STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING 00 B. WING	04/04/2024

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 the Investigation of Complaints IN00427932, IN00431026, IN00431065, IN00431198, and IN00431393. Complaint IN00427932 - Federal/state deficiencies related to the allegations are cited at F842. Complaint IN00431026 - Federal/state deficiencies related to the allegations are cited at F550. Complaint IN00431065 - Federal/state deficiencies related to the allegations are cited at F550. Complaint IN00431198 - No deficiencies related to the allegations are cited. Complaint IN00431393 - No deficiencies related to the allegations are cited. Survey dates: April 2, 3, and 4, 2024 Facility number: 000564 Provider number: 155484 AIM number: 100285610 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 3 Medicaid: 84 Other: 18 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 15, 2024	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer White	Director of Nursing	04/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure a resident was transferred to a doctor's appointment in a dignified manner for 1 of 3 residents reviewed for dignity concerns (Resident B). Finding includes: A confidential interview, during the survey, indicated Resident B was brought to the urology office for a scheduled appointment on 3/21/24 at 11:15 a.m. The resident was transported to the office from a local long term care facility by an ambulance service. He was brought in by stretcher wrapped in only a sheet covered in feces (poop), underneath the sheet he was wearing only an adult diaper. His catheter was falling out of his urethra (the tube that lets urine leave your bladder and your body). His colostomy bag (collection of poop) was full and leaking feces all over his body. His skin was red and excoriated (a place where your skin is scraped or abraded) by his stoma (an opening on the abdomen that can be connected to either your digestive or urinary system to allow waste to be diverted out of your body) and his back. On 4/2/24 at 11:45 a.m., Resident B's record was reviewed. His diagnoses included, but were not limited to, volvulus (an obstruction due to twisting or knotting of the gastrointestinal tract), neuropathic bladder (number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem), autistic disorder (a group of developmental disabilities that can cause significant social, communication, and behavioral problems), profound intellectual	F 0550	We respectively request a desk review for the tag. Thank you. F 550 Corrective actions accomplished for the resident found to be affected by the alleged deficient practice: The provided education to the staff members on 4/4/2024 utilizing the Resident Rights policy to focus on appointments and providing care with dignity. The facility ensured there were adequate clothes and ADLs were provided for all staff. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. No other residents were affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The facility will complete in-servicing for all staff utilizing the Resident Rights policy by 4/4/2024 to ensure all residents will receive resident centered care meets the psychological, physical, and emotional needs and concerns of the resident. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: the DON/ Designee will conduct	05/02/2024

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	disabilities (when a person has a severe learning disability and other disabilities that significantly affect their ability to communicate and be dependent). An admission Minimum Data Set (MDS) assessment, dated 3/2/24, indicated Resident B was not able to complete a BIMS (brief interview for mental status) assessment and was dependent on care from staff. The MDS also indicated the resident had a colostomy (an opening in the large intestine, or the surgical procedure that creates one) and an indwelling catheter (a catheter drains urine from your bladder in a bag outside of your body). Resident B was not coded on MDS for having any episodes of rejection of care towards staff. The record lacked a care plan that indicated the resident was resistive to care from staff. The record lacked a care plan that indicated the resident pulled out his indwelling foley catheter. The record lacked a care plan that indicated the resident pulled off his colostomy bag. A physician order, dated 3/14/24, indicated Resident B had a doctor's appointment at the Urology office on 3/21/24 at 11:15 a.m. Review of nurse's' note, dated 3/21/24 at 10:11 a.m., indicated Resident B had become agitated and restless. The resident was crawling around on the floor and had ripped his colotomy bag off after being placed back in bed for his doctor's appointment. During an interview, on 4/2/24 at 2:07 p.m., Licensed Practical Nurse (LPN) 3 indicated		audits on all units throughout the facility five times a week on random shift to ensure resident rights are always maintained as evidence by resident's dignity is met prior to leaving for appointments. If corrected action is needed the DON/ Designee will complete 1:1 education immediately. The results of the audit observation will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for future recommendations.	

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	Resident B was a difficult resident to care for because he was resistive to care from staff because he was nonverbal and blind. She indicated when the transport team arrived at the facility to transport the resident to his doctor's appointment, the resident had dried feces on him and was not clean. She indicated staff had tried to clean him up but were unable to. She was unaware if he had any clothes with him from the group home. The LPN indicated the resident often pulled off his colostomy bag and they went through several bags a day. During an interview, on 4/2/24 at 3:26 p.m., Certified Nurse's Assistant (CNA) 4 indicated Resident B was resistive to care and would often rip off his colostomy bag and pull at his catheter. The CNA was working the day the resident needed transported to a doctor's appointment, but she was not aware he had an appointment. CNA 4 indicated she went to the laundry room to grab the resident some clothes to wear but when she arrived to the resident's room, the transport team already had the resident on the stretcher to go to his appointment. CNA 4 indicated that the transport team would not allow her to clean up the resident before they left for his appointment. She indicated the resident was wearing a hospital gown. Review of an ambulance care report, dated 3/21/24, indicated dispatch was notified on 3/20/24 at 8:20 a.m. of Resident B needed transport to a doctor's appointment on 3/21/24. The report indicated the transport team arrived at the long-term care facility on 3/21/24 at 10:31 a.m. Resident B was lying in his feces on a mattress on the floor. The resident was noted to be agitated upon their arrival. A CNA came into the resident's room and handed the transport team the			

