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	09/04/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to ensure a thorough investigation of abuse allegations was conducted and a record of the investigation was maintained for 3 of 3 residents reviewed for abuse (Residents H, G, and F). Findings include:1. An Indiana Department of Health (IDOH) reportable incident investigation file was reviewed on 9/3/25 at 2:31 p.m. The file included an IDOH incident report dated 6/14/25. The report indicated Residents H and G had an altercation in the dining room. Resident H pushed Resident G's wheelchair across the dining room. There was no physical touch or harm. The staff immediately separated the residents, and an investigation was initiated. The report indicated the investigation would include resident statements. The incident file included two statements from staff members who witnessed the incident and three days of psychosocial follow-up for Residents H and G. The incident file lacked documentation of resident statements, including interviews to determine if other residents had experienced negative interactions with Resident H. Resident H's record was reviewed on 9/3/25 at 2:47 p.m. Diagnoses on the resident's profile included, but were not limited to, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 7/9/25, indicated the resident had moderate cognitive impairment. The resident's electronic health record, including progress notes, lacked documentation of the incident on 6/14/25. 2. Resident G's record was reviewed on 9/4/25 at 10:28 a.m. Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 7/14/25, indicated the resident had severe cognitive impairment. The resident's electronic health record, including progress notes, lacked documentation of the incident on 6/14/25. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 9/4/25 at 10:50 a.m., the Executive Director (ED) indicated normally they interviewed other residents to determine if there were any other abuse concerns during investigations. She was not sure if this was done and would look for further information. During an interview, on 9/4/25 at 11:15 a.m., the ED indicated the information regarding the altercation should have been documented in the residents' electronic health record. During an interview, on 9/4/25 at 11:38 a.m., the ED indicated she was not able to find further documentation for the incident file, including interviews with other residents, at this time. 2. An Indiana Department of Health incident report document, dated 8/17/25 at 9:52 a.m., indicated staff had reported to the Executive Director (ED) that Certified Nurse Aide (CNA) 3 had made contact with Resident C on the facility's Memory Care unit resulting in Resident C sustaining a skin tear to his right forearm. The CNA had been suspended pending the investigation of the incident. Resident C's record was reviewed on, 9/3/25 at 10:33 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia (a diagnosis given when a person experiences cognitive decline and symptoms of dementia, but the specific underlying cause or type of dementia cannot be identified through testing or observation). A quarterly Minimum Data Set (MDS) assessment, dated 7/28/25, indicated the resident had severe cognitive deficit and had no documented behaviors. A care plan, dated 7/20/23, indicated the resident had ADL (activities of daily living-the basic, routine tasks of self-care that most healthy individuals perform daily without assistance) deficit and required substantial to maximal assistance with ADLs. A care plan, dated 7/21/23, indicated the resident was at risk for altered skin integrity. A weekly skin check form, dated 8/15/25 at 5:38 a.m., indicated the resident had no new skin area issues. A weekly skin check forms, dated 8/22/25 at 5:38 a.m. and 8/22/25 at 6:25 a.m., indicated the resident had no new skin area issues. Weekly skin check form, dated 8/22/25 at 6:28 a.m., indicated the resident had a new skin area noted, but that area was not new since last skin check. The form lacked documentation of where the new skin area was located and what type of skin issue it was. The weekly skin check forms lacked documentation that any skin check was completed on 8/17/25, the date of the reported incident. Review of the nurse progress notes, dated 8/15/25 to 8/22/25, lacked documentation of any incident resulting in a skin tear to the resident's forearm. A Wound Nurse Practitioner progress note, dated 8/22/25, lacked documentation of a skin tear to the resident right forearm. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 30-day CNA Point of Care form, dated 8/5/25 through 9/3/25, lacked documentation of any observations of new skin area concerns. Review of the facility's incident investigation documentation, on 9/4/25 at 9:05 a.m., indicated the following: a. An undated statement from CNA 3. The statement lacked documentation of any situation where the resident was contacted by the CNA, any fall, or other reason where a skin tear would have been received by the resident. b. An interview of Resident C, dated 8/17/25, conducted by the ED and the Regional Director of Clinical Operations (RDCO). The interview document indicated the resident was not sure how he received the skin tear. He denied being afraid of any staff on the unit and that he felt safe on the unit. The document also included a statement which indicated that the ED and RDCO had interviewed the staff on the unit who had been working at the time of the incident. The statement lacked documentation of the names, titles, and individual statements by the staff who were interviewed. During an interview, with the ED and the RDCO, on 9/4/25 at 9:49 a.m., the ED indicated she and the RDCO were in the building when the incident happened, and the staff immediately