On 3/11/25 the 4:30 p.m. dose was documented as administered at 5:58 p.m. q. On 3/12/25 the 7:30 a.m. dose was documented			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	as administered at 9:01 a.m. r. On 3/13/25 the 11:30 a.m. dose was documented as administered at 1:39 p.m. s. On 3/14/25 the 11:30 a.m. dose was documented as administered at 1:16 p.m. t. On 3/14/25 the 4:30 p.m. dose was documented as administered at 7:47 p.m. u. On 3/25/25 the 11:30 a.m. dose was documented as administered on 3/17/25 at 5:20 p.m. v. On 3/15/25 the 4:30 p.m. dose was documented as administered at 9:10 p.m. w. On 3/16/25 the 7:30 a.m. dose was documented as administered at 9:14 a.m. x. On 3/16/25 the 4:30 p.m. dose was documented as administered at 7:20 p.m. y. On 3/17/25 the 4:30 p.m. dose was documented as administered at 7:08 p.m. z. On 3/18/25 the 4:30 p.m. dose was documented as administered at 9:33 a.m. aa. On 3/19/25 the 7:30 a.m. dose was documented as administered at 9:22 a.m. bb. On 3/21/25 the 7:30 a.m. dose was documented as administered at 9:15 a.m. cc. On 3/21/25 the 4:30 p.m. dose was documented as administered at 10:53 p.m. dd. On 3/23/25 the 11:30 a.m. dose was documented as administered at 1:23 p.m.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	ee. On 3/24/25 the 7:30 a.m. dose was documented as administered at 10:25 a.m. ff. On 3/24/25 the 11:30 a.m. dose was documented as administered at 12:50 p.m. gg. On 3/24/25 the 4:30 p.m. dose was documented as administered at 9:50 p.m. hh. On 3/25/25 the 11:30 a.m. dose was documented as administered at 4:41 p.m. ii. On 3/25/25 the 4:30 p.m. dose was documented as administered at 6:12 p.m. jj. On 3/26/25 the 7:30 a.m. dose was documented as administered at 3:42 p.m. kk. On 3/26/25 the 11:30 a.m. dose was documented as administered at 3:43 p.m. ll. On 3/26/25 the 4:30 p.m. dose was documented as administered on 3/27/25 at 9:49 a.m. mm. On 3/27/25 the 7:30 a.m. dose was documented as administered at 9:17 a.m. nn. On 3/28/25 the 11:30 a.m. dose was documented as administered at 1:04 p.m. oo. On 3/29/25 the 4:30 p.m. dose was documented as administered at 6:16 p.m. pp. On 3/30/25 the 7:30 a.m. dose was documented as administered at 9:26 a.m. qq. On 3/31/25 the 4:30 p.m. dose was documented as administered at 8:13 p.m.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	A physician order, dated 4/16/24, indicated to administer Glargine (insulin medication) solution pen injector 100unit/ml, inject 30 units subcutaneously in the evening for diabetes at 9:00 p.m. Review of March 2025 MAR indicated the Glargine insulin medication was documented as administered at the following times: a. On 3/2/25 the 9:00 p.m. dose was documented as administered on 3/12/25 at 2:05 p.m. b. On 3/10/25 the 9:00 p.m. dose was documented as administered at 11:15 p.m. c. On 3/16/25 the 9:00 p.m. dose was documented as administered on 3/17/25 at 7:21 p.m. d. On 3/17/25 the 9:00 p.m. dose was documented as administered on 3/18/25 at 10:16 a.m. e. On 3/21/25 the 9:00 p.m. dose was documented as administered at 10:53 p.m. Review of April 2025 MAR indicated the Lispro insulin medication was documented as administered at the following times: a. On 4/1/25 the 4:30 p.m. dose was documented as administered at 9:47 p.m. b. On 4/3/25 the 7:30 a.m. dose was documented as administered at 10:58 a.m. c. On 4/6/25 the 11:30 a.m. dose was documented as administered at 1:20 p.m. d. On 4/9/25 the 7:30 a.m. dose was documented as administered at 10:10 a.m.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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. On 4/9/25 the 11:30 a.m. dose was documented as administered at 12:57 p.m.

During an interview, on 4/10/25 at 11:41 a.m., Resident F indicated she sometimes received her insulin before meals and sometimes it was much later. She indicated the insulin administration times were all over the place.

3. During an interview on 4/9/25 at 11:20 a.m., Resident B indicated it was always a 50/50 shot whether he received his insulin (a hormone produced by the pancreas that helps regulate blood sugar levels) injections on time. On this date he had just received his 8:00 a.m. injection just prior to the beginning of the interview.

