STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's family had been notified of a change in condition and when the resident was transferred to the hospital for 1 of 3 residents reviewed for family notification (Resident B). Finding includes: Resident B's record was reviewed on 8/19/20 at 11:03 a.m. An annual Minimum Data Set (MDS) assessment, dated 6/15/20, indicated the resident was cognitively impaired. A progress note, dated 8/7/20 at 5:54 p.m., indicated the resident had dry lips and tongue, with difficulty swallowing and drinking. The physician was notified and new orders were received for a chest x-ray, complete blood count, complete metabolic panel, and urinalysis with culture and sensitivity. The progress notes lacked documentation the family had been notified. A progress note, dated 8/10/20 at 8:58 a.m., indicated the resident was noted to have dry lips and tongue. The resident refused to eat, drink fluids, and take medications. The physician was notified and an order was received to send the resident to the emergency room for evaluation and treatment. The progress notes lacked documentation the family had been notified. During an interview, on 8/21/20 at 1:13 p.m., the Regional Nurse indicated the resident's family should have been notified when the resident had a change of condition with new physician orders [REDACTED]. She could not find documentation where the family had been notified on either date. On 8/20/20 at 2:32 p.m., the Regional Nurse provided a document, revised 11/30/18 and titled, Notification for Changes in Condition, and indicated it was the policy currently being used by the facility. The policy indicated, Scope: This policy is applicable to all adult living centers .i. For resident representative/authorized family members .3. At least 2 (two) attempts will be made to contact the individual by telephone .II. Notifications: a. When a change in condition is noted, the nursing staff will contact the resident representative c. Notifications that are for emergency situations, require immediate notification as soon as timer permits. i. Examples may include but are not limited to: 1. Transfer to hospital. 2. Severe change in physical or mental health .III. Timing and Documentation of notifications .c. The nurse will record in the progress notes, the name of person called, the time of each attempt to contact, and the telephone number(s) attempted This Federal tag relates to Complaint IN 252 and IN 298. 3.1-5(a)(3) 3.1-5(a)(4)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure fingernail care was provided for 2 of 9 residents reviewed for activities of daily living (ADL's) (Residents D and C). Findings include: 1. On 8/19/20 at 1:36 p.m., Resident D was observed to have long, untrimmed fingernails with dark debris underneath them on both hands. At the same time, the resident indicated she was not able to do her own fingernail care, and needed assistance to keep her fingernails clean and trimmed. On 8/20/20 at 9:10 a.m., Resident D was observed sitting in the hallway. She was unable to open her right hand when asked. When she opened her left hand, an odor was noted. Resident D's fingernails on both hands were long, untrimmed, and had dark debris underneath them. On 8/21/20 at 10:17 a.m., Resident D's fingernails were observed to be long, untrimmed, with dark debris underneath them. On 8/21/20 at 10:20 a.m., Certified Nursing Assistant (CNA) 11 observed Resident D's fingernails, and indicated they needed filed and cleaned. Fingernail care should have been done with showers or bathing, and included filing and cleaning underneath nails. Resident D needed assistance with fingernail care and had not refused care. Resident D's record was reviewed on 8/20/20 at 11:50 a.m. [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 5/14/20, indicated the resident had a moderate cognitive impairment and required extensive assistance from staff for personal hygiene needs. Nurse's notes from, from August 2020, lacked documentation the resident refused fingernail care. A care plan, last revised 5/28/20, indicated the resident had an activities of daily living (ADL) self-care performance deficit and required assistance for all ADL's to meet her needs. Interventions included, but were not limited to, check nail length, trim, and clean on bath day and as necessary, report any changes to the nurse. 