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	paperwork for his appointment and indicated the resident was difficult to care for due to him being autistic. The report indicated that due to the resident's condition and mental status, crew lifted him onto the cot and was taken to ambulance for evaluation. Resident B was noted to have a foley (indwelling) catheter and colostomy bag that was pulled off. The resident's adult diaper was saturated with feces and his skin was severely irritated and redness was noted to the right side of his abdomen by the stoma and his buttocks. There was no urine output noted in the resident's urine drainage bag. The resident was taken to his urology appointment, and they arrived at 11:11 a.m. During an interview, on 4/3/24 at 8:36 a.m., the Director of Nursing (DON) indicated doctor appointments were placed in the electronic medical record for nursing staff to sign off on when the resident went out. The appointments were placed in the computer like a physician order. The doctor's appointments were also placed on a calendar at each nurse's station as well. It was the expectation of the facility that staff make sure a resident was clothed properly and cleaned up before they were transported to a doctor's appointment. If a resident did not have clothing items at the facility, they did have extra clothing items that were donated that a resident could wear. A hospital gown was not used to go out to the doctor unless that was the resident's preference and they were care planned for that. During a confidential interview, during the survey, indicated they had visited Resident B at the long-term care facility on the morning of his appointment on 3/21/24 at 9:15 a.m. They indicated the resident was laying on a mattress on the floor, he only had an adult diaper on. They			

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indicated the mattress looked wet. A CNA had walked into the room and placed a gown on the resident and indicated she had just cleaned him up. The confidential interviewee had spoken with LPN 3 about the resident and his care. LPN 3 informed them about the resident having a doctor's appointment that day at the urology office and that he had no clothes at the facility. The confidential interviewee indicated the resident was not known for removing his clothes or pulling on his colostomy bag at the group home where he had originally resided. They indicated it was not normal behavior for him to resist care.

During an interview, on 4/3/24 at 2:59 p.m., CNA 10 indicated she was working that day that Resident B was sent out to a doctor's appointment. She indicated she was not aware that he had an appointment that day. When the transport team arrived to the facility the resident had already ripped off his colostomy bag that she had just replaced. The transport team already had the resident on the stretcher, and she was unable to clean him up before they left. Resident B was wearing a hospital gown.

On 4/3/24 at 8:55 a.m., the DON provided an undated document titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Residents will be treated with dignity, and respect ...1. Personal care includes but not limited to a. Bathing, dressing, grooming ...."

This citation relates to Complaints IN00431026 and IN00431065.

3.1-3(t)

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral			

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	directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure medical records were accurately documented for 1 of 3 residents reviewed for intravenous medication administration (Resident D). Findings include: On 4/2/24 at 11:35 a.m. Resident D's record was reviewed. His diagnoses included, but were not	F 0842	We respectfully request a desk review for the tag. Thank you, **F 842** **Corrective Action accomplished for those residents found to be affected by the alleged deficit practice:** Resident D was not harmed by the facility's alleged deficient	05/02/2024

