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	12/09/2024

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00447185, IN00446509, and IN00448806. Complaint IN00447185 - No deficiencies related to the allegations are cited. Complaint IN00446509 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00448806 - Federal/state deficiencies related to the allegations are cited at F726. Survey dates: December 2, 3, 4, 5, 6, and 9, 2024 Facility number: 000564 Provider number: 155484 AIM number: 100285610 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 7 Medicaid: 72 Other: 15 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 18, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider for any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 0578	**Corrective actions**	01/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meredith Eder	Executive Director	01/02/2025

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	12/09/2024

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
	Based on observation, interview, and record review, the facility failed to ensure the code status (a medical term that indicates a patient's wishes regarding what life-saving measures should be taken if their heart stops beating or breathing stops) was documented and readily available to staff for 1 of 24 residents reviewed for advanced directives (a written document that tells the health care providers who should speak for a resident and what medical decisions they should make if the resident becomes unable to speak for themselves) (Resident 152). Findings include: Resident 152's record was reviewed on 12/3/24 at 9:51 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atherosclerotic heart disease of the native coronary artery (a condition where plaque [a buildup of cholesterol, fat, blood cells, and other substances in the walls of the heart arteries] builds up in the coronary arteries, cardiomegaly (enlarged heart), and history of myocardial infarction (heart attack). An admission Minimum Data Set (MDS) assessment, dated 11/18/24, indicated the resident had severe cognitive deficit. Review of the resident physician orders lacked an order of an established code status for the resident. The resident's electronic medical record (EMR) lacked documentation of an established code status for the resident. During an interview, on 12/3/24 at 10:33 a.m., Licensed Practical Nurse (LPN) 3 indicated the		**accomplished for those residents founds to be affected by the alleged practice:** No resident was harmed by the facilities alleged deficient practice. Resident 152's POST form was validated, and MD order was obtained on 12/3/24 for DNR. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** The facility completed and audit on 12/3/24 of all other residents and no other residents were found to be affected. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education utilizing the Advance Directives policy with emphasis on obtaining orders for code status and entering the order into the medical record will be completed by 1/17/24 with all licensed nurses. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/Designee will audit 5 resident charts per week for 4 weeks, 3 resident charts per week for 4 weeks, then 1 resident per week for 4 months to ensure	

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	12/09/2024

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
	resident's code status should be documented in the EMR and in the physician's orders. At the same time, the LPN was unable to locate the resident's code status in the EMR. On the third attempt to locate the resident's code status, the LPN looked in the hard chart (the medical record with paper documents) and found the resident's POST (Physician Orders for Scope of Treatment) document in the record. At the same time, the LPN indicated it should not have been so difficult and time consuming to find the code status for the resident. During an interview, on 12/3/24 at 10:39 a.m., the Regional Director of Clinical Operations (RDCO) indicated the expectation was that the code status should be a physician's order and appear on the first page of the EMR. The POST form would be kept in the hard chart and scanned into the EMR, and available for the staff to locate. The nurses were all educated to first look in the hard chart during a code situation. During an interview, on 12/3/24 at 10:42 a.m., the Director of Nursing (DON) indicated she was not sure why the resident did not have an established code status in her EMR and/or a physician's order for her code status. It was the expectation that a code status would be easily available for staff in the resident's record. A care plan, dated 12/3/24, indicated the resident had a DNR (Do Not Resuscitate) code status. Interventions included, but were not limited to, code status will be established at time of admission and/or re-admission and would be reviewed quarterly and as needed. On 12/3/24 at 10:45 a.m., the RDCO provided a document, dated 2/3/23, titled, "Advanced		orders for code status are entered in the medical record. Any discrepancies will be immediately corrected, and re-education will be provided as needed. 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	12/09/2024

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
	Directives (Resident's Right to Choose)," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines...2. On admission, the facility will review any medical orders for life-sustaining treatment that the resident may have in place...4. Upon admission...copies will be made and placed on the...medical record as well as communicated to the staff...10. Any decision making regarding the resident's choices in their medical order for life-sustaining treatment...will be documented in the resident's medical record...." 3.1-4(f)(5)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure notification of a resident discharge had been reported to the Ombudsman (a person who investigates and resolves complaints and represents or protects the interests of another person or group) for 1 of 2 residents reviewed for hospitalization (Resident 6). Findings include: Resident 6's record was reviewed on 12/3/24 at 3:47 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis (hemiplegia refers to a severe or complete loss of strength, whereas hemiparesis refers to a relatively mild loss of strength) following a cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD-a common lung disease that makes it difficult to	F 0623	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were harmed by the alleged deficient practice. Resident 6's transfer information was sent to the local Ombudsman with the facilities December transfer notification list. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All the residents that were discharged from the facility in October of 2024 were found to be affected. The notification was sent to the local Ombudsman with the	01/17/2025

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	12/09/2024

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
	breathe), and congestive heart failure (CHF-a condition where the heart is unable to pump enough blood to the body's tissues). A change of condition assessment, dated 10/1/24, indicated the resident complained of new or worsening abdominal pain, shortness of breath, and had abnormal vital signs. A transfer document, dated 10/1/24, indicated the resident's physician had been notified of the change in condition and an order was obtained to send the resident to the hospital for evaluation and treatment related to abdominal pain. The resident had been sent out emergently, on 10/1/24 at 11:43 a.m. The record lacked documentation of the Ombudsman having been notified of the resident's discharge to the hospital. During an interview, on 12/5/24 at 9:51 a.m., the Social Services Director (SSD) indicated she had just come into her position in late November. She had completed and sent the November 2024 Ombudsman discharge notification on the first of December. She was not in her position during the time when the October 2024 notification was to be sent out. During an interview, on 12/5/24 at 11:10 a.m., the Regional Director of Clinical Operations (RDCO) indicated she had spoken with the SSD and they had determined that the notification for October 2024 had not been completed and sent. During an interview, on 12/6/24 at 11:24 a.m., the Ombudsman indicated she had not received an October 2024 notification of discharge document from the facility.		December discharges. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education was provided to the Social Services Department utilizing the Bed Hold Policy with emphasis on notifying Ombudsman with transfers. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** SSD/Designee will complete a monthly audit to ensure notification to Ombudsman occurred for 3 months. Any discrepancies will be immediately corrected, and re-education will be provided as needed. 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	12/09/2024

