| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155484 | A. BUILDING 00<br>B. WING | 05/01/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SOUTHWOOD HEALTHCARE CENTER | 2222 MARGARET AVE<br>TERRE HAUTE, IN 47802 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00407302. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy.<br><br>Complaint IN00407302 - Federal/State deficiencies related to the allegations are cited at F689, F656, and F657.<br><br>Survey dates: April 27, 28, 29, and May 1, 2023.<br><br>Facility number: 000564<br>Provider number: 155484<br>AIM number: 100285610<br><br>Census Bed Type:<br>SNF/NF: 108<br>Total: 108<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 87<br>Other: 16<br>Total: 108<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on May 11, 2023. | F 0000 | | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jennifer Hamilton | Director of Nursing | 05/25/2023 |

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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| | and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the | | | |

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| | comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>Based on interview and record review, the facility failed to ensure a comprehensive plan of care was created for a resident (Resident B), who had a history of mental illness, to ensure appropriate supervision, monitoring and interventions were in place to prevent the potential for accidents for 1 of 4 residents reviewed for comprehensive care plans.<br><br>Findings include:<br><br>On 4/27/23 at 11:25 a.m., Resident B's medical record was reviewed. Upon her admission in April of 2022, she had diagnoses which included, but were not limited to, type II diabetes (a blood sugar disorder) with neuropathy (numbness, tingling and/or pain in the extremities and hyperglycemia (high blood sugar), other stimulant abuse, severe and reoccurring major depressive disorder.<br><br>A Pre-Admission Screen and Resident Review (PASRR), dated 12/5/22, indicated Resident B was considered mentally ill and met PASRR criteria with the diagnoses of bipolar disorder and schizophrenia.<br><br>An initial Psychiatrist evaluation and assessment, dated 2/115/23 indicated, " ...mood variability is present ... having problems with a literal host of medical, psychiatric, and substance abuse issues ... Diagnosis: Poly-substance abuse and Bipolar Disorder Type I, mixed ...."<br><br>During an interview on 4/27/23 at 10:05 a.m., the Activity Director (AD), indicated Resident B was engaged with activities, especially the ones she liked. That was how she was, independent and did | F 0656 | F656<br>**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** *Resident B no longer resides at this facility*.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** *Other residents that were identified as having a history of mental illness care plans were reviewed and diagnosis and interventions for monitoring and supervision were added as needed.*<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** *Education was provided to all nursing staff and social services using The Plan of Care Overview Policy with emphasis on history of mental illness and updating interventions for monitoring and supervision.*<br>**How the corrective action will be monitored to ensure the deficient practice will not recur**: *The DON/designee will conduct audits of 5 resident's per week to ensure care plans are up to date with any mental illness* | 06/02/2023 |

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| | what she wanted to do, when she wanted to do it.<br><br>During an interview on 4/27/23 at 1:00 p.m., Unit Manager, (UM) 16 indicated Resident B was pleasant and outgoing, even after her stroke, but she would need constant reminders to use her walker or wheelchair. She was impulsive and would basically just do what she wanted to do.<br><br>During an interview on 4/27/23 at 2:16 p.m., with the Director of Nursing (DON) and Schedular present, the Scheduler indicated Resident B had behaviors such as not being compliant with her care, and she was going to do what she wanted to do.<br><br>During an interview on 4/28/23 at 12:01 p.m., the facility's attending Psychiatrist indicated he knew of Resident B from a previous stay in another nursing home and found her to be unreceptive to psychiatric care, "she was not very open." After Resident B admitted to the current facility, he saw her twice before she left. An initial face-to-face visit and assessment was conducted on 2/15/23 and he determined psychiatric services were needed due to her bipolar disorder and polysubstance abuse. In his opinion and professional judgement, Resident B needed a mood-stabilizing medication, "in the worst way," but Resident B was unaccepting of his recommendation. When asked if Resident B exhibited behaviors related to her bipolar disorder he indicated, "Constantly! She had no impulse control; her mood swings were erratic. She was going to do something stupid." When asked if her behaviors were problematic enough to require increased supervision and medical management, he indicated, "of course she needs more supervision that's why she's there, she's a mess." When asked if Resident B would be considered | | *diagnosis, interventions and monitoring. Any discrepancies will be immediately corrected and reeducation will be provided as needed.*<br>*The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.* | |

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| | cognitively impaired, he indicated, it was difficult to determine as a comprehensive cognitive exam of her baseline status due to her refusal to answer questions and non-compliance with a medication regimen. He indicated the notes he documented for her were rather short and general due to the fact she was unreceptive to the service.<br><br>The record lacked documentation that bipolar disorder had been added as a diagnosis, and therefore, no comprehensive care plan had been created for her diagnosis of bipolar disorder.<br><br>The record lacked documentation that her history of schizophrenia had been recognized, and therefore, no comprehensive care plan had been created.<br><br>The record lacked documentation of her impulsive behaviors, and therefore lacked a comprehensive plan of care.<br><br>During an interview on 4/28/23 at 2:52 p.m., with the Administrator (ADM) and Vice President of Risk Management and Performance Improvement, (VP, RM-PI), the ADM indicated, when Resident B could not be located on 3/30/23 the police were not immediately contacted because it was normal for her to forget to sign out, she was impulsive and did what she wanted to do.<br><br>The VP, RM-PI, indicated, when new diagnoses were added from the psychiatrist, it would need to be discussed with the Social Service Director who would initiate a plan of care.<br><br>On 4/27/23 at 2:04 p.m., the RDCO provided a copy of current, but undated, facility policy titled, "Resident Rights." The policy indicated, " ...It is the policy of this facility to provide resident | | | |

