PRINTED: 02/24/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPI	LETED	
		155484	B. WING 01/		01/10	0/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	ER			MARGARET AVE		
SOUTHV	VOOD HEALTHCA	ARE CENTER			E HAUTE, IN 47802		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00			F 04	200			
		the Investigation of Complaints 0395999, and IN00398056.	F 00	)00			
	Complaint IN0039 lack of evidence.	93397 - Unsubstantiated due to					
	Complaint IN0039 lack of evidence.	95999 - Unsubstantiated due to					
	Complaint IN0039	98056 - Substantiated.					
		ciencies related to the					
	allegations are cite						
		au 1 000.					
	Survey dates: Jan	uary 09 and 10, 2023					
	Facility number: 0	000564					
	Provider number:						
	AIM number: 100	285610					
	Census Bed Type:						
	SNF/NF: 109						
	Total: 109						
	Census Payor Typ	e:					
	Medicare: 05						
	Medicaid: 86						
	Other: 18						
	Total: 109						
	This deficiency reaccordance with 4	flects State Findings cited in 10 IAC 16.2-3.1.					
	Quality review con	mpleted January 19, 2023.					
F 0686	483.25(b)(1)(i)(ii)	)					

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

Treatment/Svcs to Prevent/Heal Pressure

TITLE (X6) DATE

Brenda Hatfield Administrator 02/06/2023

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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Ulcer

SS=E

Bldg. 00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155484		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  01/10/2023		
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD HEALTHCARE CENTER			2222 M	ADDRESS, CITY, STATE, ZIP COD MARGARET AVE E HAUTE, IN 47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(b) Skin In §483.25(b) (1) Pre Based on the coma resident, the fact (i) A resident receprofessional stand pressure ulcers and pressure ulcers and pressure ulcers and condition demons unavoidable; and (ii) A resident with necessary treatment with professional promote healing, new ulcers from desident and promote healing, new ulcers from desident and promote healing of the promote h	ntegrity essure ulcers. Inprehensive assessment of cility must ensure that- ives care, consistent with dards of practice, to prevent and does not develop nless the individual's clinical trates that they were  In pressure ulcers receives ent and services, consistent estandards of practice, to prevent infection and prevent developing. In pressure ulcers receives ent and services, consistent estandards of practice, to prevent infection and prevent developing. In pressure ulcers receives developing. In pressure devices, and ty failed to ensure pressure developing of treatment and services to pressure ulcers. (Residents D,  ical records were reviewed on the 11:10 a.m. Diagnoses included, deto anemia, hypertension, affection, aphasia, asthma, and	F 0686	Facility respectfully requests a desk review for compliance.  F0686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer – Tag  Corrective actions accomplishe for those residents found to be affected by the alleged deficien practice: Residents D, E, and I could not be identified due to confidentiality.  Identification of other resident having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents identified wounds have the potential to be affected. Resident's identified wounds have the potential to be affected. Resident's identified reviewed on 1/10/23 to ensure current treatment was in place being followed. No concerns would noted.	01/16/2023  - E ed ent F es exted s with one were ea eand

injuries having developed in house.