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
	On 12/5/24 at 11:18 a.m., the RDCO provided an undated document, titled, "Bed Hold Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...1a. The nurse or designee will present the Acute Transfer Letter at time of transfer with a copy going to the resident and a copy going to the Business Office Manager. The designee will scan to the Ombudsman...." 3.1-12(a)(6)(A)(iv)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record reviews and interviews, the facility failed to ensure Minimum Data Set (MDS) resident assessments were completed timely for 2 of 2 residents reviewed for MDS records over 120 days old (Residents 42 and 2). Findings include: 1. On 12/4/24 at 9:32 a.m., Resident 42's record was reviewed. She was discharged on 8/10/24, and the record indicated her return was not anticipated. The record lacked documentation of a discharge MDS assessment being completed. On 12/9/24 at 2:13 p.m., Resident 42's record indicated that a discharge MDS assessment had been signed and completed on 12/9/24 with an export ready status. During an interview on 12/9/24 at 2:33 p.m., Employee 19 indicated they did an audit every few months and so did the corporate office. She was not aware they had missed completing the discharge MDS assessment in a timely manner for	F 0640	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** Resident 42 and 2's MDS was reviewed, completed and transmitted to CMS. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** An audit of all other discharged resident in last 30 days was completed no other discrepancies were noted. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education was provided utilizing the RAI manual with emphasis on	01/17/2025

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	12/09/2024

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
	Resident 42 until 12/9/24 when the corporate office called and let her know. The corporate office maintained an audit log, but she did not, she would just go through and check things. 2. On 12/9/24 at 2:23 p.m., Resident 2's record was reviewed. She was discharged on 8/27/24, and the record indicated her return was not anticipated. The record indicated the discharge MDS assessment was not signed and completed until 12/2/24 and was not accepted until 12/3/24. During an interview on 12/9/24 at 2:33 p.m., Employee 19 indicated they did an audit every few months and so did the corporate office. The corporate office maintained an audit log, but she did not, she would just go through and check things. She was not familiar with Resident 2's discharge MDS situation, but knew the corporate office was the one who discovered it had not been completed in a timely manner. On 12/5/24 at 2:20 p.m., the Regional Director of Clinical Operations (RDCO) provided a copy of Section J of the "Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2023, " ...Discharge Assessment-Return Not anticipated ...must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed ...within 14 days after the discharge date ...must be submitted within 14 days after the MDS completion date ...."		encoding and transmitting MDs for discharged residents. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** MDS Nurse/ Designee will audit all discharged residents each week for 4 weeks then, 3 resident per month for 2 months. Any discrepancies will be immediately corrected, and re-education will be provided as needed. 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.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility	F 0641	No plan of correction was required for this citation.	01/17/2025

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	12/09/2024

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
	failed to ensure the accuracy of coding on the Minimum Data Set (MDS) assessments for 3 of 29 resident MDS assessments reviewed (Residents 32, 1, and 48). Findings include: 1. Resident 32's record was reviewed on 12/5/24 at 10:53 a.m. The census indicated the resident had been admitted to hospice (end of life) care on 8/16/24. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out simple tasks) and heart failure (a serious long-term condition that occurs when the heart can't pump enough blood to meet the body's needs). A significant change MDS assessment, dated 8/31/24, indicated the resident received hospice care services. The assessment lacked documentation of a terminal illness prognosis (an educated guess by a doctor about how long a patient with a terminal illness is likely to live). A hospice plan of care (POC) document, for the service period of 8/16/24 through 11/14/24, indicated the physician had determined the resident had a terminal illness prognosis due to the diagnoses of heart failure. During an interview, on 12/5/24 at 2:17 p.m., the MDS Coordinator indicated Section J1400 of the Significant Change MDS had been coded incorrectly. On 12/5/24 at 2:20 p.m., the Regional Director of			

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	12/09/2024

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
	Clinical Operations (RDCO) provided a copy of Section J of the "Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2023," and indicated it was the policy currently being used by the facility. The policy indicated, "...J1400: Prognosis: ...Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident was terminally ill and the resident was not receiving hospice services. Code 1, yes: if the medical record included physician documentation: 1) that the resident was terminally ill; or 2) the resident was receiving hospice services...."2. On 12/6/24 at 9:55 a.m., Resident 1's electronic record was reviewed. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disorder (lung disease that makes it difficult to breathe), inflammatory spondylopathy (leads to extra bone growth across individual bones converting all the involved bones into a single bone), chronic respiratory failure with hypoxia (lungs are not able to get enough oxygen over a long period of time leading to a constant lack of oxygen in the body), chronic systolic heart failure (the heart is too weak to pump enough blood efficiently), pulmonary hypertension (high blood pressure in the blood vessels of the lungs), and stage 3 chronic kidney disease (kidneys are not working as well as they should). A physician's order, dated 10/22/24, indicated to have hospice (end of life care) evaluation and treatment. On 12/5/24 at 9:34 a.m., Resident 1's hospice binder was reviewed. The face sheet indicated that the resident was referred to hospice on 10/22/24.			

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	12/09/2024

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
	On 12/6/24 at 12:01 a.m., Resident 1's Minimum Data Set (MDS) assessment, dated 11/4/24, indicated the resident did not have a condition or chronic disease that may result in a life expectancy of less than six months. On 12/6/24 at 12:01 p.m., Resident 1's MDS assessment indicated it was amended on 12/5/24 at 12:59 p.m., and indicated the resident did have a condition or chronic disease that may result in a life expectancy of less than six months. During an interview on 12/6/24 at 2:13 p.m., Employee 19 indicated that Resident 1's MDS should have indicated that she did have a condition or chronic disease that may result in life expectancy of less than six months. They did not know it was incorrect until it was brought to their attention related to another resident. After they were made aware, they completed an audit and discovered 2 additional records that were inaccurate. Resident 1's record was amended on 12/5/24. On 12/5/24 at 2:20 p.m., the Regional Director of Clinical Operations (RDCO) provided a copy of Section J of the "Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2023," and indicated it was the policy currently being used by the facility. The policy indicated, "...J1400: Prognosis: ...Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident was terminally ill and the resident was not receiving hospice services. Code 1, yes: if the medical record included physician documentation: 1) that the resident was terminally ill; or 2) the resident was receiving hospice services...." 3. On 12/4/24 at 1:00 P.M., the medical record of			

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	12/09/2024

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
	Resident 48 was reviewed. The most recent admission to the facility was on 8/7/24. Diagnosis included but not limited to, unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) with anxiety (a feeling of fear, dread, and uneasiness), anxiety disorder, schizoaffective disorder (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder like major depressive disorder or bipolar disorder), bipolar type (a mental illness that causes unusual shifts in a person's mood), dependent personality disorder (a mental health condition where a person has an excessive need to be taken care of by others), major depressive disorder recurrent, severe with psychotic symptoms (a group of symptoms that indicate a loss of contact with reality), and obsessive compulsive disorder (a mental disorder that causes people to have unwanted, recurring thoughts and repetitive behaviors that they can't control). Physician order, dated 11/11/23, ordered to give 1 tablet olanzapine 10 mg (milligrams) by mouth in the morning for schizophrenia. Physician order, dated 11/11/23, ordered to give 1 tablet clonazepam 1 mg by mouth three times a day for anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 2/16/24 indicated the resident was not coded as to having bi-polar or psychosis disorder. The MDS indicated the resident was on psychotropic medication. The MDS was coded as Gradual Dose Reduction (GDR) contraindicated. An annual MDS, dated 6/18/24, 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	12/09/2024