2. On 8/19/20 at 1:34 p.m., Resident C was observed lying in bed. Her thumb nails were observed to be very long and chipped with dark debris underneath them. On 8/21/20 at 10:10 a.m., Resident C was observed lying in bed. The thumb nails on both hands were long, chipped, with dark debris underneath them. On 8/21/20, Certified Nursing Assistant (CNA) 11 observed Resident C's fingernails. When CNA 11 assisted the resident to open her hands, there was an odor noted. At the same time, CNA 11 indicated Resident C had an old set of acrylic fingernails on, and she was unsure what to do about this. The nurse was aware of it, but had not provided any guidance on what to do. Resident C's bilateral hands were observed to have outgrown acrylic fingernails, long, chipped, with dark debris underneath them. CNA 11 indicated Resident C's fingernails needed cleaned. Resident C needed assistance with fingernail care and had not refused care. Resident C's record was reviewed on 8/19/20 at 2:23 p.m. [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 6/30/20, indicated the resident had a severe cognitive impairment and required extensive assistance from staff for personal hygiene needs. Nurse's notes from, from August 2020, lacked documentation the resident refused fingernail care. A care plan, last revised 7/5/20, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to [MEDICAL CONDITIONS], and was dependent on staff to meet her needs. Interventions included, but were not limited to, check nail length, trim, and clean on bath day and as necessary, report any changes to the nurse. During an interview, on 8/20/20 at 11:27 a.m., CNA 10 indicated fingernail care should have been provided when residents were bathed. On 8/21/20 at 12:40 p.m., the Regional Nurse provided a document titled, Nail and Hair Hygiene Services, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: .This facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident .Routine care also includes nail hygiene services including routine trimming, cleaning and filing. Routine Nail hygiene .may be performed in conjunction with bathing or performed separately .Procedure: 1. Routine Nail Hygiene a. Residents will have routine nail hygiene .as part of the bath or shower. i. Nails should be trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming and filing .d. Daily hand washing will be completed with nail care to include cleaning and trimming or filing of sharp edges to prevent infection and damage to skin from scratching This Federal tag relates to Complaint IN 592, IN 252, and IN 298. 3.1-38(a)(3)(E)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.**

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure sufficient nursing staff to provide nursing and related services resulting in medications not being administered to four of seven residents reviewed for medication administration accuracy (Residents P, C, D, and E); call lights not being answered for two of nine residents reviewed for sufficient staffing and nursing services (Residents P and Q); and nail care was not being provided to two of nine residents reviewed for activities of daily living (Residents C and D). Findings include: Confidential interviews were conducted during the course of the survey. The interviewee indicated they usually worked in the Secure Unit. They were often asked to cover the other units but refused because they did not feel there were enough staff to take care of the residents on the other units and it was not safe. Confidential interviews were conducted during the course of the survey. The interviewee did not feel the staff levels were safe. They had a lot of occurrences of nursing staff not coming to work (no calls/no shows), quitting with no notice or leaving mid shift. There was an issue of understaffing CNAs as well. Residents' briefs did not get changed, mouth care was not done, and residents were not able to get showers because there was not enough staff to take care of the residents. 1. During an interview, on 8/20/20 at 11:40 a.m., Resident P indicated she did not think there was enough staff. She did not always get her medications on time. One shift she did not get them at all. She had diabetes, so she was worried about not having her medication. Review of Resident P's Medication Administration Record (MAR) for July 2020, provided by the Regional Nurse on 08/21/20 at 2:00 p.m., reflected the five medications scheduled to be administered on the morning of 7/26/20 (between 7:30 a.m. and 11:30 a.m.) were not documented as given, held or refused, including [MEDICATION NAME] Insulin (a rapid-acting insulin). The following scheduled interventions were also not documented as completed: COVID-19 symptom evaluation, pain monitoring, and blood sugar monitoring. Review of Resident P's Progress Notes, provided by the Regional Nurse on 