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	limited to, metabolic encephalopathy (a problem in the brain. It is caused by a chemical imbalance in the blood), acute kidney failure (kidneys suddenly stopped working properly), presence of cardiac pacemaker (a device used to control an irregular heart rhythm implanted into the heart), type 2 diabetes (blood sugar disorder), atrial fibrillation (heart rate irregularity), bacteremia (presence of bacteria in the bloodstream), bilateral sensorineural hearing loss (damage either to the tiny hair cells in your inner ear or to the nerve pathways that lead from your inner ear to the brain causing hearing loss), and congestive heart failure (the heart's capacity to pump blood cannot keep up with the body's need). A physician order, dated 1/29/24, indicated to administer cefazolin sodium injection solution, reconstituted 2 grams, intravenously (IV) (into the vein) every 8 hours at 6:00 a.m., 2:00 p.m., and 10:00 p.m. for urinary tract infection (UTI) (bacteria in the urine tract) until 2/9/24. The February 2024 medication administration record (MAR) lacked documentation of IV medication administration on 2/3/24 at 10:00 p.m., and 2/9/24 at 2:00 p.m. On 2/15/24 the dosing times were changed to 7:00 a.m., 3:00 p.m., and 11:00 p.m. the MAR further lacked documentation of medication administration on 2/17/24 at 11:00 p.m. The record lacked documentation for omission or resident refusal. A physician order, dated 1/29/24, indicated to administer heparin sodium lock flush IV solution 10 unit/milliliter (mL) (used to keep IV catheters open and flowing freely), 5 mL intravenously every 8 hours for IV usage until 2/9/24. Flush port/lumen (vein access) before and after each usage. The February 2024 MAR lacked		practice. Resident D no longer resides at the facility. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents with IV orders have the potential to be affected. On 4/4/2024 the facility conducted an audit to identify residents who were receiving IV medication per order and documentation was completed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:** Education was provided to all clinical staff utilizing the Medication Administration policy with emphasis on documentation of IV medication when orders are executed. **How the corrective action measures will be monitored to ensure the alleged deficient practice does not recur:** The DON/ Designee will audit 5 residents IV administration records (MAR) a week for four weeks, then three charts a week for four weeks, then 1 chart a week for four months to ensure all IV medications were given per order and documentation was complete. Any discrepancies will immediately be addressed and education provided. The results of the audits will o be	

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	documentation of medication administration on 2/3/24 at 10:00 p.m., 2/9/24 at 2:00 p.m., and 2/17/24 at 11:00 p.m. The record lacked documentation for omission or resident refusal. A physician order, dated 1/29/24, indicated to administer sodium chloride flush intravenous solution 0.9% (fluid used to clear/rinse the IV), 10 mL IV every 8 hours for IV usage until 2/29/24. Flush port/lumens before and after each usage. The February 2024 MAR lacked documentation of medication administration on 2/3/24 at 10:00 p.m., 2/9/24 at 2:00 p.m., and 2/17/24 at 11:00 p.m. The record lacked documentation for omission or resident refusal. Review of nurse's note, dated 2/14/24 at 12:02 p.m., indicated Resident D's wife was concerned the resident might have been missing doses of his intravenous (IV) antibiotics. Registered Nurse (RN) 12 indicated administration was scheduled for 6:00 a.m., 2:00 p.m., and 10:00 p.m., which were due right at shift changes. The RN indicated he changed the administration times to 7:00 a.m., 3:00 p.m., and 11:00 p.m. so oncoming nurses would not miss administration times and asked to pass along in report that if Resident D was down to a 24-hour supply of IV antibiotic, to contact the pharmacy and reorder. A care plan, dated 1/31/24, indicated Resident D had an infection, was admitted with IV antibiotics for UTI until 2/29/24, and was at risk for complications. Interventions included, but were not limited to, administration of antibiotics per medical provider's orders. Report abnormal findings to the medical provider, resident/resident representative. During an interview on 4/3/24 at 1:30 p.m.,		reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months, then randomly, thereafter for further recommendation.	

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	Licensed Practical Nurse (LPN) 8 and LPN 9 indicated that they did not understand the blanks in Resident D's MAR and that it should not have been blank. If the resident was out on leave of absence it would still be entered, and they would use the number coding system to indicate code three for not being given if they were out or absent from home/facility. If the medication was on backorder, they were to select option nine for other and it required a nurses' note to be put in and should be associated with it. Code zero indicated the medication was given. During an interview on 4/3/24 at 2:45 p.m., the Regional Director of Clinical Operations (RDCO) indicated that normally a hole in the MAR indicated the nurse did not document it. During an interview on 4/3/24 at 3:02 p.m., the Director of Nursing (DON) indicated that if the resident was out of the facility during the scheduled administration time, but returned within two hours of the scheduled dose, he should have received his medications. If he did not receive a dose of the IV medications, they would have been required to call telehealth, notify the family, and document the reason. Leave of absence records were provided by the Administrator (ADM) on 4/3/24 at 2:50 p.m. The records indicated Resident D signed out for leave of absence on 2/3/24 at 4:00 p.m. and indicated it was for a few hours. On 2/9/24 at 2:55 p.m. after the scheduled IV administration at 2:00 p.m. There was no documentation for leave of absence on 2/17/24. On 4/4/23 at 8:37 a.m., the DON provided an undated document, titled, "Medication Administration," and indicated it was the policy			

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	155484	A. BUILDING 00 B. WING	04/04/2024

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
	currently being used by the facility. The policy indicated, " ...Procedure: I. General Procedures ...dd. Medications will be charted when given ...ff. medications will be administered within the time frame of one hour before and up to one hour after the time ordered ...gg. Medications that are refused or withheld or not given will be documented. i. Critical medications that are refused including insulin, warfarin, heparin, or other anticoagulants will be followed up with physician contact ...." This citation relates to Complaint IN00427932. 3.1-50(a)(2)			