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
	resident was not coded as to having bi-polar or psychosis disorder. The MDS indicated the resident was on psychotropic medication. The MDS was coded as GDR contraindicated. A quarterly MDS, dated 9/13/24, indicated the resident was not coded as to having bi-polar or psychosis disorder. The MDS indicated the resident was on psychotropic medication. The MDS was coded as GDR contraindicated. A care plan, dated 5/24/23, indicated the resident used, anti-psychotic medication for schizoaffective disorder. Interventions included but not limited to, consult with pharmacy / medical provider to consider dosage reduction when clinically appropriate. On 12/4/24 at 2:10 p.m., during an interview, the facility Psychologist indicated the resident continued to be symptomatic and acknowledged the supporting documentation was poor. The medical record documentation included a detailed visit note by the facility psychologist, dated 4/1/20, which indicated the resident had a diagnosis of schizoaffective disorder, and bipolar type. On 12/4/24 at 2:19 p.m., during interview with the MDS coordinator she indicated they were unable to claim the Bipolar diagnosis due to corporate decision to hold off on this till all documentation supporting the diagnosis was obtained. On 12/5/24 at 11:46 a.m., during an interview with the Regional Director of Clinical Operations (RDCO) indicated according to the Resident Assessment Instrument (RAI) manual, they were directed not to code the MDS section I diagnosis as schizoaffective disorder with bipolar, unless			

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	12/09/2024

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
	they have six months of supporting documentation with diagnosis. On 12/5/2024 at 9:00 a.m., the RDCO provided an undated document, titled, "CMS's RAI version 3.0 Manual ," and indicated it was the policy currently being used by the facility. The policy indicated, "...I: Active Diagnosis in the last 7 Days (cont.) ...4. The Resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychological, psychosocial, and functional status (483.45(e) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards ...Coding: Schizophrenia item (1600), would not be checked. Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of detailed evaluation, in accordance with professional standards (483.21(b)(3)(i)), of the resident's mental, physical, psychological, and functional status (483.45(e)) and persistent behaviors for the time period required ...."			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to obtain and implement treatment orders upon admission for a stage 4 pressure ulcer (full thickness tissue loss with exposed muscle and/or	F 0686	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No resident was harmed by the	01/17/2025

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	12/09/2024

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
	bone) for 1 of 1 resident reviewed for pressure ulcers (Resident K). Findings include: On 12/9/24 at 11:00 a.m., the medical record of Resident K was reviewed. The resident was admitted to the facility on 10/25/24. Admitting diagnosis included but not limited to, paraplegia (paralysis that occurs in the lower half of the body), osteomyelitis (an inflammation or swelling that occurs in the bone), enterocolitis (inflammation of the colon) to clostridium (bacterial infection in the colon), and pressure ulcer (bed sore) sacral (tail bone) region stage 4 (full thickness ulcer with the involvement of the muscle or bone). A Physician order, dated 10/28/24, indicated the following wound treatment was to be applied on day shift every Monday, Wednesday, Friday, and as needed. Staff were to cleanse the wound on the sacrum with wound cleanser, apply skin prep (application of a disinfectant to the skin) surrounding tissue or peri wound (skin directly around the wound), apply black foam (solid treatment foam) to wound bed (inside of the wound) and undermining area (areas under the skin surrounding the wound), cover with wound vacuum (a medical device that uses suction to help heal wounds by applying negative pressure to the wound area with a special dressing that creates a vacuum over a wound to aid in healing process), and apply drape (dressing). Staff were to bridge (join to another section) disc from hip to base of the wound, and secure with continuous 125mmhg (suction). A Physician order, dated 10/28/24, indicated if wound vacuum came off staff were to cleanse		facilities alleged deficient practice. Resident K's orders were reviewed and found to have treatment orders in place for wounds. Resident K's wounds continue to improve. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** On 12/9/24 the facility completed an audit of all residents with pressure wounds to ensure all wounds had treatment orders in place. No discrepancies were noted. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education will be provided to all licensed nurses utilizing the Wound Care Overview Policy with emphasis on ensuring treatment orders are obtained and entered into the medical record upon admission. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** DON/Designee will audit 5 resident charts per week for 4 weeks, then 3 resident charts per week for 4 weeks, then 3 resident per month for 1month to ensure treatment orders are obtained at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING 00 B. WING	12/09/2024

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
	wound with wound cleanser, apply skin prep to surrounding tissue, apply calcium alginate (wound dressing) to wound bed and cover with super absorbent ABD pads and retention tape. Staff were to change the dressing daily. An admission Minimum Data Set (MDS) assessment, dated 10/31/24, indicated the resident was cognitively intact with a diagnosis of stage 4 wound which was present upon admission to the facility. A care plan, dated 10/29/24, indicated the resident had impaired skin integrity, or at risk for altered skin integrity. Interventions included but not limited to, encourage resident to turn and reposition or assist as needed and as resident allowed, provide appropriate off-loading mattress and off-loading cushion, if applicable. The care plan lacked documentation of an updated care plan reflecting medical treatment or presence of a stage 4 pressure wound. The medical record indicated that the resident was admitted to the facility on 10/25/24 with a stage 4 pressure wound on the sacrum. A physician order for treatment to the wound using a wound vacuum was obtained on 10/28/24. The wound treatment orders included an order to apply the wound vacuum as needed. The wound vacuum treatment was started on 10/30/24. The record lacked documentation of wound treatment for five days. The wound was assessed by the wound care provider on 10/28/24. The wound measured 7.5 cm (centimeters) long x (by) 5.60 cm x 3.10 cm. Wound evaluation was completed on 11/4/24. Wound measurements were 7.50 cm long x 5.60 cm wide x		the time of admission. Any discrepancies will be immediately corrected and reeducation 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	12/09/2024