08/21/20 and dated 7/26/20, reflected no notes related medication administration. Review of Resident C's MAR for July 2020 reflected the 12 medications scheduled to be administered on the morning of 7/26/20 were not documented as given, held, or refused, including insulin. The following scheduled interventions were also not documented as completed for the day shift (6:00 a.m. to 2:00 p.m.): COVID-19 symptom evaluation, measuring and recording indwelling urinary catheter, administering 40 cubic centimeters (cc) of water per her gastrostomy tube ([DEVICE]) every four hours, administering 200 cc of Glucerna via [DEVICE], monitoring for pain, and monitoring blood sugar and administering insulin as indicated. Review of Resident C's Progress Notes dated 7/26/20 reflected no notes related medication administration. Review of Resident D's MAR for July 26 reflected the 11 medications scheduled to be administered on the morning of 7/26/20 were not documented as given, held, or refused. The following scheduled/ordered interventions were also not documented as completed during the day shift: COVID-19 symptom evaluation, vital signs, and monitoring for pain. Review of Resident D's Progress Notes dated 7/26/20 reflected no notes related medication administration. Review of Resident E's MAR for July 2020 reflected the 12 medications scheduled to be administered on the morning of 7/26/20 were not documented as given, held, or refused, including insulin, and pain and antipsychotic medication. The following scheduled interventions were also not documented as completed: COVID-19 symptom evaluation and monitoring for side effects of antianxiety medications, behaviors, pain, and blood sugar. Review of Resident Q's Progress Notes dated 7/26/20 reflected no notes related medication administration. Reference F760. During an interview, on 8/21/20 at 1:00 p.m., Registered Nurse (RN) 17 indicated he recalled that Sunday, July 26. There were only two nurses working in the whole building including the Secure Unit. Two of the scheduled nurses were no call/no show. RN 17 usually worked on units 2A and 400, which he did on that day, but then he had to split up the rest of the work with LPN 23. They also had only four CNAs to cover six units, which he did not think was enough to provide resident care. He did not recall seeing a Unit Manager. RN 17 and LPN 23 did the best they could but did not get everything done. Administration said they were getting someone else to come in, but one hour before the shift was to end, 1:00 p.m., RN 17 and LPN 23 still had no help. During an interview, on 8/21/20 at 12:43 p.m., the Administrator and Regional Nurse indicated nurses were supposed to document in the MAR if they administered a medication. If they did not administer a scheduled medication, they should document why they did not on the MAR and/or progress notes. If they could not document that they gave the medication at the time they administered it, they should make a late entry. They confirmed there was no documentation that medications were administered for Residents P, C, D, and E for the day shift of 7/26/20. During an interview, on 8/21/20 at 2:09 p.m., the Regional Nurse indicated/confirmed there were no progress notes for Residents P, C, D and E on 7/26/20 related to missing medications. They were not aware of the missed medications, did not understand what happened, and were unable to contact the Nurse Manager assigned to work that day for a possible explanation. During an interview, on 8/19/20 at 2:42 p.m., the CNA Scheduler, said the Daily Assignment Sheet reflected what was scheduled and was noted to reflect what staffing occurred during each shift. Review on 08/20/2 at 10:26 a.m. of the facility Daily Assignment Sheet, dated 7/26/20, reflected there were originally four nurses assigned to work the day shift (6:00 a.m. to 2:00 p.m.). RN 17 was assigned to work units 400 and 2A. The nurse assigned to work the 500 and 100 units never showed, the nurse assigned to work on 2B never showed, and the nurse assigned to work on units 2B and 600 (LPN 23) was late. Five CNAs and two Hospitality Aides were scheduled to work the day shift on 7/26/20, but one CNA was late, and one CNA was no call/no show. There were two Unit Manager assigned to work during the 24-hour period, but it was not documented what hours or units they worked. Review of Individual Employee Timecards, provided by the Administrator on 08/20/20 at 2:00 p.m. for 7/19/20 to 08/01/20, reflected only following direct-care staff clocked in during the 6:00 a.m. to 2:00 p.m. shift on 7/26/20: five CNAs, two Hospitality