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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwood Healthcare Center	2222 Margaret Ave Terre Haute, IN 47802

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35317 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 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. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49068 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 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 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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., 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 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)