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
	2.50 cm deep. On 12/9/24 at 1:00 p.m., during an interview, Licensed Practical Nurse (LPN) 33 indicated the wound vacuum was discontinued due to continual contamination. The employee indicated the facility provided wound vac education as needed, and nurses had been trained in treatment and application of the wound vacuum. On 12/9/24 at 2:16 p.m., during interview, LPN 6 indicated Resident K was not admitted from the hospital with a wound vacuum device, and indicated the hospital usually discharged the resident with a dressing over the wound and the facility would contact the physician and obtain wound care orders. If the Nurse Practitioner (NP) was in the facility at the time of admission, the NP would enter an order for wet to dry wound dressing until the wound vacuum arrived. LPN 6 acknowledged the admitting nurse must contact the physician or NP and receive orders for wound care at the time of admission. The wound vacuum order was obtained and entered into the medical record on 10/28/24. It took 1 to 4 hours for delivery of the wound vacuum to the facility. The LPN acknowledged the documentation indicated the treatment was not started until 10/30/24 as per the schedule of Monday, Wednesday, Friday. LPN 6 indicated the medical record of Resident K contained a physician order to apply the wound vacuum as needed. If a treatment was completed as ordered the nurse would sign the treatment record. LPN 6 acknowledged the order was not signed as being completed in the medical record. On 12/9/24 at 3:08 p.m., the Regional Director of Clinical Operations (RDCO) provided an undated document, titled, "Skin Care and Wound Management Overview," and indicated it was 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	12/09/2024

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, "...Policy: Application of treatment protocols based on clinical "best practice" standards for promoting wound healing ...Treatment ...3. Obtain a physician's order ...5. Document treatment in the Treatment Administration Record (TAR) ...." This citation relates to Complaint IN00446509. 3.1-40(a)(2)			
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on record review and interview, the facility failed to ensure there was sufficient weekend staffing for 1 of 4 fiscal year quarters reported for sufficient and competent nurse staffing (4/1/24-6/30/24). Findings include: On 12/2/24 at 11:00 a.m., the staffing data report was reviewed. The facility had reported low weekend staffing for the third fiscal year quarter (4/1/24-6/30/24). During an interview on 12/4/24 at 1:43 p.m., Certified Nursing Assistant (CNA) 13 indicated staff did not have enough time to complete their daily assignments, they needed more staff, and the biggest problem at the facility was with retaining staff. The facility asked her to stay late or work overtime nearly every day, but she declined because she wanted to avoid burnout. During an interview on 12/4/24 at 2:42 p.m., Licensed Practical Nurse (LPN) 15 indicated the facility did not have enough staff to do	F 0725	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were found to have adverse outcomes as a result of alleged weekend insufficient staffing. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents have the potential to be affected by the alleged deficient practice. No residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** The facility completed a wage	01/17/2025

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	12/09/2024

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
	everything that needed to be done, and the staff they did have struggled to get things done. Each CNA had up to 2 halls on day and evening shifts, and on weekend shifts they were staffed even shorter. On 12/9/24 at 11:08 a.m., the staffing schedules were reviewed. The scheduling sheets for April, May, and June of 2024 did not include census, required number of staff, or assigned number of staff. During an interview with the Nurse Staff Scheduler on 12/9/24 at 1:09 p.m., she indicated they have had weekends with low weekend staffing and were aware that they triggered for low weekend staffing in the third fiscal year quarter. Since the third quarter, she was sure they had additional weekends with low weekend staffing. When she first started back in June, the scheduling template was different, now it included the daily census, required number of staff, and number of staff scheduled for each discipline and area. They had been trying to hire more staff, specifically for the night shift. They always keep the nursing staff requirements the same, and only changed CNA staffing based on census information. She indicated the low weekend staffing was usually due to CNA's. On 12/9/24 at 2:16 p.m., the Regional Director of Clinical Operations (RDCO) indicated they did not have a policy related to staffing. 3.1-17(a)		analysis and increased LPN wages. The facility continues daily staffing meetings, to work the retention program and complete interview and hire as appropriate. Implement on call rotation with clinical managers to ensure the weekends are sufficiently staffed. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The ED/ Designee will audit staffing schedules weekly for 12 weeks to ensure weekend coverage is sufficient to meet the needs of the facility. Any discrepancies will be immediately addressed. 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.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff Based on observation, interview, and record	F 0726	**Corrective actions**	01/17/2025

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	12/09/2024

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
	review, the facility failed to ensure staff was competent in completing tasks accurately for 2 of 5 residents reviewed for medication administration (Residents 51 and M). Findings include: 1a. During the medication administration observation, on 12/6/24 at 7:50 a.m., Licensed Practical Nurse (LPN) 23 obtained a glucometer machine from the top of her medication cart and wiped it with an alcohol pad from front to back, she then placed it back down on the medication cart, she grabbed a lancet (medical tool for drawing blood and a cutting instrument used in surgery), test strip (a small disposable plastic strip that measures blood sugar levels), and a alcohol pad and proceeded into Resident 51's room. Upon entering the resident's room, she set the glucometer machine on the bedside table without a barrier underneath. The nurse put on gloves. She attempted to use the glucometer machine but had an error message and was unable to use it. She exited the resident's room and obtained a second glucometer machine from a different medication cart and wiped it down front to back with an alcohol pad. She entered back into the resident's room and set the second glucometer down on the bedside table without a barrier underneath. She obtained the resident's blood sugar and threw the lancet into the trash can in the resident's room. She left the room and placed both glucometers on the medication cart, one on top of the other with no barrier underneath. During the time the nurse was in the resident's room both medication carts were left unlocked in the hallway and the computer on top of the medication cart was left on and opened to the resident's information that contained her name, room number, and mediation orders.		**accomplished for those residents founds to be affected by the alleged practice:** No residents were harmed by the alleged deficient practice. LPN 23 was immediately sent home until further training could be completed. The facility requested a medication review for Resident M from the NP to ensure all medications currently ordered for resident M are able to be crushed. RDCO completed immediate education with QMA on 5 rights of medication administration. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents who reside on the same unit that LPN 23 worked and have orders for blood glucose testing have the potential to be affected by the alleged deficient practice. The facility audited those residents to ensure they were not affected by the alleged deficient practice with no findings. Resident who take medications crushed have the potential to be affected. The facility reviewed all residents who require crushed medications, and any discrepancies noted were taken to the NP for review and medications orders were changed to reflect the needs of the resident.	

