STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155484	A. BUILDING -- B. WING	11/08/2023

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 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/08/23 Facility Number: 000564 Provider Number: 155484 AIM Number: 100285610 At this Emergency Preparedness survey, Southwood Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 121 certified beds. At the time of the survey, the census was 97. Quality Review completed on 11/09/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/08/23 Facility Number: 000564 Provider Number: 155484 AIM Number: 100285610 At this Life Safety Code survey, Southwood	K 0000		

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

Brenda Hatfield | Administrator | 11/15/2023

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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	Healthcare Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridors. The Reflections and southwest section of 2B have hard wired smoke detectors in resident rooms. All other resident rooms were equipped with battery powered smoke alarms. The facility has a capacity of 121 and had a census of 97 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/09/23			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, record review and interview, the facility failed to ensure 2 of 2 sprinkler system gauges on the front lobby sprinkler system riser were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 11/08/23 between 12:20 p.m. and 1:35 p.m. during a tour of the facility with the Maintenance Director, the facility has a supervised dry sprinkler system and had two pressure gauges. The manufacture date of 2018 was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observation, the Maintenance Director confirmed the sprinkler system gauges had not been recalibrated within the most recent five year period and would have the gauges replaced as soon as possible. Based on record review on 11/08/23 from 9:50 a.m. to 12:20 p.m., the fourth quarter sprinkler inspection was conducted on 10/03/23.	K 0353	Facility respectfully request a desk review for paper compliance. There were no residents or staff affected by this deficient practice. All residents and staff have the potential to be affected. In order for the facility to ensure the sprinkler gauges are maintained in a safe operating condition, the facility has contracted with SafeCare to provide these services. SafeCare replaced the 2 gauges on 11-15-2023. Any issues will be addressed and reported to the Executive Director. Monthly report will be provided to the Executive Director for review in QAPI monthly meeting for 3 months of continued compliance. Director of Maintenance will ensure continued compliance while conducting rounds throughout the areas of the facility. To ensure continued compliance, the gauges shall be replaced every 5 years or tested every 5 years by comparison will a calibrated gauge. Gauges not accurate to within 3 percent of the	11/15/2023

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		full scale shall be recalibrated or replaced. Director of Maintenance Services is responsible for continued compliance. Date of compliance is 11-15-2023.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of over 50 resident room corridor doors contain decorations that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is	K 0753	Facility respectfully request a desk review for paper compliance. There were no residents or staff affected by this deficient practice. All residents and staff have the potential to be affected.	11/15/2023

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	applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect over 20 residents and staff in one smoke compartment. Findings include: Based on observation with the Maintenance		Photos and paper decoration of the corridor of resident room 513 were removed on 11-09-2023. Remaining doors have been verified that there were no other issues of concerns. Director of Maintenance and facility managers will ensure continued compliance while conducting daily rounds throughout the facility. Any issues will be reported to the Executive Director. Monthly report will be provided to the Executive Director for review in QAPI monthly meeting for a minimum of 3 months or until continued compliance has occurred. Director of Maintenance Services is responsible for continued compliance. Date of compliance is 11-15-2023.	

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	Director on 11/08/23 at 12:38 p.m., the corridor door of resident room 513 had photos and paper decorations that covered over 80% of the door. Based on interview at the time of the observation, the Maintenance Director agreed the corridor door was covered with combustible decorations and stated it was over 80% covered. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			