notified her. She made the decision to suspend the CNA at that time. She indicated a skin assessment should have been done after the resident received the skin tear. She was unsure why there was not an assessment completed until 8/22/25. At the same time, the RDCO indicated they interviewed staff who had been working on the unit at the time of the incident. The staff indicated they could not determine that any type of abuse had been committed. He thought they had obtained individual statements from the staff who were interviewed but were not able to locate them. On 9/4/25 at 10:57 a.m., the ED provided a written statement from a housekeeper who indicated she was not on the unit during the time of the incident. No other statements were presented. During an interview, on 9/4/25 at 11:38 a.m., the ED indicated they had not been able to find any further documentation for this investigation. The nurse on the unit during the incident with the CNA had been interviewed and a statement was written. However, they could not find a copy of this statement. She had contacted the nurse, via telephone, and the nurse remembered writing a statement, but she did not have a copy of it. On 9/3/25 at 11:14 a.m., the ED provided an undated document, titled, “Indiana Abuse & Neglect & Misappropriation of Property,” and indicated it was the policy currently being used by the facility. The policy indicated, “…Investigation of Incidents…1…e. Statements will be obtained from the resident or from the reporter of the incident…g. Documentation of the facts and findings will be completed in each resident medical record…2. Suspected Abuse…d. Statements will be obtained from staff related to the incident, including victim, person reporting the incident, accused perpetrator and witnesses. This statement should be in writing, signed, and dated at the time written….” This citation relates to Intake 2591628. 3.1-28(d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to accurately document wound description upon admission to the facility for 1 of 3 residents reviewed for wounds (Resident B), and failed to ensure medications were documented according to physician orders for administration of insulin for 1 of 3 residents reviewed for medication administration (Resident D). Findings include: 1. On 9/3/25 at 11:00 a.m., the medical record of Resident B was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but were not limited to paraplegia (paralysis that occurs in the lower half of the body), and type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A physician order, dated 8/11/25, indicated to administer Medi honey Wound/Burn Dressing External Gel to coccyx wound topically every dayshift for pressure ulcer care cover with ABD pad and secure. A physician order, dated 8/10/25, indicated administer Miconazole Nitrate 2 % Cream to perimeter of coccyx wound topically two times a day for fungal. A physician order, dated 8/13/25, indicated apply Santyl (a prescription ointment that removes dead tissue from wounds to help them heal) external ointment to coccyx wound daily for wound care. A physician order, dated 8/10/25, indicated to perform daily coccyx wound assessment and document abnormalities in progress notes every shift for Wound Management. A physician order, dated 8/10/25, indicated the resident was on a pressure reducing/relieving mattress every shift for pressure reducing/relieving. A care plan, dated 8/10/25, indicated the resident had impaired skin integrity and was at risk for further altered skin integrity related to dependent on staff for turning/repositioning, peri care after incontinent episodes, has an unstageable wound to coccyx. Interventions included but were not limited to complete skin at risk assessment upon admission/readmission, encourage resident to turn and reposition or assist as needed as resident allows, provide appropriate off-loading mattress and off-loading cushion if applicable, and treatments as ordered. An admission MDS assessment, dated 8/14/25, indicated the resident was cognitively intact and dependent upon the staff for personal care. On 9/4/25 at 9:05 a.m., during an interview the Minimum Data Set Assessment (MDS) coordinator indicated she would measure wounds and would stage the wounds at the time of admission. She indicated she entered the wound measurements in centimeters. She indicated when she measured Resident B's wound on admission she measured the wound in centimeters she acknowledged the measurement of 4 x 4 was in centimeters not in inches. She indicated the resident informed her when he was at the hospital he was left in one position for several hours and he developed a wound on his bottom. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/25 at 10:15 a.m., during phone interview with outside wound center facility (Nurse at wound center), indicated the resident was seen on 8/7/25. This was 3 days prior to the resident admission to the facility on 8/10/25. The wound center record indicated the sacral wound measured 6.1cm x 8.8 cm x 0.1 cm. The resident was seen by the wound center on 8/14/25, the day the resident was discharged from the facility. The wound center nurse indicated their record indicated the sacral wound measurements were 10.7 cm x 13.5 cm x 0.1 cm. The medical record indicated the wound had deteriorated prior to the resident's admission to the facility. On 9/4/25 at 10:31 a.m., during interview the DON indicated the initial measurements should be made by the RN or the MDS Coordinator. The wound nurse would follow up with the resident. She did not know if they were allowed to stage a wound. She indicated the nurse should measure wound in centimeters not in inches. On 9/4/25 at 10:50 a.m., the Director of Nursing (DON) provided a document, titled, “Measuring a Wound,” dated12/19/24, and indicated it was the policy currently being used by the facility. The policy indicated, “ .Dimensions 1. Measure length, width, depth, undermining and tunneling in centimeters….” 