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| | centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care ...."<br><br>This Federal tag related to Compliant IN00407302.<br><br>3.1-35(a) | | | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | | | |

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| | Based on interview and record review, the facility failed to ensure comprehensive care plans were revised in a timely manner for a resident (Resident B), who had a history of mental illness, to ensure appropriate supervision, monitoring and interventions were in place and updated as needed, to prevent the potential for accidents for 1 of 4 residents reviewed for comprehensive care plans.<br><br>Findings include:<br><br>On 4/27/23 at 11:25 a.m., Resident B's medical record was reviewed. Upon her admission in April of 2022, she had diagnoses which included, but were not limited to, type II diabetes (a blood sugar disorder) with neuropathy (numbness, tingling and/or pain in the extremities and hyperglycemia (high blood sugar), other stimulant abuse, severe and reoccurring major depressive disorder.<br><br>Although Resident B had a care plan, initiated 1/3/23 which addressed her use of an antidepressant medication, however, lacked person-centered documentation of her formal diagnosis of her severe and recurrent major depressive disorder. The care plan included an intervention to monitor for the side effects of the medication, but was not revised to include person-centered interventions to observe for increased signs or symptoms of depression and/or what that looked like for Resident B.<br><br>Resident B had a care plan, initiated 1/3/23 which addressed her use of an antipsychotic medication, however, lacked person-centered documentation of her formal diagnosis, an/or description of her history of bipolar disorder and schizophrenia. The care plan included an intervention to monitor for the side effects of the medication, but was not | F 0657 | **F657**<br>**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** *Resident B no long resides at the facility.*<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** *Other residents that were identified as having a history of mental illness care plans were reviewed and diagnosis and interventions for monitoring and supervision were added as needed.*<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** *Education was provided to all nursing staff and social services using The Plan of Care Overview Policy with emphasis on updating history of mental illness and updating interventions for monitoring and supervision.*<br>**How the corrective action will be monitored to ensure the deficient practice will not recur:** *The DON/designee will conduct audits of 5 resident's per week to ensure care plans are up to date with any mental illness diagnosis, interventions and monitoring. Any discrepancies will be immediately corrected and* | 06/02/2023 |

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| | revised to include person-centered interventions to observe for increased signs or symptoms of bipolar and schizophrenia and what that looked like for Resident B.<br><br>Resident B had a care plan, initiated, 1/3/23 which indicated, Resident B was at risk for complications due to her noncompliance with care regarding medications, treatments and ADLs (activities of daily living). An intervention added on 1/30/23 indicated, Resident B remained on 1:1 supervision.<br><br>Resident B had a care plan initiated, 1/20/23 which indicated, Resident B exhibited substance abuse behavior. An intervention added on 1/20/23 indicated, Resident B was on 1:1 supervision.<br><br>A corresponding nursing progress note, dated 2/6/23 at 4:23 p.m., indicated, Resident B was removed from one on one (1:1) supervision, but was educated on, "no visitors allowed in room."<br><br>The care plan lacked revision that 1:1 supervision had been completed and education was provided for not allowing visitors in her room.<br><br>A Pre-Admission Screen and Resident Review (PASRR), dated 12/5/22, indicated Resident B was considered mentally ill and met PASRR criteria with the diagnoses of bipolar disorder and schizophrenia.<br><br>A comprehensive care plan for Resident B's PASRR qualification was not added until 3/1/23, further, the care plan lacked revision to include her person-centered diagnosis of bipolar disorder and schizophrenia.<br><br>Resident B had a care plan initiated on 1/3/23 which indicated she used nicotine products and | | *reeducation will be provided as needed.*<br>*The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.* | |

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| | understood the facility's smoking policy. A goal for this plan of care indicated, she would be able to go outdoors to smoke with staff supervision. The goal was resolved on 3/22/23 but was the care plan was not revised to specify is she was appropriate to continue smoking independently. Further, an intervention for the plan of care indicated, staff needed to accompany Resident B to smoke at all times, which was also resolved on 3/22/23, but was note revised to specify her appropriate smoking status.<br><br>During an interview on 4/28/23 at 2:52 p.m., the Vice President of Risk Management and Performance Improvement, (VP, RM-PI), indicated, resident's diagnoses should be care planned through social services as needed.<br><br>On 4/27/23 at 2:04 p.m., the RDCO provided a copy of current, but undated, facility policy titled, "Resident Rights." The policy indicated, " ...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care ...."<br><br>This Federal tag related to Compliant IN00407302.<br><br>3.1-35(d)(2)(B) | | | |