Resident B's record was reviewed on 4/9/25 at 10:51 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (a chronic condition that happens when a person has persistently high blood sugar levels).

An admission Minimum Data Set (MDS) assessment, dated 3/12/25, indicated the resident had no cognitive deficit, no documented behaviors for rejection of care, and received insulin injections.

The resident's care plans lacked documentation of the resident having care plans related to his diagnosis of diabetes or that he received insulin injections.

A physician's order, dated 3/6/25, indicated to administer insulin Lispro (a rapid-acting insulin used to lower blood sugar levels in people with diabetes) injection solution 100 units/milliliter (ml), subcutaneously (below the skin) before meals and

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	at bedtime, (at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.) for diabetes, per the following sliding scale: if blood sugar of 151 - 199 = 2 units; blood sugar of 200 - 249 = 4 units; blood sugar of 250 - 299 = 6 units; blood sugar of 300 - 349 = 8 units; blood sugar of 350 - 399 = 10 units; blood sugar of 400 - 449 = 12 units; blood sugar of 450 - 499 = 14 units; blood sugar of 500 - 549 = 16 units; blood sugar of 550 - 599 = 18 units. If blood sugar was greater than 599 call the physician. Review of the March 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates: a. The 8:00 a.m., dose was documented as administered late on, 3/7/25, 3/8/25, 3/9/25, 3/11/25, 3/14/25, 3/16/25, 3/18/25, 3/21/25, 3/22/25, 3/24/25, 3/26/25, 3/29/25, 3/30/25, and 3/31/25. b. The 11:00 a.m., dose was documented as administered late on, 3/7/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, 3/15/25, 3/17/25, 3/18/25. 3/19/25, 3/20/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/25/25, 3/26/25, 3/28/25, 3/30/25, and 3/31/25. c. The 4:00 p.m., dose was documented as administered late on, 3/6/25, 3/7/25, 3/8/25, 3/10/25, 3/11/25, 3/12/25, 3/13/25, 3/15/25, 3/16/25, 3/17/25, 3/18/25, 3/19/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/25/25, 3/28/25, 3/29/25, 3/30/25, and 3/31/25. d. The 9:00 p.m., dose was documented as administered late on, 3/6/25, 3/10/25, 3/16/25, 3/17/25, 3/20/25, 3/21/25, 3/23/25, and 3/2/5/25. Review of the April 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	following dates: a. The 8:00 a.m., dose was documented as administered late on, 4/1/25, 4/4/25, 4/7/25, and 4/9/25. b. The 11:00 a.m., dose was documented as administered late on, 4/2/25, 4/4/25, 4/7/25, and 4/9/25. c. The 4:00 p.m., dose was documented as administered late on, 4/1/25, 4/2/25, 4/6/25, 4/7/25, 4/8/25, and 4/9/25. d. The 9:00 p.m., dose was documented as administered late on, 4/2/25, 4/4/25, 4/5/25, and 4/6/25. A physician's order, dated 3/6/25, indicated to administer 35 units of insulin Glargine (a synthetic version of human insulin) subcutaneous solution 100 units/ml, two times daily for diabetes, at 7:00 a.m., and 9:00 p.m. Review of the March 2025 Medication Administration Audit Report, the resident's Glargine administrations had been administered late on the following dates: a. The 9:00 p.m., dose was documented as administered late on, 3/10/25, 3/16/25, 3/17/25, and 3/20/25. Review of the April 2025 Medication Administration Audit Report, the resident's Glagine administrations had been administered late on the following dates: a. The 7:00 a.m., dose was documented as administered late on, 4/18/25, 4/26/25, and 4/29/25.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	b. The 9:00 p.m., dose was documented as administered late on, 4/10/25, 4/16/25, 4/17/25, and 4/20/25. 