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	10/09/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from neglect, when the facility failed to ensure a resident was provided adequate monitoring and care during the night shift for 1 of 4 residents reviewed for neglect (Resident B). The immediate jeopardy began on [DATE] when staff failed to visualize a resident during the 8-hour night shift and the resident was found deceased on the floor between the bed and wheelchair the next morning at 7:15 a.m. The Administrator, Director of Nursing (DON), Regional Director of Clinical Operations (RDCO), and a RDCO in training were notified of the immediate jeopardy on [DATE] at 4:52 p.m. The immediate jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:Resident B's record was reviewed on [DATE] at 10:40 a.m. Census information indicated the resident was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses on the resident's profile included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of lung diseases that cause airflow obstruction and breathing problems), unspecified systolic congestive heart failure (a condition where the heart's left ventricle cannot pump blood effectively enough to meet the body's needs), type two diabetes mellitus without complications (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and atherosclerotic heart disease of native coronary artery (buildup of fats, cholesterol and other substances in and on the walls of the heart arteries) without angina pectoris (chest pain). A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact, had not refused care, used a walker and wheelchair, required supervision or touching assistance with toileting hygiene, showering/bathing, upper/lower body dressing, personal hygiene, chair/bed transfers, toilet transfers, and tub/shower transfers. A Physician's Orders for Scope of Treatment (POST) form (a medical document that outlines a patient's end-of-life care preferences, designed for individuals who are seriously ill or frail and may have limited life expectancy), dated [DATE], was signed by the resident. The form indicated the resident wanted cardiopulmonary resuscitation (CPR) (an emergency lifesaving procedure performed when the heart stops beating) if the resident was found not breathing and with no pulse. A care plan, current at the resident's death and goal target dated [DATE], indicated the resident had an activities of daily living (ADL) performance deficit and required assistance with ADLs related to cognitive deficit, disease process, and functional deficit. Interventions included, but were not limited to, the resident preferred to go to bed by 9:30 p.m. to 10:00 p.m.; required the assistance of one staff member for transfers; staff were to place the resident's call light within reach and remind the resident to call for assistance if cognitively intact; and required supervision/touching assistance where the helper cued and touched/steadied the resident for toileting hygiene, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, rolling left and right in bed, sitting to lying, lying to sitting on the side of the bed, sit to stand movement, chair to bed and bed to chair transfers, and toilet transfers. A care plan, current at the resident's death and goal target dated [DATE], indicated the resident was incontinent of urine related to impaired mobility. Interventions included, but were not limited to, check the resident for incontinence, wash, rinse, and dry the perineum (layer of skin between genitals and anus), and change clothing as needed after incontinence episodes. A care plan, current at the resident's death and goal target dated [DATE], indicated the resident had impaired thought processes related to the resident being developmentally delayed with a long history of mental illness and mild intellectual disability. Interventions included, but were not limited to, provide the resident approaches that maximize her involvement in daily decision making and activities using cueing, task segmentation, and instructions. A care plan, current at the resident's death and goal target dated [DATE], indicated the resident was at risk for falls related to decreased mobility, anxiety, osteoarthritis (a common joint disease that causes pain, stiffness, and loss of function) to the right hip, type two diabetes mellitus, COPD, and systolic heart failure. The resident received psychotropic medication which increased the risk of falls and had a history of falls. Interventions included, but were not limited to, ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed and remind the resident and reinforce safety awareness including locked brakes on the bed and wheelchair before transfers, and sit on the side of the bed for a few minutes before transfers. A care plan, current at the resident's death and goal target dated [DATE], indicated the resident was able to make health care decisions and was a full

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient staffing was provided to care for and supervise the residents that resided at the facility for 1 of 7 residents reviewed for sufficient staffing (Resident B). The immediate jeopardy began on [DATE] when the facility staff failed to provide care and supervision of residents residing at the facility during the eight hour night shift resulting in a resident not being checked on all night and was found deceased on [DATE] at 7:15 a.m. The Administrator, Director of Nursing (DON), Regional Director of Clinical Operations (RDCO), and a RDCO in training were notified of the immediate jeopardy on [DATE] at 4:52 p.m. The immediate jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:Resident B's record was reviewed on [DATE] at 10:40 a.m. Census information indicated the resident was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses on the resident's profile included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of lung diseases that cause airflow obstruction and breathing problems) unspecified, unspecified systolic congestive heart failure (a condition where the heart's left ventricle cannot pump blood effectively enough to meet the body's needs), type two diabetes mellitus without complications (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and atherosclerotic heart disease of native coronary artery (buildup of fats, cholesterol and other substances in and on the walls of the heart arteries) without angina pectoris (chest pain). A Physician's Orders for Scope of Treatment (POST) form (a medical document that outlines a patient's end-of-life care preferences, designed for individuals who are seriously ill or frail and may have limited life expectancy), dated [DATE], was signed by the resident. The form indicated the resident wanted cardiopulmonary resuscitation (CPR) (an emergency lifesaving procedure performed when the heart stops beating) if the resident was found not breathing and with no pulse. A nursing progress note, dated [DATE] at 7:15 a.m., indicated, Writer went into resident room to obtain [blood sugar] and pass morning medication. Resident was found on floor between wheelchair and bed, face down, resident unresponsive and cool to touch at this time. Writer called for other staff to help, resident had no pulse at this time, DON [Director of Nursing], MD [Medical Doctor], Admin [Administrator] were all called to report death. A plan of care (POC) response history report, dated [DATE] to [DATE], indicated the amount of support provided for toilet use was to be documented and included, .how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad.adjusts clothes. The last recorded entry was on [DATE], and the report lacked documentation toilet assistance was provided after [DATE]. A POC response history report indicated the resident had no bowel movement on [DATE] at 11:37 p.m. The POC history report lacked further documentation after the entry on [DATE] at 11:37 p.m. A POC response history report indicated the resident was continent of bladder on [DATE] at 11:37 p.m. The POC history report lacked further documentation after the entry on [DATE] at 11:37 p.m. A POC response history report for toilet use indicated the number of times the resident used the toilet should be documented, between numbers one and ten. The last entry on the report was dated [DATE], and the report lacked documentation the resident used the toilet on [DATE] or [DATE]. On [DATE] at 1:39 p.m., the Regional Director of Clinical Operations (RDCO) provided an incident file regarding Resident B's death. The following documentation was included in the file. -A timeline of events indicated, on [DATE], at 7:15 a.m., Resident B was found by oncoming shift nurse Licensed Practical Nurse (LPN) 4 during morning rounds. The resident was located next to her bed with her wheelchair on her right side, was nonresponsive to verbal stimuli, and there was no pulse or respirations. LPN 4 identified Resident B had irreversible signs of death including rigor mortis (a post-death phenomenon where the muscles of the body become stiff and inflexible), and CPR was not initiated. At 7:16 a.m., LPN 4 called 911, the Administrator, and the DON. At 7:20 a.m., the resident's body was left untouched, and the door was closed. At 7:30 a.m., the first attempt to notify Resident B's family was made with multiple calls made until the resident's family was reached. At 7:30 a.m., the Administrator notified corporate management, and they instructed the Administrator to start an investigation. At 8:30 a.m., the Coroner arrived at the facility and requested the police be notified. At 9:10 a.m., the detective arrived at the facility. At 10:45 a.m., the body was released to the Coroner. -A typed statement from Licensed Practical Nurse (LPN) 7, dated [DATE], indicated, I did not physically go in to see her [Resident B], if she needs anything she typically comes out of