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	12/09/2024

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
	During an interview, on 12/6/24 at 7:52 a.m., LPN 23 indicated she wasn't sure if she needed to wipe down the glucometer machine and then grabbed an alcohol wipe and proceeded to wipe down the machine. The nurse indicated the residents do not have their own glucometer machines and they must share them between residents. 1b. During an observation, on 12/6/25 at 8:10 a.m., LPN 23 entered Resident 51's room to administer oral medications and left a medication cart unlocked along with the computer screen open to the resident's medication record. The record included the resident's name, room number, and medication orders. During an interview, on 12/6/24 at 8:16 a.m., LPN 3 indicated that bleach wipes should be used when cleaning the glucometer machines. Staff should also use a barrier when placing the glucometer on a bedside table since they are not clean. The nurse also indicated that a lancet should always be placed in a sharp container after use. LPN 3 indicated medication carts should always be locked when not in use and computers should be closed. During an interview, on 12/6/24 at 11:30 a.m., the Regional Director of Clinical Operations indicated LPN 23 was sent home for the remainder of her shift and would not return to the nursing schedule until she could complete nursing competency to prove she was able to care for the residents according to policy and procedure. 2. During an interview, on 12/9/24 at 2:13 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident M was not cognitively intact and he would have to administer her medication in		**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education will be completed by 1/17/25 with all licensed nurses and QMAs utilizing the following policies, Medication Administration policy with emphasis on right route, locking medication carts and locking screen with HPI when entering rooms, Glucometer Cleaning Policy with emphasis on what to clean the glucometer with and utilizing barriers to maintain cleanliness. Hazardous Materials Storage Policy with emphasis on placing sharps in sharps containers immediately after use. DO NOT CRUSH list with emphasis on extended-release medications not being appropriate for crushing. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/ Designee will observe 5 nurse/QMA per week x 4 weeks, 3 nurses/QMAS per week for 4 weeks then 3 nurse/QMA per month for 1 month to ensure medications are administered per policy. Any discrepancies will be immediately corrected, and re-education will be provided as needed.	

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	12/09/2024

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
	pudding. He indicated Resident M would spit out the medication if they were given in applesauce. The nurse was not aware of anyone administering the mediation in coffee or other liquids. During an interview, on 12/9/24 at 2:16 p.m., LPN 31 indicated she would never put medications in liquid, she would only use pudding or applesauce. During an interview, on 12/9/24 at 2:23 p.m., Qualified Medication Aide (QMA) 30 indicated she typically worked the evening shift and would crush Resident M's bedtime medications in coffee because that was the only way he would take her medication for her. She indicated another staff member had told her to administer the medication in coffee, but she couldn't recall who it was. She had been administering the medications to the resident in coffee since she first started working as a QMA. The QMA indicated she had not been licensed for long as a QMA and wasn't aware if she was doing anything wrong giving the resident medications in coffee. During an interview, on 12/9/24 at 2:40 p.m., QMA 30 indicated she did add milk to the coffee so that it wasn't too hot for the resident to drink. If the resident didn't finish the coffee, she would throw out the remaining liquid. Resident M's record was reviewed on 12/9/24 at 2:58 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified fracture of right femur (a broken right thigh bone where the exact fracture is not specified), unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and major depressive disorder (mental health disorder characterized by persistently		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	12/09/2024

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
	depressed mood or loss of interest in activities, causing significant impairment in daily life). A quarterly Minimum Data Set (MDS) assessment, dated 10/4/24, indicated the resident was rarely understood. A physician order, dated 6/23/23, indicated may crush meds unless contraindicated. A physician order, dated 3/27/24, indicated to administer Depakote (medication used to treat seizures and bipolar disorder) ER (extended release) 24-hour 250 mg (milligrams) by mouth at bedtime for manic episodes. Review of nursing schedules indicated QMA 30 had worked on the unit Resident M resides on 6 times in the last 30 days. Review of QMA 30's license indicated she had been active since 7/25/24 as a QMA and was originally hired by the facility on 6/26/23 as a certified nurse's assistant. During an interview, on 12/9/24 at 3:10 p.m., the Regional Director of Clinical Operations indicated Depakote ER was on the list of do not crush medications and the QMA should not have crushed the medication in coffee. She indicated the QMA would be educated on the proper procedure. Review of pharmacy reference guide dated 8/24, indicated a list of medications that should not be crushed. Depakote ER tablet was on the list. On 12/6/24 at 11:59 a.m., the RDCO provided an undated document, titled, "Staff Education and Competency Testing," and indicated it was 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	12/09/2024

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, " ...Safety is the primary concern for out residents, staff and visitors. Education needs and competencies are evaluated/measured through clinical observation/skill demonstrations to maintain safe and effective nursing practice skills in care delivery to residents. Competency testing includes knowledge, skills, and ability and may be measured through a variety of methods including but not limited to direct observation knowledge testing, case studies, or other acceptable methods of academic learning ...3) Infection control and prevention safety for PPE ...a) Medication administration safe practices for nurses ...." This citation relates to Complaint IN00448806. 3.1-14(i)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record reviews and interviews, the facility failed to ensure the correct supporting diagnosis was used to prescribe an antipsychotic for 1 of 5 residents reviewed for unnecessary medications (Resident 1), and failed to attempt a Gradual Dose Reduction (GDR) or provide evidence to support the denial of a GDR for 2 of 5 residents reviewed for unnecessary medications (Resident 48). Findings include: 1. On 12/5/24 at 9:02 a.m., Resident 1's record was reviewed for unnecessary medications. Her diagnoses included, but were not limited to, major depressive disorder (a mental health condition that can cause persistent low mood and loss of	F 0758	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were harmed by the alleged deficient practice. Resident 1's Invega order was updated to reflect the diagnosis of Psychosis per the MD. Resident 48's medications were reviewed by Psychologist and recommendation were given to facility NP for reduction on 12/27/24. **Identification of other residents having the potential to be affected by the same alleged**	01/17/2025

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	12/09/2024

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
	interest in activities), psychotic disorder with delusions (serious mental illness where people lose touch with reality and have abnormal thinking, and have false beliefs), agoraphobia (fear of being in places that may be difficult to escape or help would not be available) with panic disorder (anxiety that causes repeated unexpected panic attacks). On 12/5/24 at 9:36 a.m., Resident 1's pharmacy recommendations were reviewed. A pharmacy recommendation, dated 11/21/24, indicated the resident received Invega 9 mg daily for schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors, making it hard to function in daily life). A physician's order, dated 9/3/24, indicated to administer Invega (paliperidone)(a medication used to treat psychotic disorders), 9 milligrams (mg) extended release (ER) 24-hour tablet (medication is released slowly over a 24-hour period), 1 tablet by mouth in the morning for mood/schizophrenia. A historical physician's order, dated 5/30/24, indicated to administer paliperidone ER 6 mg, one tablet by mouth at bedtime for schizophrenia. On 10/5/24 at 10:37 a.m., Resident 1's Minimum Data Set Assessment, dated 10/20/24, was reviewed. The records assessment lacked documentation of a diagnosis for schizophrenia. A quarterly psychotropic medication evaluation form, dated 11/27/24, indicated that Resident 1 was being assessed for the use of an antipsychotic, Invega, and the supporting diagnosis was psychosis.		**practice and corrective action taken:** Any resident who receives antipsychotic mediations have the potential to be affected. The facility completed an audit of all residents who receive antipsychotics to ensure diagnosis is accurate and any resident who has not had a GDR in the last 6 months will be reviewed at the next GDR meeting on 1/15/25. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education will be provided utilizing the Medication Management Policy with emphasis on ensuring diagnosis is accurate associated to medication and GDRs are attempted unless clinical contraindication is documented. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** DON/Designee will audit 5 resident charts per week for 4 weeks, then 3 resident charts for 4 weeks then 3 resident per month x1 month to ensure diagnoses are accurate and GDR are attempted appropriately. Any discrepancies will be immediately corrected and re-education will be provided as needed.	