4. Resident E's record was reviewed on 4/10/25 at 8:53 a.m. The profile indicated the resident diagnoses included, but were not limited to, type 2 diabetes with diabetic chronic kidney disease (a chronic condition that happens when a persons high blood sugar levels damage the kidneys so that they cannot filter blood effectively). A quarterly Minimum Data Set (MDS) assessment, dated 3/28/25, indicated the resident had no cognitive deficit, no documented behaviors of refusals of medications, and the resident received insulin injections. A care plan, revised on 3/20/22, indicated the resident had a potential for complications related to her diagnoses of diabetes. Interventions included, but were not limited to, administer diabetes medication as ordered by the doctor. A physician's order, dated 11/4/24, indicated to administer 50 units of Lantus solution (a a long-acting man-made-insulin used to control high blood sugar in adults) 100 units/ml, subcutaneously two times a day for diabetes, at 8:00 a.m., and 8:00 p.m. Review of the March 2025 Medication Administration Audit Report, the resident's Lantus administrations had been administered late on the following dates: a. The 8:00 a.m., dose was documented as administered late on, 3/2/25, 3/3/25, 3/4/25, 3/6/25, 3/13/25, 3/14/25, 3/16/25, 3/18/25, 3/21/25. 3/22/25,			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	3/24/25, 3/26/25, 3/29/25, 3/30/25, and 3/31/25. b. The 8:00 p.m., dose was documented as administered late on, 3/1/25, 3/4/25, 3/5/25, 3/6/25, 3/8/25, 3/10/25, 3/12/25, 3/13/25, 3/16/25, 3/19/25, 3/20/25, 3/21/25, 3/23/25, 3/24/25, and 3/25/25. Review of the April 2025 Medication Administration Audit Report, the resident's Lantus administrations had been administered late on the following dates: a. The 8:00 a.m., dose was documented as administered late on, 4/3/25, 4/4/25, 4/7/25, 4/9/25, and 4/10/25. b. The 8:00 p.m., dose was documented as administered late on, 4/1/25 and 4/5/25. A physician's order, dated 11/21/24, indicated to administer insulin Lispro (a rapid-acting insulin used to lower blood sugar levels in people with diabetes) solution Pen-injector (an injection device used to deliver preloaded insulin into the subcutaneous [under the skin] tissue) 100 units/milliliter (ml). Inject 22 unit subcutaneously before meals for diabetes, at 7:30 a.m., 11:30 a.m., and 4:30 p.m. Review of the March 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates: a. The 7:30 a.m., dose was documented as administered late on, 3/1/25, 3/2/25, 3/3/25, 3/4/25, 3/5/25, 3/6/25, 3/9/25, 3/13/25, 3/14/25, 3/16/25, 3/17/25, 3/18/25, 3/19/25, 3/20/25, 3/21/25, 3/22/25, 3/24/25, 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/30/25, and 3/31/25.			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	b. The 11:30 a.m., dose was documented as administered late on, 3/2/25, 3/6/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, 3/15/25, 3/19/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/26/25, 3/30/25, and 3/31/25. c. The 4:30 p.m., dose was documented as administered late on, 3/1/25, 3/3/25, 3/4/25, 3/6/25, 3/8/25, 3/10/25, 3/11/25, 3/12/25, 3/13/25, 3/14/25, 3/15/25, 3/16/25, 3/18/25, 3/21/25, 3/22/25, 3/23/25, 3/24/25, 3/29/25, 3/30/25, and 3/31/25. Review of the April 2025 Medication Administration Audit Report, the resident's Lispro administrations had been administered late on the following dates: a. The 7:30 a.m., dose was documented as administered late on, 4/2/25, 4/3/25, 4/4/25, 4/7/25, 4/8/25, 4/9/25, and 4/10/25. b. The 11:30 a.m., dose was documented as administered late on, 4/3/25, 4/4/25, 4/7/25, and 4/9/25. c. The 4:30 p.m., dose was documented as administered late on, 4/1/25, 4/8/25, and 4/9/25. During an interview, on 4/9/25 at 1:40 p.m., Licensed Practical Nurse (LPN) 7 indicated she was late administering insulin to residents because she was administering insulin to residents on three different halls and was completely overwhelmed. During interview, on 4/10/25 at 7:10 a.m., Registered Nurse (RN) 8 indicated she would document medications at the time she administered them. If the medication was			