02/24/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/10/2023 155484 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2222 MARGARET AVE SOUTHWOOD HEALTHCARE CENTER TERRE HAUTE, IN 47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Measures put in place and A current care plan (non-dated) with focus of systemic changes made to ensure wounds indicated a goal (non-dated) that wounds the alleged deficient practice does would show signs of healing by next review. Staff not recur: DON or designee will treatment interventions to achieve goal indicated, re-educate the License nurses on but were not limited to, "Perform treatments as the following facility policy. Skin ordered." Care and Wound Management Overview. a. Resident D's record indicated the following for the right posterior thigh, stage 3 pressure ulcer: How the corrective measures will be monitored to ensure the alleged The most current Nurse Practitioner Wound deficient practice does not recur: Evaluation, dated January 04, 2023, indicated The following audits and/or current measurements of wound length at 12.69 observations for 5 residents will be centimeters (cm) and width at 7.61 cm, for a total conducted by the DON or wound size of 39.32 cm. The pressure injury had designee 2 times per week times improved since last review, dated December 28, 8 weeks, then monthly times 4 2022. months to ensure compliance. Residents identified with wounds Review of Treatment Administration Records will be reviewed to ensure current (consistent with physician orders) indicated the treatment is completed as following: ordered. Any discrepancies will be Right posterior thigh: Apply calcium alginate immediately corrected and (provide a dry physiologically moist wound re-education will be completed. environment to promote granulation tissue formation) to wound and cover with foam The results of the audit dressing every Monday, Wednesday, and Friday. observations will be reported. Treatment records had not been signed as reviewed and trended for completed on January 01 and 04, 2023. compliance thru the facility Quality Assurance Committee for a b. Resident D's record indicated the following for minimum of six months then the left foot, bottom stage 3 pressure ulcer: randomly thereafter for further recommendation. The most current Nurse Practitioner Wound Evaluation, dated January 04, 2023, indicated current measurements of wound length at 1.7 cm and width at 2.35 cm, for a total wound size of 1.26

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cm. The pressure injury had been stable since last

review dated December 28, 2022.

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			ON	1B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155484	B. WING			01/10/2023	
						-	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
TWINE OF T	RO VIDER OR SOLVEIER	•	2222 M	IARGARET AVE			
SOUTHW	VOOD HEALTHCAF	RE CENTER	TERRE	HAUTE, IN 47802			
(V4) ID	CIDANADV	CTATEMENT OF DEFICIENCIE		T		(V.5)	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	Review of Treatmen	nt Administration Records					
	(consistent with phy	ysician orders) indicated the					
	following:						
	Left foot, bottom: a	apply Medihoney (supports					
		ent/breakdown of damaged					
	-	vound healing environment)					
		lered gauze (for wounds with					
		te drainage to aid in absorption					
		vide a low-adherent layer to					
	-	urface) every day. Treatment					
		n signed as completed on					
		0, 2022 and January 01, 02, 04,					
	07, and 08, 2023.						
	c. Resident D's reco	ord indicated the following for					
	the left buttock, stag	ge 3 pressure ulcer:					
	The most current N	urse Practitioner Wound					
	Evaluation, dated Ja	anuary 04, 2023, indicated					
		nts of wound length at 7.54 cm					
		m, for a total wound size of					
		ssure injury had been stable					
	-						
	since last review, da	ated December 28, 2022.					
	D						
		nt Administration Records					
		ysician orders) indicated the					
	following:						
	* * *	collagen particles (encourage					
	cell proliferation to	promote wound healing) and					
	cover with foam dre	essing every Monday,					
	Wednesday, and Fri	iday. Treatment records had					
	-	completed on December 10, 19,					
	and 30, 2022.	•					
	,						
	d. Resident D's reco	ord indicated the following for					
		stage 3 pressure ulcer:					
	inc ion giuteai ioid,	suge 5 pressure dicer.					
	The most summer N.	urse Practitioner Wound					
	Evaluation, dated Ja	anuary 04, 2023, indicated					

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current measurements of wound length at 4.32 cm