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	12/09/2024

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
	Resident 1's electronic and paper records, lacked documentation for a diagnosis of schizophrenia. During an interview on 12/5/24 at 3:40 p.m., the Regional Director of Clinical Operations (RDCO) indicated the diagnosis was incorrect and she could not find any information indicating that the resident had a diagnosis of schizophrenia. She changed the order to match the psychiatric notes from when it was prescribed. When she looked at the order, she indicated that it looked like a nurse put in the previous medication order with the diagnosis and when it was changed the next nurse followed suit. 2. On 12/4/24 at 1:00 p.m., the medical record of Resident 48 was reviewed. Diagnosis included but not limited to, unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) with anxiety (a feeling of fear, dread, and uneasiness), anxiety disorder, schizoaffective disorder (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder like major depressive disorder or bipolar disorder), bipolar type (a mental illness that causes unusual shifts in a person's mood), dependent personality disorder (a mental health condition where a person has an excessive need to be taken care of by others), major depressive disorder recurrent, severe with psychotic symptoms (a group of symptoms that indicate a loss of contact with reality), and obsessive compulsive disorder (a mental disorder that causes people to have unwanted, recurring thoughts and repetitive behaviors that they can't control). A care plan, dated 6/9/22, indicated the resident had a diagnosis of schizoaffective disorder and took an anti-psychotic medication. Intervention		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	12/09/2024

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
	included but not limited to, non-pharmacological interventions to encourage resident to participate in activities of interest. Encourage to discuss feelings and staff to offer support and reassurance, and provide a calm environment. A care plan, dated 5/24/23 indicated the resident used anti-psychotic medication for schizoaffective disorder. Interventions included but not limited to, consult with pharmacy/medical provider to consider dosage reduction when clinically appropriate and provide anti-psychotic medication per medical provider's orders. A care plan, dated 8/8/23, indicated the resident had major depressive recurrent severe psychotic features, other specified obsessive compulsive and related disorder, dependent personality disorder, unspecified anxiety disorder, and visual hallucinations. Interventions included but were not limited to, monitor medication administration, notify medical health professional(s) if refusals occur, and ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms. Physician Orders, dated 11/11/23, ordered 1 tablet olanzapine 10 mg (milligrams) by mouth in the morning. A quarterly Minimum Data Set (MDS) assessment, dated 9/13/24, indicated the resident was not coded as to having bi-polar or psychosis disorder. The assessment indicated the resident was on psychotropic medication. The assessment was coded as GDR contraindicated. The assessment indicated that the resident was not cognitively intact and required assistance from the staff for all care needs.			

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	12/09/2024

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
	The medical record indicated pharmacy reviews had been completed monthly. On 1/6/24 a pharmacy review of psychotropic medication included a physician note indicating the resident had failed gradual dose reductions in the past. A review of psychotropic medication was completed in 7/21/24 and indicated a GDR was refused due to resident having positive mood behaviors. A progress note, dated 7/24/24, indicated a team meeting discussing the GDR for psychotropic medication was completed and the team disagreed with a dose reduction. The record lacked documentation of behaviors presented by the resident supporting the use of psychotropic medication or of clinical GDR related to psychotropic drug use. On 12/4/24 at 2:10 p.m., during an interview, the Psychologist providing care to Resident 48 indicated a Gradual Dose Reduction (GDR) was not attempted for the resident due to failed previous GDR attempts. He indicated when the facility attempted to change the resident's medications the resident's family would take her home and discontinue all medications and then return the resident to the facility. He indicated this was considered a failed GDR. He indicated the resident continued to be symptomatic and acknowledged the supporting documentation was poor. On 12/4/24 at 2:21 p.m., during interview, Licensed Practical Nurse (LPN) 3 indicated the resident was at times fixed on different things, sometimes bodily functions and sometimes a runny nose. The resident wanted to talk about those issues, and she was difficult to re-direct at times. LPN 3 did not know if the resident had any reduction in medication. The documentation of behaviors 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	12/09/2024

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
	under the behavior tab in the medical record. They would also put a narrative in the nurses' notes and it would be recorded as a behavior note. On 12/4/24 at 2:25 p.m., during an interview, Certified Nurse Aide (CNA) 17 indicated documented behaviors would be entered into the Point of Care (POC) charting. The CNA indicated she had not noted any behaviors other than the resident yelled out and they would ask what she needed then she may yell out again. She indicated the resident yelled out instead of using the call light. She indicated the CNA Kardex, which was the assignment record, would indicate what behaviors the resident was being monitored for. On 12/5/2024 at 11:46 p.m., the Regional Director of Clinical Operations (RDCO)provided a document, titled, "Medication Management," dated8/2020, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures ...a. For Antipsychotics: If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility should attempt a GDR in two separate quarters (with at lease one month between the attempts) within the first year, unless clinically contraindicated. After the first year the GDR must be attempted at least annually, unless clinically contraindicated ...ii. The continued use is in accordance with relevant current standards of practice and the physician document the clinical rational for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating ab underlying medical or psychiatric disorder ...." 3.1-48(b)			

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	12/09/2024

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 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly for 1 of 3 medication carts reviewed for medication storage (Resident 51). Findings include: On 12/6/24 at 8:13 a.m., the 200 B hall (front) medication cart contained an undated and opened Novolog (medication used to lower blood sugar) insulin pen. The insulin pen contained a label that indicated it was for Resident 51 and was delivered to the facility on 9/11/24. During an interview, on 12/6/24 at 8:14 a.m., Licensed Practical Nurse (LPN) 23 indicated insulin was good for 30 days once opened and she was not aware of how long the Novolog pen for Resident 51 had been opened. During an interview, on 12/6/24 at 8:16 a.m., Licensed Practical Nurse (LPN) 3 indicated insulin pens should have an open date placed on them when they are used. LPN 3 indicated insulin was good for 28 days once opened. Resident 51's record was reviewed on 12/6/24 at 9:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) with diabetic neuropathy (a type of nerve damage that occurs with diabetes). A physician order, dated 4/17/24, indicated to administer Novolog FlexPen (insulin medication) insulin pen 100 unit/ml (milliliter). Inject 15 units	F 0761	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** Resident 51's insulin was disposed of immediately and a new pen was dated and placed in the medication cart. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken**: All resident whom are prescribed insulin have the potential to be affected. The facility conducted and immediate audit of all medication carts to ensure no other pens were undated upon opening and no other discrepancies were noted. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education will be completed with all licensed nurse utilizing the Medication Storage policy with emphasis on open dates for all insulins. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:**	01/17/2025

