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	04/08/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to arrange transportation to an acute care hospital for a scheduled stay prior to a surgical procedure, causing cancellation of the surgical procedure, for 1 of 3 residents reviewed for quality of care and administration/personnel (Resident B).Findings include:During a telephone interview on 4/7/26 at 11:03 a.m., Resident B's resident representative indicated the resident had moved to the facility in December 2025. He had a surgical procedure scheduled to remove his bladder and divert his urinary function to be able to live without tubing exiting his back for urine drainage. In October of 2025, the surgery had been scheduled to be performed on 3/31/26. He was to be admitted to the acute care hospital on 3/29/26 to complete a neurology assessment prior to the surgery on 3/31/26. The hospital had called her on 3/29/26 at 3:40 p.m. and indicated Resident B's bed was ready for him to be transported. She asked them to call the facility so they could transport him. She had not called the facility to confirm, as she had stressed the importance in prior conversations with the Director of Nursing (DON) and had been assured that arrangements were in place. She received a call from the surgeon's office between 8:00 and 8:30 a.m. on the morning of 3/30/26 and was told the resident was not at the hospital. She had clearly communicated and confirmed with the DON regarding the need for Resident B to arrive on 3/29/26 and had stressed the importance of these procedures for Resident B. When she received the call the morning of 3/30/26, she was told by the hospital that they had spoken to the DON and were told the resident was not transferred on 3/29/26 and was preparing to leave the facility now. The hospital staff had told the DON to wait until they confirmed his procedures would remain on the schedule. The facility sent the resident to the hospital, and the resident was eventually returned to the facility due to the procedures being cancelled because the pre-surgical consultation with the neurologist could not be completed.A clinical record review for Resident B was completed on 4/7/26 at 10:14 a.m. Diagnoses included chronic kidney disease, obstructive and reflux uropathy, artificial openings of the urinary tract, and major depressive disorder.A significant change Minimum Data Set (MDS) assessment, dated 3/17/26, indicated the resident was cognitively intact and was dependent on staff for bathing, hygiene, dressing, and transfers. The resident had a urinary catheter.A current health care plan, revised 3/23/26, indicated Resident B had a communication problem. Interventions included allowing family support per resident's preference.A current health care plan, dated 1/1/26, indicated Resident B had a suprapubic catheter related to obstructive uropathy. Interventions included observing and document for pain or discomfort due to his catheter.A current health care plan, revised 3/23/26, included Resident B had impaired skin integrity and was at risk for altered skin integrity due to drains to his back. Interventions included to provide appropriate off-loading mattress and to encourage resident to turn and reposition.A nursing progress note, dated 3/30/26 at 9:31 a.m., indicated Resident B had been transported to an acute care hospital for admission for surgery tomorrow.A nursing progress note, dated 3/30/26 at 4:38 p.m., indicated Resident B had returned to the facility at this time. A neurology consultation was needed prior to surgery per urology.A review of the facility scheduling log lacked indication of any appointments on 3/29/26.During an interview on 4/7/26 at 1:08 p.m., the DON indicated Resident B's surgery was scheduled for 3/31/26, and the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off at the hospital and left. The DON indicated to her that she had called transport and cancelled the pick-up. Transport had dropped him off at the hospital between 11:00 and 11:30 a.m. They returned to the hospital to pick up Resident B at 1:42 p.m. to return to the facility. Resident B was to see the neurologist first thing on 3/30/26. It had been made clear to the DON and the resident representative that he needed to be admitted 48 hours prior to surgery because it could take 24 hours for neurology to clear him for surgery.During an interview on 4/8/26 at 10:27 a.m., the DON indicated she had received a call from the Surgery Scheduler from the surgeon's office at 8:30 a.m., who indicated not to transport Resident B to the hospital. She had been in the waiting room for a family member's appointment and sent a text to the facility not to send the resident out until further notice. She had not called the facility. After the appointment, she went to the facility at 11:00 a.m. and found the resident had been transferred out to the hospital. She realized at that time that her text message had not gone through to the facility. The Surgical Scheduler called her again sometime after 12:00 p.m. and indicated the surgery had been cancelled and would need to be rescheduled. She had since learned the transport company can arrange quick transport for an extra fee. She had not been aware this was an option and felt she had no way to arrange for transportation on 3/29/26 without a specific time. She did not recall talking to the Surgical Scheduler on 3/18/26, but it probably had happened because she had spoken to her several times. She does not recall being told the date of the transport being changed to 3/29/26. She indicated after the resident returned, she had attempted to speak with him and was asked to get out of his room. She had spoken to his resident representative several times to inform her of status of getting his procedures re-scheduled. A current facility policy, undated, titled, Resident Transportation, provided by the Administrator on 4/7/26 at 2:40 p.m., included the following: Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. The facility will assist the resident in making transportation arrangements to and from the source of any needed service, such as dental visits, or physician visits in the event the resident requires such assistance.This citation relates to Intake 2972240.410 IAC (Indiana Administrative Code) 16.2-3.1-37(b)