Aides, RN 17 and LPN 23. It was not documented that the Unit Manager clocked in because she was salaried. During an interview, on 8/21/20 at 1:07 p.m., the Administrator indicated the facility was supposed to have the Unit Manager and four nurses during the 6:00 a.m. to 2:00 p.m. shift on 7/26/20. Licensed Practical Nurse 23 arrived at 7:15 a.m. instead of 6:00 a.m. and two nurses were no call/no show. Instead, they had LPN 23 and RN 17. The Administrator did not know how the nurses split up the resident assignments. Review on 8/21/20 at 1:51 p.m. of the facility's publicly posted staffing levels, dated 07/26/20, reflected the facility had a census of 117 residents. For the 24-hour period of 7/26/20, there were 2 Registered Nurses (RN) for a total of 16 RN hours, 7 LPNs for a total of 56 LPN hours, and 17 CNAs for a total of 127.5 hours. On 8/21/20 at 1:37 the Regional Nurse provided a document titled: Policies and Standard Procedures, Subject: Medication Administration dated 5/29/19. The policy reflected 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.I. dd. Medications will be charted when given . ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered. Medications that are refused or withheld or not given will be documented. IV. Documentation a. Documentation of medication will be current for medication administration. B. Document of medications will follow accepted standards of nursing practice. 2. During an interview, on 8/20/20 at 11:40 a.m., Resident P indicated the staff were slow to answer the call light. She was legally blind, so she did not know how much time elapsed between the time she hit her call light and they responded, but she had fallen because she used the call light and no one came. When no one answered her call light she wheeled herself to the bathroom. She locked her wheelchair, but the lock did not stay, and she fell . She knocked on the pipes of the bathroom sink to get attention, but no one came. She was continent when she was admitted , and she wanted to remain continent, so she would take herself to the bathroom and carefully lock her wheelchair. Review of Resident P's clinical record was initiated on 8/20/20 at 11:57 a.m. Her record reflected she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident P's most recent comprehensive Minimum Data Set (MDS) assessment, dated 6/16/20, reflected she was cognitively intact and required extensive assistance by one person for bed mobility, transfers, personal hygiene, and toilet use. She had impaired range of motion on one upper extremity and both lower extremities. She was occasionally incontinent of bladder and frequently incontinent of bowel. Resident P's Admission MDS dated [DATE] documented she was always continent of bladder and occasionally incontinent of bowel. Resident P's Post-Fall Assessment, dated 7/25/20, documented that on 7/25/20 at 3:35 p.m. the resident fell near the toilet on a tile floor when she was trying to go to the bathroom. The assessment documented: nursing staff in hallways but not near resident's room. The last time the resident was toileted was unknown. The assessment documented the resident was legally blind and the intervention to prevent further falls was to move the wheelchair away from resident's bed. Observation on 8/19/20 at 11:27 a.m. revealed there were no visible staff members in Resident Q's unit, either in the hall or at the nurses' station. Resident Q motioned to the surveyor to enter his room. The resident was laying diagonally in the bed and his pillow was on the floor. He was nonverbal but motioned he wanted his pillow. With the resident's permission, the surveyor pushed the call light for the resident at 11:27 a.m. Continued observation, on 8/19/20 from 11:27 a.m. to 11:44 a.m., revealed three staff members were able to see the light above Resident Q's door and hear the alarm indicating the resident's call light was triggered, but they did not respond to the call light. - At 11:35 a.m. the CNA Scheduler walked onto the unit, walked by each room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) including Resident Q's room, looked into the resident's room and did not enter. - At 11:39 a.m. the Administer walked by the unit in the common area where the resident's call light was visible, and alarm was audible. - At 11:42 a.m. CNA 21 walked onto Resident Q's unit at 11:42 a.m. On 11/19/20 at 11:44 the Central Supply Coordinator entered Resident Q's room. She held a communication board up to the resident and he was able to communicate that he needed his pillow and to be repositioned up in his bed. During an interview, on 