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	12/09/2024

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
	subcutaneously (under the skin) before meals. On 12/6/24 at 10:10 a.m., the RDCO (Regional Director of Clinical Operations) provided and identified a document as a current facility policy, titled, "Storage of Medications," with a revised date 8/24. The policy indicated, " ...5. When the manufacturer has specified a usable duration after opening (...beyond use date), the nurse shall place a "open date" sticker on the medication and record the date opened and the new date of expiration ...." 3.1-25(j)		The DON/ Designee will conduct observation of 5 medication carts per week for 4 weeks, then 3 carts per week for 4 weeks, then 1 cart per week for 1 month to ensure all insulins are labeled with an open date. Any discrepancies will be immediately corrected and reeducation 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.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure proper handwashing during 2 of 2 dining observations and 1 of 1 kitchen observations and the facility failed to ensure adequate dishwashing temperatures were maintained for 1 of 1 kitchen observations. Findings include: 1a. During a dining observation, on 12/2/24 at 11:59 a.m., Central Supply Aide washed her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll that was on the counter. She left drops of water on the top of the paper towel roll from where she ripped it off with her wet hands. She dried her hands and proceeded to turn off the water faucet with the	F 0812	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were identified as being affected by the alleged deficient practice. On 12/2/24 the DM called for repair to the dish machine and the temperature gauge was replaced. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All have the potential to be affected by the alleged deficient	01/17/2025

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	12/09/2024

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
	same paper towel she dried her hands with. She then went to the kitchen window and obtained a tray to serve to a resident. During a dining observation, on 12/2/24 at 12:01 p.m., Certified Nurse's Assistant (CNA) 35 washed her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll that was on the counter. She obtained the paper towel with wet hands and the roll is now wet on top and wet down the side. She threw away the paper towel after drying her hands and lifted the lid of the trashcan with her bare hands, she then proceeded to obtain a lunch tray from the kitchen staff and served it to a resident. During a dining observation, on 12/2/24 at 12:06 p.m., CNA 35 washed her hands at the sink and tore off a piece of paper towel by placing her arm against the roll and ripping the paper towel with her other wet hand. She went to the kitchen window and obtained a tray to serve a resident their lunch. During a dining observation, on 12/2/24 at 12:08 p.m., Licensed Practical Nurse (LPN) 7 washed her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll that was on the counter. She dried her hands and turned off the water faucet with the same paper towel she dried her hands with. She proceeded to throw away the paper towel by lifting the lid of the trash can with her bare hands. She went to the kitchen staff and obtained a lunch tray and served a resident. During a dining observation, on 12/2/24 at 12:13 p.m., Central Supply Aide washer her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll, she dried		practice. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education will be provided utilizing the Standard Precautions policy with emphasis on hand hygiene to all employees. Education will be provided by 1/17/25 to all kitchen staff utilizing the Ware washing policy with emphasis on what to do when dishwashing temps are outside of the parameter. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The IP/Designee will conduct hand hygiene observation of 5 employees weekly for 4 weeks, 3 employees per week for 4 weeks then 3 employees per month for 1 month to ensure compliance with hand hygiene per policy. The DM/Designee will conduct audits of dish temp 3 times a day to ensure temperature is maintained per policy. Any discrepancies will be immediately corrected and re-education will be provided as needed. 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	

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	12/09/2024

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
	her hands and turned off the water faucet with the same paper towel she dried her hands with. The paper towel roll contained drops of water on the top of the roll and was discolored on top where it had been previously wet and now dried. 1b. During a dining observation, on 12/5/24 at 11:43 a.m., CNA 35 washed her hands at the sink and tore off a piece of paper towel by holding to top of the roll with her left hand and ripping off a piece of paper towel with her right hand. The paper towel roll was wet on top where she touched it. She threw away the paper towel and began to serve coffee and juice to the residents. During an interview, on 12/5/24 at 11:47 a.m., CNA 35 indicated the facility had a supply issue and was not able to get the sheets of paper towel that was used in the holder, they had to use the big rolls of paper towel for the last few days. During an interview, on 12/5/24 at 1:12 p.m., the Director of Nursing indicated she was not aware the staff were using a commercial paper towel roll in the dining room. She indicated it should not be used in the dining room because it would not be appropriate for proper hand hygiene. During an interview, on 12/5/24 at 1:44 p.m., the Regional Director of Clinical Operations indicated they had ordered the sheets of paper towel for the holder on 12/2/24 but it had not been delivered to the facility yet. She indicated staff should have used hand sanitizer in the dining room to serve trays to prevent contamination, the paper towel roll should not have been used for proper hand hygiene. 2. During observation of pureed food (food prepared in a smooth, thick manner with no lumps that doesn't require chewing or biting before		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	12/09/2024

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
	swallowing) preparation, with Cook 27, on 12/6/24 at 9:31 a.m., the Cook was observed performing handwashing. When he finished hand washing, he was observed to tear a piece of paper towel from a commercial size roll sitting on the counter next to the handwash sink. He touched the paper towel roll with his wet hands and wet marks were observed on the side and top of the paper towel roll. He then was observed to turn off the faucet with the same towel as he used to dry his hands. During an interview, on 12/6/24 at 9:33 a.m., the Dietary Manager (DM) indicated the paper towels for the dispenser were not available. She understood they had been ordered but had not yet been delivered. On 12/5/24 at 3:37 p.m., the Regional Director of Clinical Operations (RDCO) provided a document, with a review date of 6/24/2021, titled, " Standard Precautions," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: ...Practicing hand hygiene is a simple but effective way to prevent the spread of infections...This facility will adhere to CDC (Centers for Disease Control) guidelines and recommendations for hand hygiene...Procedure: ...III. Procedure for Hand Hygiene...B. Using liquid soap and water...6. Dry hands thoroughly with clean paper towel. 7. Turn off faucet with clean, dry paper towel-discard...." 3. During the initial kitchen tour, on 12/2/24 at 9:51 a.m., the Dietary Manager (DM) indicated the facility used a high temperature dish machine. Observation of the dish machine indicated the wash temperature measured 148 degrees Fahrenheit (F) and the rinse temperature measured 155 F. At the same time, Dishwasher 26 indicated the temperature requirements for the dish machine			

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	12/09/2024

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
	were 150 F or above for the wash and 180 F for the rinse. The dish machine temperature gauges indicated a proper wash temperature of a minimum of 150 F and a rinse temperature of a minimum of 180 F. A second observation of the dish machine temperatures indicated a wash temperature of 155 F and a rinse temperature of 158 F. During an interview, on 12/4/24 at 2:09 p.m., the DM indicated she had contacted the dish machine company on 12/2/24, and they came to the facility to look at the machine. The repair man indicated to her that the temperature had been "hit and miss," at staying at the proper temperature. The temperature gauges were replaced. On 12/6/24 at 8:10 a.m., the Regional Director of Clinical Operations (RDCO) provided a service request document, dated 12/2/24. The document indicated the dish machine had been inspected and was found to have significant lime buildup. The temperature gauges were also inspected. A handwritten note, dated 12/2/24, by the DM, indicated the dish machine company had been contacted to inspect the dish machine. The temperature gauge had been replaced. on 12/5/24 at 11:46 a.m., the RDCO provided a document, with a revision dated of 9/2017, titled, "Warewashing," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedures...2. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature...machines...."			