2. Resident D's record was reviewed on 9/3/25 at 1:15 p.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus with hyperglycemia (occurs when a person with diabetes has persistently high blood sugar levels due to insulin resistance and/or insufficient insulin production). A quarterly Minimum Data Set (MDS) assessment, dated 7/16/25, indicated the resident had moderate cognitive deficit and was on insulin injections. A care plan, dated 2/2/24, indicated the resident had diabetes and was at risk of complications. Interventions included but were not limited to, administer medication per provider's orders and observe for side effects and effectiveness. A physician order, dated 4/17/24, indicated to administer Lispro (insulin medication) subcutaneous (under the skin) solution pen injector 100 unit/ml (milliliter), inject 10 units subcutaneously before meals for type 2 diabetes mellitus at 7:30 a.m., 11:30 a.m., and 4:30 p.m. A physician order, dated 4/16/24, indicated to administer Glargine (insulin medication) subcutaneous pen injector 100 unit/ml, inject 30 units subcutaneously in the evening for dates at 9:00 p.m. Review of August 2025 MAR (medication administration record) indicated the Lispro insulin medication was documented as administered at the following times: a. On 8/3/25 the 7:30 a.m. dose was documented as administered at 11:47 a.m. b. On 8/4/25 the 7:30 a.m. dose was documented as administered at 8:50 a.m. c. On 8/5/25 the 4:30 p.m. dose was documented as administered at 10:08 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 8/6/25 the 7:30 a.m. dose was documented as administered at 8:47 a.m. e. On 8/6/25 the 4:30 p.m. dose was documented as administered at 6:47 p.m. f. On 8/10/25 the 4:30 p.m. dose was documented as administered at 6:03 p.m. g. On 8/11/25 the 11:30 a.m. dose was documented as administered at 3:17 p.m. h. On 8/10/25 the 4:30 p.m. dose was documented as administered at 6:07 p.m. i. On 8/12/25 the 7:30 a.m. dose was documented as administered at 8:40 a.m. j. On 8/12/25 the 4:30 p.m. dose was documented as administered at 11:32 p.m. k. On 8/13/25 the 11:30 a.m. dose was documented as administered at 1:25 p.m. l. On 8/15/25 the 7:30 a.m. dose was documented as administered at 9:30 a.m. m. On 8/15/25 the 11:30 a.m. dose was documented as administered at 1:34 p.m. n. On 8/15/25 the 4:30 p.m. dose was documented as administered at 10:10 p.m. o. On 8/18/25 the 7:30 a.m. dose was documented as administered at 8:39 a.m. p. On 8/18/25 the 4:30 p.m. dose was documented as administered at 7:56 p.m. q. On 8/21/25 the 7:30 a.m. dose was documented as administered at 8:39 a.m. r. On 8/26/25 the 7:30 a.m. dose was documented as administered at 9:49 a.m. s. On 8/28/25 the 7:30 a.m. dose was documented as administered at 8:39 a.m. t. On 8/31/25 the 4:30 p.m. dose was documented as administered at 5:42 p.m. Review of August 2025 MAR indicated the Glargine insulin medication was documented as administered at the following times: a. On 8/3/25 the 9:00 p.m. dose was documented as administered on 8/4/25 at 1:10 a.m. b. On 8/5/25 the 9:00 p.m. dose was documented as administered at 10:09 p.m. c. On 8/8/25 the 9:00 p.m. dose was documented as administered at 11:09 p.m. d. On 8/10/25 the 9:00 p.m. dose was documented as administered at 11:29 p.m. e. On 8/11/25 the 9:00 p.m. dose was documented as administered at 10:06 p.m. f. On 8/15/25 the 9:00 p.m. dose was documented as administered at 11:02 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 820/25 the 9:00 p.m. dose was documented as administered on 8/21/25 at 12:50 a.m. h. On 8/27/25 the 9:00 p.m. dose was documented as administered at 11:18 p.m. i. On 8/15/25 the 9:00 p.m. dose was documented as administered at 11:49 p.m. Review of September 2025 MAR indicated the Lispro insulin medication was documented as administered at the following times: a. On 9/1/25 the 7:30 a.m. dose was documented as administered at 9:02 a.m. b. On 9/2/25 the 4:30 p.m. dose was documented as administered at 6:10 p.m. During an interview, on 9/4/25 at 10:00 a.m., Licensed Practical Nurse (LPN) 5 indicated that the nurses would have to administer insulins to the residents on the halls that had a Qualified Medication Aide (QMA) working because QMAs were not allowed to give insulin injections. LPN 5 indicated it could be hard to administer the insulin medication on time if the nurse didn't prioritize her time management properly. During an interview, on 9/4/25 at 10:10 a.m., Registered Nurse (RN) 6 indicated that she would often get the insulin medications administered on time, but she would not always get the insulin documented at the time of administration; therefore, on the medication administration record it would appear as if the medication was administered late. During an interview, on 9/4/25 at 10:31 a.m., the Director of Nursing (DON) indicated staff should document the administration of medications when they were administered to the residents to ensure adequate documentation. On 9/4/25 at 10:48 a.m., the DON provided a document, dated 12/2/24, titled, Medication Administration, and indicated it was the currently policy being used by the facility. The policy indicated, .MAR: Medication Administration Record - the legal documentation for medication administration .f. Observe the five rights in giving each medication: .ii. the right time .dd. Medications will be charted when given .a. Documentation of medication will be current for medication administration b. Documentation of medications will follow accepted standards of nursing practice This citation relates to Intake 2602845. 3.1-50(a)(2) 3.1-50(f)