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	scheduled for morning or bedtime she would administer the medication within two hours. If a medication was scheduled for a specific time she would give it according to the scheduled administration time. During interview, on 4/10/25 at 7:30 a.m., LPN 7 indicated she administered medications according to the administration times. If she was late documenting the administration of a medication, she would change the administration time to the actual time she administered the medication. On 4/10/25 at 9:00 a.m., the Regional Nurse Consultant provide a document, dated 2013, titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated , "...Procedure: I. General Procedures: 1 a. Administer medications only as prescribed by the provider...f. Observe the "five rights" in giving medication: ...ii. the right time...ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered...IV. Documentation: a. Documentation of medication will be current for medication administration. b. Documentation of medication will follow accepted standards of nursing practice...." This citation relates to Complaint IN00456945. 3.1-48(c)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions were followed during a dressing change for 1 of 3 residents reviewed for	F 0880	**1 Corrective actions accomplished for those residents founds to be affected by the alleged practice:**	05/16/2025

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	pressure ulcers (Resident G). Findings include: During a continuous observation, on 4/10/25 from 9:56 a.m. to 10:16 a.m., the following was observed. Licensed Practical Nurse (LPN) 7 performed hand hygiene, donned gloves and a gown, and completed the dressing change to Resident G's sacrum (bone at the base of the spine). Near the end of the sacrum dressing change, Certified Nurse Aide (CNA) 11 entered the room to assist LPN 7. CNA 11 did not perform hand hygiene after entering the room. CNA 11 donned gloves but did not put on a gown. CNA 11 held up Resident G's left heel so LPN 7 could complete the dressing change to that area. CNA 11 removed the dressing from Resident G's left heel and continued to hold up the resident's leg. CNA 11 did not perform hand hygiene or change gloves after she removed the resident's dressing. On 4/10/25 at 10:16 a.m., the continuous observation was completed. At the same time, LPN 7 indicated CNA 11 should have performed hand hygiene before she put on her gloves. CNA 11 should have worn a gown and should not have removed the dressing from Resident G's heel. Resident G required enhanced barrier precautions (strategic use of gown and gloves during high-contact resident care activities) during his wound care. Resident G's record was reviewed on 4/9/25 at 2:33 p.m. Diagnoses on the resident's profile included, but were not limited to, stage four (deep wound that extends into all underlying tissues such as muscles, tendons, and bones) pressure ulcer (local injury to the skin and underlying tissues caused by prolonged pressure) of the sacral		Resident G was found to be potentially affected by the alleged practice. Education was provided to all nursing staff regarding use of Enhanced Barrier Precautions with wound care and donning/doffing of the PPE appropriately. Resident assessed for any signs of infection or discomfort related to alleged deficient practice, and no concerns noted. MD notified of findings. **2 Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents with wounds and orders for Enhanced Barrier Precautions have the potential to be affected. Education was provided to all nursing staff regarding use of Enhanced Barrier Precautions with wound care and donning/doffing of the PPE appropriately. Facility completed an audit on all residents with wounds to ensure residents have appropriate Enhanced Barrier Precautions orders and door signage. There were no other residents found to be affected by the alleged practice. **3 Measures put in place and**	

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	region. A quarterly Minimum Data Set (MDS) assessment, dated 3/10/25, indicated the resident was cognitively intact and required pressure ulcer care. A physician's order, dated 1/7/25, indicated the resident required enhanced barrier precautions related to wounds. A physician's order, dated 3/24/25, indicated to cleanse the resident's left heel wound with wound cleanser, pat dry with gauze, apply skin prep (skin barrier) around the wound, apply collagen (promotes wound healing) to the wound bed, and cover with bordered gauze daily. A physician's order, dated 4/7/25, indicated to cleanse the resident's sacrum wound with wound cleanser, pat dry with gauze apply skin prep around the wound, apply Hydrofera Blue (absorbent foam wound dressing) to wound bed, cover with an abdominal (ABD) pad (dressing that manages moderately draining wounds), and secure with tape daily. On 4/10/25 at 11:30 a.m., the Nurse Consultant provided an undated document titled, "Skin Care & Wound Management Overview," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy...Skin care and wound management program includes, but is not limited to...Application of treatment protocols based on clinical 'best practice' standards for promoting wound healing...." On 4/10/25 at 11:30 a.m., the Nurse Consultant provided an undated document titled, "Enhanced Barrier Precautions," and indicated it was the		**systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with all nursing staff regarding use of Enhanced Barrier Precautions with wound care and donning/doffing of the PPE appropriately. 4 **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct visual audits of 5 staff per week for 4 weeks, then 3 staff per week for 4 weeks, and then 4 staff per month for 4 months to ensure staff caring for residents with wounds and Enhanced Barrier Precautions are donning and doffing PPE appropriately in care of these residents. Any discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 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
	policy currently being used by the facility. The policy indicated, "...Definitions...PPE [personal protective equipment] required-gowns and gloves...Policy: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include...Wound care: any skin opening requiring a dressing...EBP are indicated for residents with any of the following...Wounds...even if the resident is not know to be infected or colonized with a MDRO [multi-drug resistant organisms]...." During an interview, on 4/10/25 at 11:38 a.m., the Nurse Consultant indicated there was no specific facility policy for dressing changes. She indicated she provided the applicable policies. This citation relates to Complaint IN00455170. 3.1-18(b)(1)			