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	12/09/2024

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 0880 SS=D Bldg. 00	3.1-21(a)(3) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during medication administration pass for 1 of 4 residents reviewed during medication administration (Resident 51) and the facility failed to maintain a separation of clean and dirty mechanical lift pads and mop heads supplies in the laundry room for 1 of 1 laundry room observations. Findings include: 1. During the medication administration observation, on 12/6/24 at 7:50 a.m., Licensed Practical Nurse (LPN) 23 obtained a glucometer machine from the top of her medication cart and wiped it with an alcohol pad from front to back, she then placed it back down on the medication cart, she grabbed a lancet (medical tool for drawing blood and a cutting instrument used in surgery), test strip (a small disposable plastic strip that measures blood sugar levels), and a alcohol pad and proceeded into Resident 51's room. Upon entering the resident's room, she set the glucometer machine on the bedside table without a barrier underneath. The nurse put on gloves. She attempted to use the glucometer machine but had an error message and was unable to use it. She exited the resident's room and obtained a second glucometer machine from a different medication cart and wiped it down front to back with an alcohol pad. She entered back into the	F 0880	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** No residents were found to be affected by the alleged deficient practice. LPN 23 was sent home immediately until further education could be completed. The glucometers were cleaned per policy by the oncoming nurse. No residents were affected by the mop head and lift slings not being separated. The Housekeeping supervisor placed the lift slings in the laundry to be washed, when completed the slings were stored in a covered carts on each unit. The mop heads were cleaned and stored on shelves in the clean linen side. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All who reside on the same unit as resident 51 and have orders for blood glucose checks have the potential to be affected. No other resident were found to be affected. All residents who use lift slings have the potential to be affected none were identified as being	01/17/2025

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	12/09/2024

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
	resident's room and set the second glucometer down on the bedside table without a barrier underneath. She obtained the resident's blood sugar and threw the lancet into the trash can in the resident's room. She left the room and placed both glucometers on the medication cart, one on top of the other with no barrier underneath. During an interview, on 12/6/24 at 8:16 a.m., LPN 3 indicated that bleach wipes should be used when cleaning the glucometer machines. Staff should also use a barrier when placing the glucometer on a bedside table since they are not clean. The nurse also indicated that a lancet should always be placed in a sharp container after use. Resident 51's record was reviewed on 12/6/24 at 9:00 a.m. The profile indicated the resident diagnosis included but were not limited to, type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A quarterly Minimum Data Set (MDS) assessment, dated 11/14/24, indicated Resident 51 had severe cognitive impairment and had received insulin injections in the last 7 days. Review of blood sugar logs indicated the nursing staff had obtained Resident 51's blood sugars four times a day. During an interview, on 12/6/24 at 11:30 a.m., the Regional Director of Clinical Operations (RDCO) indicated staff should use bleach wipes to clean glucometer machines and a barrier should be placed underneath when setting them down on a bedside table. On 12/6/24 at 11:14 a.m., the RDCO provided an undated document, titled, "Cleaning &		affected. All residents have the potential to be affected by the alleged deficient practice with the mop heads, no resident were found to be affected. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Education will be provided to all licensed nurses and QMAs utilizing the Glucometer cleaning policy with emphasis on cleaning the meter with bleach wipes and using a barrier to prevent contamination. Education was provided to Housekeeping staff utilizing Infection Control Practices for Laundry Services with emphasis on storing clean mop heads and slings. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** DON/Designee will complete 5 observations of blood glucose checks per week x4 weeks, then 3 residents per week for 4 weeks, then 3 residents per month for 1 month to ensure blood glucose are obtained per policy. Housekeeping/Designee will audit clean and dirty laundry areas 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 3 times per month for 1 month to ensure proper storage.	

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	12/09/2024

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
	Disinfection of Glucose Meter," and indicated it was the policy currently being used by the facility. The policy indicated, " ...This facility uses shared devices for glucose testing and will perform cleaning and disinfection procedures for each resident ...i. One meter may be in use while the other meter is undergoing disinfection with the high-level antimicrobial wipe for wet contact time per the manufacture's guidelines ...iii. Place the wrapped meter in a clean cup on the med cart for the appropriate length of time. iv. Allow meter to air dry prior to use ...g. Place all used sharps immediately in the sharps safety disposal box ...e. Place a clean barrier on resident bedside table, over bed table or other hard surface area when testing ...i. Do not place a contaminated glucometer on top of the medication cart or other surface without a clean protective barrier ...." 2. On 12/6/24 at 2:15 p.m., during a laundry room observation with the Infection Preventionist Nurse and Laundry Supervisor, mechanical lift slings hung in the soiled linen area next to a washer. On 12/6/24 at 2:16 p.m., mop heads and cleaning linens were observed on an uncovered metal cart in the soiled linen area of the laundry room. Two bags of soiled linen were on the floor next to the uncovered cart. On 12/6/24 at 2:18 p.m., during an interview, the Laundry Supervisor indicated the slings were clean and indicated once they were washed they were hung in a covered laundry cart. She acknowledged they were on the soiled linen side of the laundry room. The supervisor indicated the mop heads and cleaning linens were clean but acknowledged they were in the soiled linen area. On 12/6/24 at 2:30 p.m., the Regional Director of		Any discrepancies will be immediately corrected and re-education will be provided as needed. 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	12/09/2024

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
	Clinical Operations (RDCO) provided a document, titled, "Infection Control Practices for Laundry Services," dated 2/24/22, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: 1. Laundry personnel will ...a. Provide the storage, handling and processing of linen activities following practices to decrease the risk of spreading infection and exposure to blood borne pathogens ... Folding and Transporting of Clean Linen ...Clean linens shall be in a separate room area from soiled linen areas ...Laundry area ... a. In the laundry, the soiled linen processing area shall be clearly separated from areas where clean linen is handled ...." 3.1-18(a) 3.1-18(b) 3.1-18(b)(1)			