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155484	B. WING	01/10/2023		
			CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD		
COLITUM	VOOD HEALTHOAI	DE CENTED				
300100	VOOD HEALTHCAI	RECENTER	TERRE	E HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	and width at 3.06 ca	m, for a total wound size of 8.68				
	cm. The pressure in	njury had improved since last				
	review; dated Dece	mber 28, 2022.				
	Review of Treatme	nt Administration Records				
	(consistent with phy	ysician orders) indicated the				
	following:					
		pply collagen (encourage cell				
		mote wound healing) and cover				
		n dressing (for wounds with				
		te drainage to aid in absorption				
		vide a low-adherent layer to				
		surface) every Monday,				
	•	iday. Treatment records had				
	_	completed on December 19				
	and 30, 2022 and Ja	anuary 02 and 04, 2023.				
		ord indicated the following for				
	the left groin, stage	3 pressure ulcer:				
	Tri ( )	. D. ('.' W. 1				
		urse Practitioner Wound				
		anuary 04, 2023, indicated				
		nts of wound length at 1.67 cm				
		m, for a total wound size of 2.70 njury had been stable since last				
	review; dated Dece	· •				
	review, dated Dece	muci 20, 2022.				
	Review of Treatme	nt Administration Records				
		ysician orders) indicated the				
	following:	sician orders, indicated the				
		iad cream (wound healing)				
		nent records had not been				
	•	d on January 01, 02, 04, 07 and				
	08, 2023.					
	,					
	f. Resident D's reco	and indicated the following for				
	the right heel, stage					
	The most current N	urse Practitioner Wound				
1	i		i i	1	i	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155484	B. W	NG		01/10	/2023
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
COLITIN	VOOD LIEAL TUGAL	DE CENTED			ARGARET AVE		
500 THV	VOOD HEALTHCAI	RE CENTER		IERRE	HAUTE, IN 47802		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Evaluation, dated Ja	anuary 04, 2023, indicated					
	current measuremen	nts of wound length at 2.33 cm					
	and width at 2.60 cr	m, for a total wound size of 3.43					
	cm. The pressure in	njury had been stable since last					
	review dated Decer	mber 28, 2022.					
		nt Administration Records					
	(consistent with phy	ysician orders) indicated the					
	following:						
		fedihoney (supports autolytic					
		lown of damaged tissue and a					
		ng environment), and cover					
	_	e (for wounds with minimal to					
	_	to aid in absorption of drainage					
		adherent layer to protect the					
		ery Monday, Wednesday, and					
	1	records had not been signed as					
	1 -	mber 30, 2022 and January 02					
	and 04, 2023.						
	D 11 (D)	1: 1: . 14 611 : 6					
	_	ord indicated the following for					
		ral thigh, stage 2 pressure					
	ulcer:						
	The meet exament N	urse Practitioner Wound					
		anuary 04, 2023, indicated					
		nts of wound length at 1.13 cm m, for a total wound size of 3.11					
		m, for a total wound size of 3.11  njury had improved since last					
	review dated Decer						
	leview dated Decei	11061 28, 2022.					
	Review of Treatme	nt Administration Records					
		ysician orders) indicated the					
	following:	, sician oracis, maicatea me					
	_	ollagen (encourage cell					
	1	mote wound healing) and cover					
		n dressing (for wounds with					
		te drainage to aid in absorption					
		vide a low-adherent layer to					
		surface) Treatment records					
	Protect the would s	arrace, freatment records	1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155484		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/10/2023	
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD HEALTHCARE CENTER		2222 M	ADDRESS, CITY, STATE, ZIP COD ARGARET AVE HAUTE, IN 47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	10, 2022 and Januar				
	a.m., Unit Manager interviewed. Durin December 2022 and Administration Rec Manager 2 verified	3 from 10:00 a.m. through 11:15 2 (interim wound nurse) was g the interview, Resident D's 1 January 2023 Treatment ords were reviewed. Unit the above treatments for been signed off as completed. ank.			
	January 10, 2023 at	cal records were reviewed on 11:10 a.m. Diagnoses included I to type 2 diabetes mellitus us syndrome.			
	dated December 02 required extensive a dependent on staff 1 She had two stage 2 thickness tissue loss (full thickness tissue	imum Data Set assessment, , 2022, indicated Resident F assistance to being totally for activities of daily living. 2 pressure ulcers (partial s), one stage 3 pressure ulcer e loss), and 3 unstageable had been present on			
	impaired skin integr (non-dated) that wo healing by review d interventions to ach	unds would show signs of ate. Staff treatment ieve goal indicated, but were ninister treatments as ordered			
		rd indicated the following for pressure ulcer (full thickness xposed bone):			
	The most current N	urse Practitioner Wound			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			LETED	
		155484		ING	<del></del>	01/10	01/10/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIEF	R			ARGARET AVE			
SOUTHV	WOOD HEALTHCAI	RE CENTER			HAUTE, IN 47802			
	Т							
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI		(X5)	
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	· ·	anuary 04, 2023, indicated						
		nts of wound length at 6.90 cm						
		m, for a total wound size of						
	_	ssure injury had improved since						
	last review dated D	December 28, 2022.						
	Review of Treatmo	ent Administration Records						
		ysician orders) indicated the						
	following:	ysician orders) maicated the						
		kins (agent to promote wound						
		with Bordered gauze (for						
		nal to moderate drainage to aid						
		ainage and provide a						
	•	to protect the wound surface)						
	1	ecords had not been signed as						
	1 -	ember 06, 07, 14, 19, 20 and 27,						
	2022 and January 0	94, 05, 06 and 07, 2023.						
	b. Resident F's reco	ord indicated the following for						
	the Right gluteal fo	old, unstageable pressure ulcer:						
		Jurse Practitioner Wound						
		anuary 04, 2023, indicated						
		nts of wound length at 2.80 cm						
		m, for a total wound size of 7.91						
	_	njury had remained stable since						
	last review; dated I	December 28, 2022.						
	D							
		ent Administration Records						
		ysician orders) indicated the						
	following:	annly Donlin- (						
	1	apply Dankins (agent to						
		aling) and cover with Bordered						
		with minimal to moderate						
	_	bsorption of drainage and erent layer to protect the wound						
		atment records had not been						
	1						1	
	giornad as somulate	d on December 06, 07, 14, 10						
		d on December 06, 07, 14, 19, 2 and January 04, 05, 06, and 07,						