8/9/20 at 11:44 a.m., the Central Supply Coordinator indicated she could not assist the resident with repositioning but would get help from two CNAs. During an interview, on 8/21/20 at 1:07 p.m., the Administrator indicated all staff members were expected to respond to call lights, whether they were nursing staff or not. If they were not nursing staff, they were expected to respond to the call light and leave the call light on until they could get nursing staff to help if needed. Review of Resident Q's clinical record was initiated on 8/21/20 at 12:30 p.m. His record reflected that he was admitted on [DATE]. His [DIAGNOSES REDACTED]. He did not speak but usually made himself understood. The resident's Care Plan dated 6/22/20 documented he was at risk for falls and that interventions included ensuring his call light was within reach and encouraging him to use it for assistance as needed. 3. On 8/19/20 at 1:36 p.m., Resident D was observed to have long, untrimmed fingernails with dark debris underneath them on both hands. At the same time, the resident indicated she was not able to do her own fingernail care, and needed assistance to keep her fingernails clean and trimmed. On 8/20/20 at 9:10 a.m., Resident D was observed sitting in the hallway. She was unable to open her right hand when asked. When she opened her left hand, an odor was noted. Resident D's fingernails on both hands were long, untrimmed, and had dark debris underneath them. On 8/21/20 at 10:17 a.m., Resident D's fingernails were observed to be long, untrimmed, with dark debris underneath them. On 8/21/20 at 10:20 a.m., CNA 11 observed Resident D's fingernails, and indicated they needed filed and cleaned. Fingernail care should have been done with showers or bathing and included filing and cleaning underneath nails. Resident D needed assistance with fingernail care and had not refused care. Resident D's record was reviewed on 8/20/20 at 11:50 a.m. [DIAGNOSES REDACTED]. An admission MDS assessment, dated 5/14/20, indicated the resident had a moderate cognitive impairment and required extensive assistance from staff for personal hygiene needs. Nurse's notes from, from August 2020, lacked documentation the resident refused fingernail care. A care plan, last revised 5/28/20, indicated Resident D had an activities of daily living (ADL) self-care performance deficit and required assistance for all ADL's to meet her needs. Interventions included, but were not limited to, check nail length, trim, and clean on bath day and as necessary, report any changes to the nurse. On 8/19/20 at 1:34 p.m., Resident C was observed lying in bed. Her thumb nails were observed to be very long and chipped with dark debris underneath them. On 8/21/20 at 10:10 a.m., Resident C was observed lying in bed. The thumb nails on both hands were long, chipped, with dark debris underneath them. On 8/21/20, CNA 11 observed Resident C's fingernails. When CNA 11 assisted the resident to open her hands, there was an odor noted. Resident C's bilateral hands were observed to have outgrown acrylic fingernails, long, chipped, with dark debris underneath them. CNA 11 indicated Resident C's fingernails needed cleaned. Resident C needed assistance with fingernail care and had not refused care. Resident C's record was reviewed on 8/19/20 at 2:23 p.m. [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 6/30/20, indicated Resident C had a severe cognitive impairment and required extensive assistance from staff for personal hygiene needs. Nurse's notes from, from August 2020, lacked documentation Resident C refused fingernail care. A care plan, last revised 7/5/20, indicated Resident C had an activities of daily living (ADL) self-care performance deficit related to [MEDICAL CONDITIONS], and was dependent on staff to meet her needs. Interventions included, but were not limited to, check nail length, trim, and clean on bath day and as necessary, report any changes to the nurse. During an interview, on 8/20/20 at 11:27 a.m., CNA 10 indicated fingernail care should have been provided when residents were bathed. During an interview, on 8/21/20 at 1:13 p.m., CNA 11 indicated it was really difficult to get things like fingernail care done because there was not enough staff to take care of the residents. They had to focus on changing and turning the residents and did not have time to do fingernail care. They were very short staffed. At the same time, CNA 12 indicated both she and CNA 11 were scheduled for double shifts that day because there was not enough staff to cover the day shift, so they came in early. They were scheduled to work 16 hours. On 8/20/20 at 9:44 a.m., the Regional Nurse provided a document titled, Nurse Staffing Information, and indicated it was the policy currently being used by the facility. The policy indicated, .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 provide the sufficient number of staff to care for the resident population. Daily nurse staffing requirements will vary based upon resident census, acuity and safety needs This Federal tag relates to Complaints IN 592 and IN 298. 3.1-17(a) 3.1-17(b)
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure 3 of 7 residents reviewed for medication administration accuracy (Residents C, E and P) were free of significant medication errors. The facility failed to ensure Resident C received an anticoagulant (blood thinner) and anti-[MEDICAL CONDITION] medication as ordered and Residents C, E and P received insulin and blood sugar monitoring as ordered. Findings include: 1. Resident C's record was reviewed on 8/21/20 at 2:00 p.m. Census information reflected she was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident C's Medication Administration Record (MAR) documented physicians' orders that included but were not limited to the following: - [MEDICATION NAME] ([MEDICATION NAME]) Sodium Solution (anticoagulant, blood thinner, used to treat and prevent [MEDICAL CONDITION] and [MEDICAL CONDITION] embolism) 40 milligrams (mg) per 0.4 milliliter (ml), 40 mg subcutaneously (SQ, an injection into the fatty tissue just beneath the skin) once a day for preventative. It was scheduled to be administered at 9:00 a.m. - Leveiracetam (anticonvulsant used to treat [MEDICAL CONDITION]) Solution 100 mg/ml, 1000 mg via gastrostomy ([DEVICE]) every 12 hours. It was scheduled to be administered at 9:00 a.m. and 9:00 p.m. - Humalog (rapid-acting insulin) solution 100 unit/ml, 4 units SQ every 4 hours for Diabetes Mellitus. Resident C's physician orders [REDACTED]. Both doses (4 units and per sliding scale) were scheduled to be administered at 1:00a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. Review of Resident C's MAR for July 2020 reflected 12 medications scheduled to be administered on the morning of 7/26/20 lacked documentation they there given, held, or refused, including [MEDICATION NAME], Leveiracetam and Humalog. The MAR lacked evidence that blood sugar monitoring was performed as ordered at 9:00 a.m. and 1:00 p.m. Review of Resident C's Progress Notes dated 7/26/20 reflected no notes related to medication administration. 2. Resident E's record was reviewed on 8/21/20 at 2:00 p.m. Census information reflected he was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident E's MAR documented physicians' orders that included but were not limited the following: - Tresiba FlexTouch Solution Pen-injector 100 unit/ml Degludec (long-acting insulin), 30 units SQ in the morning for Diabetes. The MAR documented it was scheduled to be administered at 8:00 a.m. - Novalog (rapid-acting insulin) 100 unit/ml, 20 units SQ before meals for Diabetes. It was scheduled to be administered at 8:00 a.m., 12:00 p.m. and 4:00 p.m. Review of Resident E's MAR for July 2020 reflected 12 medications scheduled to be administered on the morning of 7/26/20 lacked documentation they were given, held, or refused, including insulins Tresiba at 8:00 a.m. and Novalog at 8:00 a.m. and 12:00 p.m. The MAR also lacked documentation that the resident's blood sugar was monitored as scheduled at 8:00 a.m. and 12:00 p.m. on 7/26/20. 3. During an interview on 8/20/20 at 11:40 a.m. Resident P indicated she did not always get her medications on time. One shift she did not get them at all. She had diabetes, so she was worried about not having her medication. Resident P's record was reviewed on 8/20/20 at 11:57 a.m. Census information reflected she was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Resident P's MAR documented her physicians' orders included but were not limited to the following: - Ten units of [MEDICATION NAME] (a rapid-acting insulin) injected two times a day for a [DIAGNOSES REDACTED]. - [MEDICATION NAME] per sliding scale based on blood sugar monitoring subcutaneously before meals and at bedtime related to type 2 Diabetes Mellitus. Resident P's MAR for July 2020 provided by the Regional Nurse on 08/21/20 at 2:00 p.m. reflected five medications scheduled to be administered on the morning of 7/26/20 (between 7:30 a.m. and 11:30 a.m.) were not documented as given, held or refused, including [MEDICATION NAME]scheduled to be administered at 8:00 a.m. The MAR lacked documentation that the resident's blood sugar