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f ´		(X2) MULTIPLE (		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155484		A. BUILDING B. WING	00	COMPLETED 01/10/2023	
			STREET	T ADDRESS, CITY, STATE, ZIP COD	- · · · · · · · · · · · · · · · · · · ·	
NAME OF I	PROVIDER OR SUPPLIER			MARGARET AVE		
SOUTHV	VOOD HEALTHCAF	RE CENTER	TERR	E HAUTE, IN 47802		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG	c. Resident F's recothe Left heel, unstaged The most current N Evaluation, dated Jacurrent measurement and width at 1.87 cm. The pressure in last review; dated D Review of Treatment (consistent with physical fold: a Bordered gauze (for moderate drainage that and provide a low-awound surface) twich had not been signed to 40,07,14, and 19,2023.  On January 10, 202 a.m., Unit Manager interviewed. Durin December 2022 and Administration Recomber 2022 and Administration Recomber 2023 at 2:30 p.m., i implemented without Wounds had been completed on January 3. Resident E's climitation and the service of the service of the service of 2023 at 2:30 p.m., i implemented without wounds had been completed on January 3. Resident E's climitation E's climitation and the service of the service of 2023 at 2:30 p.m., i implemented without wounds had been completed on January 3. Resident E's climitation E's climitation and the service of the se	ant Administration Records visician orders) indicated the spply Betadine and cover with a wounds with minimal to so aid in absorption of drainage adherent layer to protect the see a day. Treatment records as completed on December 2022 and January 04, 06, and 07, 3 from 10:00 a.m. through 11:15 2 (interim wound nurse) was go the interview, Resident F's, 1 January 2023, Treatment ords were reviewed. Unit the above treatments for been signed off as completed. Jank.  wound care, on January 09, andicated wound treatments were set identified concerns. onsistent with assessments	TAG	DEPICIENCY	DATE	