was monitored as ordered at 7:30 a.m. and 11:30 a.m. to determine whether she needed additional [MEDICATION NAME] as directed by her sliding scale. Review of Resident P's Progress Notes provided by the Regional Nurse on 08/21/20 and dated 7/26/20 reflected no notes related medication administration. During an interview on 8/21/20 at 12:43 p.m. the Administrator and Regional Nurse indicated nurses were supposed to document in the MAR if they administered a medication. If they did not administer a scheduled medication, they should document why they did not on the MAR and/or progress notes. If they could not document that they gave the medication at the time they administered it, they should make a late entry. They confirmed there was no documentation that medications were administered for Residents C, E, and P for the day shift of 7/26/20. During an interview on 8/21/20 at 2:09 p.m. with the Administrator and Regional Nurse,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) the Regional Nurse indicated there were no progress notes for Residents C, E, and P on 7/26/20 related to missed medications or physician notified related to the missed medications. The Regional Nurse and Administrator indicated they were not aware of the missed medications, did not understand what happened, and were unable to contact the Nurse Manager assigned to work on July 26 for a possible explanation. During an interview on 8/21/20 at 1:00 p.m. Registered Nurse (RN) 17 indicated he recalled that Sunday, July 26. There were only two nurses working in the whole building including the Secure Unit. Two of the scheduled nurses were no call/no show. RN 17 and LPN 23 did the best they could but did not get everything done. Administration said they were getting someone else to come in, but one hour before the shift was to end, 1:00 p.m., RN 17 and LPN 23 still had no help. Reference F725. On 8/21/20 at 1:37 the Regional Nurse provided a document titled: Policies and Standard Procedures, Subject: Medication Administration dated 5/29/19. The policy reflected 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.I General Procedures . dd. Medications will be charted when given . ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered. gg. Medications that are refused or withheld or not given will be documented i. Critical medications that are refused including insulin, [MEDICATION NAME] or other anticoagulants will be followed up with physician contact. IV. Documentation a. Documentation of medication will be current for medication administration. B. Document of medications will follow accepted standards of nursing practice. This Federal tag relates to Complaint IN 592. 3.1-48(c)(2)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's Foley catheter (F/C) (a tube inserted into the bladder to drain urine) bag was not in contact with a mattress next to a resident's bed and was positioned to drain urine effectively for 1 of 11 residents reviewed for quality of care (Resident C). Findings include: On 8/20/20 at 10:07 a.m., Resident C was observed lying in bed, with a mattress on the floor next to the bed. The resident's Foley catheter (a tube inserted into the bladder to drain urine) (F/C) bag was lying on the mattress with the tubing above the bag impeding the flow of urine. The F/C bag was empty. On 8/20/20 at 11:11 a.m., Resident C remained lying in bed, with a mattress on the floor next to the bed. The resident's F/C bag remained lying on the mattress with the tubing above the bag impeding the flow of urine. There was urine observed in the tubing, but the bag remained empty. Resident C's record was reviewed on 8/19/20 at 2:23 p.m. [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 6/30/20, indicated the resident had a severe cognitive impairment. A physician's orders [REDACTED]. During an interview, on 8/20/20 at 11:27 a.m., Certified Nursing Assistant (CNA) 10 indicated the F/C bag should not have been placed on the mattress next to the resident's bed. The bag should be placed so urine can drain into the bag. During an interview, on 8/21/20 at 10:20 a.m., CNA 11 indicated she fixed the resident's F/C bag yesterday when she noticed how it was positioned. The bag should not have been lying on the mattress next to the bed. The bag should have been positioned so the urine could flow into the bag. On 8/21/20 at 12:40 p.m., the Regional Nurse provided a document titled, Catheter Care, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: .V. Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back into the bladder This Federal tag relates to Complaint IN 298. 3.1-18(b)