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A BUILDING B WING OO COMPLETED 01/10/2023  NAME OF PROVIDER OR SUPPLIER SOUTHWOOD HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION included, but were not limited to hypertension with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER  SOUTHWOOD HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
SOUTHWOOD HEALTHCARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  included, but were not limited to hypertension with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his			155484	B. W	NG		01/10/	2023
SOUTHWOOD HEALTHCARE CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  included, but were not limited to hypertension with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his				I	STREET A	ADDRESS CITY STATE ZIP COD		
SOUTHWOOD HEALTHCARE CENTER   TERRE HAUTE, IN 47802	NAME OF I	PROVIDER OR SUPPLIEF	8					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  included, but were not limited to hypertension with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his	SOUTHV	VOOD HEALTHCAF	RE CENTER					
TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  included, but were not limited to hypertension with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
included, but were not limited to hypertension with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
with heart failure, ischemic cardiomyopathy, obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his	TAG				TAG	DEFICIENCY)		DATE
obstructive pulmonary disease, type I diabetes mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his								
mellitus, systolic heart failure and physical debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his								
debility.  The quarterly Minimum Data Set assessment, dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his		_						
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dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his		debility.						
dated December 15, 202, indicated Resident E required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his		The quarterly Minis	mum Data Set accessment					
required extensive assistance from nursing staff for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his								
for activities of daily living. He had one, stage 3 pressure sore (full thickness tissue loss) on his								
pressure sore (full thickness tissue loss) on his		_						
left heel, that had been present upon admission		•	*					
(July 2022).			1 1					
A current care plan (non-dated) with a focus of		A current care plan	(non-dated) with a focus of					
left heel stage 3 wound indicated a goal		left heel stage 3 wo	und indicated a goal					
(non-dated) that the wound would improve by		(non-dated) that the	wound would improve by					
next review. Staff treatment interventions to		next review. Staff t	treatment interventions to					
achieve goal indicated, but were not limited to,		achieve goal indica	ted, but were not limited to,					
"Treatments as ordered."		"Treatments as orde	ered."					
The most current Nurse Practitioner Wound		The most current N	urce Practitioner Wound					
Evaluation, dated January 04, 2023, indicated a left								
heel stage 3 pressure ulcer. Current								
measurements indicated a wound length of 5.22		~ .						
cm and width of 2.13 cm, for a total wound size of								
7.90 cm. The pressure injury had improved since								
last review, dated December 28, 2022.		_						
			•					
Review of Treatment Administration Records		Review of Treatment	nt Administration Records					
(consistent with physician orders) indicated the		(consistent with phy	ysician orders) indicated the					
following:		following:						
Heel: apply Medihoney (supports autolytic		* * *						
debridement/breakdown of damaged tissue and a			e e					
moist wound healing environment), and cover			-					
with bordered gauze (for wounds with minimal to		_	The state of the s					
moderate drainage to aid in absorption of drainage		_	,					
and provide a low-adherent layer to protect the		_						
wound surface) every day. Treatment records had								
not been signed as completed on December 19		not been signed as of	completed on December 19					

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Event ID:

M06811 Facility ID: 000564

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
	155484 B. WING		01/10/2023				
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD HEALTHCARE CENTER			2222 M TERRE	ADDRESS, CITY, STATE, ZIP COD ARGARET AVE HAUTE, IN 47802			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	and 20, 2022 and Ja On January 10, 2022 a.m., Unit Manager interviewed. During December 2022 and Administration Reco Manager 2, verified Resident E had not b The records were bl On January 10, 2022 (interim wound nurs facilities Clinical De and procedure (non- policy indicated, " contains enough is status of the individ Nurses will follow t for documentation in providing a timely a resident information Procedure: 1. Basic Documentation: a. medical record(s) is I. Other reasons also of care and treatmer care"	nuary 01, 2023.  3 from 10:00 a.m. through 11:15 2 (interim wound nurse) was g the interview, Resident E's, l January 2023, Treatment ords were reviewed. Unit the above treatments for been signed off as completed.					

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