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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/31/2024 |
| NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Terre Haute | | STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Maple Ave Terre Haute, IN 47804 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34129</p> <p>Based on record review and interview, the facility failed to provide personalized care and interventions for a resident (Resident F) with the diagnoses of schizophrenia (serious mental health condition that affects how people think, feel and behave) and behaviors for 1 of 5 residents reviewed for behavior management which resulted in Resident F having resident to resident altercations with 4 cognitively impaired residents residing on the same locked unit (Residents B, G, H, and J).</p> <p>Findings include:</p> <p>During the survey a document titled, All About Me, undated, was observed in Resident F's room. The document described the resident's likes and dislikes, such as her favorite hobbies, food, movies, snacks, etc. Her dislikes included when people touched her without letting her know and when people tried to make her eat when she didn't want to eat.</p> <p>The clinical record for Resident F was reviewed on 7/30/24 at 1:43 p.m. Resident F was [AGE] years old and resided in the facility's secured behavioral unit. Diagnoses included, but were not limited to, schizophrenia, behaviors, cerebral palsy, mild cognitive impairment, developmental disorder of speech and language, blindness in the left eye, and normal vision in the right eye.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/6/24, indicated the resident had a moderate cognitive impairment with no behaviors noted during the 7-day look back assessment period.</p> <p>An Indiana Department of Health (IDOH) facility reported incident record (FRI), dated 6/17/24 at 9:01 p.m., submitted by the facility indicated Resident F made physical contact with Resident B. Both residents resided on a secure unit. Resident B had diagnoses, including but not limited to, severe dementia, frontotemporal neurocognitive disorder, and Alzheimer's disease. Both residents were assessed and there were no injuries.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported 6/17/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>An IDOH FRI report, dated 6/29/24 at 6:10 p.m., submitted by the facility indicated Resident F tossed a two handled cup into the air. The cup landed on Resident G's left shoulder. Resident G tossed the cup back to Resident F and the cup struck Resident F above the eyebrow causing a laceration on Resident F's left temple. Resident G had diagnoses, including but not limited to, vascular dementia, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 6/29/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/6/24 at 6:50 p.m., submitted by the facility indicated Resident B was walking into the dining room and Resident F reached out and touched Resident B's legs. Staff tried to intervene and redirect residents from touching each other. Resident B fell to the ground. The residents were immediately separated and redirected by staff. Resident B had diagnoses, including but not limited to, severe dementia, frontotemporal neurocognitive disorder, and Alzheimer's disease. Both residents were assessed and there were no injuries.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/6/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/8/24 at 4:30 p.m., submitted by the facility indicated Resident G was sitting in a chair in the day room. Resident F came over to Resident G and began raising fists up and down hitting Resident G's chair and arms. Resident G had diagnoses, including but not limited to, vascular dementia, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>A behavioral care plan, dated 7/9/24, indicated Resident F was involved in a resident-to-resident altercation with the interventions of head-to-toe assessment, report to regulatory entities, and separate residents immediately with the target goal, dated 8/2/24, of the resident would not have any adverse effects from the incident. The plan lacked documentation of interventions to prevent further events.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/9/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>(continued on next page)</p> | | |

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| <p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A behavioral care plan, dated 7/11/23 and revised on 7/17/24, indicated the resident was at risk and active behavior problems, such as: smacking self, accusatory actions, attention seeking, physical aggression such as biting/grabbing at others, disrobing in public spaces, urinating on the floor, sitting/lying on the floor, refusal of care, such as medications, showers and meals, and yelling out. Interventions on the care plan, included but were not limited to, assist resident away from other residents, observe for triggers of inappropriate behaviors and alter environment as needed, and observe for unmet needs such as toileting, rest, food, fluids, companionship, etc. The long-term care plan goal, target dated 8/7/24, indicated the resident's behaviors will not result in disruption of others environment.</p> <p>An IDOH FRI report, dated 7/18/24 at 3:15 p.m., submitted by the facility indicated Resident F pushed her hand against Resident J's shoulder causing Resident J to fall to the floor on her left side. Resident J's diagnoses, included but were not limited to, dementia, cognitive communication deficit, hearing loss, and seizures. Both residents were assessed and had no injury.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/18/29/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/20/24 at 7:23 p.m., submitted by the facility indicated Resident F tossed a dinner tray at Resident G. Resident G was assessed with a 1.5 centimeter (cm) by 1.5 cm pink area above the right eyebrow. Resident G had diagnoses, including but not limited to, vascular dementia, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>A behavioral care plan, dated 7/20/24, indicated Resident F was involved in a resident-to-resident altercation with the interventions of notify family, notify physician, and separate residents immediately with the target goal, dated 8/2/24, of the resident would not have any adverse effects from the incident. The care plan lacked documentation of interventions implemented to prevent further events after the incident reported on 7/20/24.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/20/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/26/24 at 11:57 p.m., submitted by the facility indicated Resident F went to Resident H's room, as Resident H was asleep in bed. Resident F began to hit Resident H with an open hand waking Resident H. Staff removed Resident F from Resident H's room and another staff stayed in the room with Resident H. Resident H had diagnoses, including but not limited to, vascular dementia, Parkinson's disease, cognitive communication deficit, and depression. Both residents were assessed and had no injuries.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/26/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>(continued on next page)</p> | | |

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| <p>F 0742</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Resident F's electronic medical record lacked documentation to implement person-centered, individualized care to prevent Resident F from physically making contact with or throwing items at other residents.</p> <p>On 7/29/24 at 11:18 a.m., Qualified Medication Aide (QMA) indicated staff tried to redirect Resident F if she went into another resident's room or got too close to another resident.</p> <p>On 7/30/24 at 8:57 a.m., the Director of Nursing (DON) indicated Resident F had multiple behaviors and the staff's immediate intervention for Resident F was to get the residents separated, check them out from head to toe, and notify the physician, Administrator (ADM), and family of the incident. They tell the family there was an altercation with another resident and the facility was investigating. Resident F was [AGE] years old and was inappropriate for the facility. She was diagnosed with dementia (a group of thinking and social symptoms that interfered with daily functioning), but the DON did not believe Resident F had dementia, but the resident did have an intellectual cognitive disability deficit. Staff tried to keep her away from the other residents with diversional activities, but she was harming the older female residents on the unit.</p> <p>On 7/31/24 at 9:34 a.m., ADM provided documentation of Resident F's 30-day Notice of Transfer or Discharge, dated 7/30/24, and indicated she had mailed the 30-day Notice of Transfer or Discharge to the resident's mother. The notice indicated the reason for the transfer or discharge was due to the safety of the individuals in the facility were endangered. The ADM indicated she and the Social Services Director (SSD) had a care plan meeting with Resident F's mother a couple of weeks ago and told her that Resident F was not appropriate for the facility, due to her interactions with the other residents and she was younger and stronger than the other residents.</p> <p>The ADM, on 7/26/24 at 10:45 a.m., provided and identified a document as a current facility policy titled, Abuse, Neglect, and Misappropriation of Property, dated 5/27/16 and revised on 9/15/23. The policy indicated, .It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident in the facility</p> <p>This citation relates to Complaint IN00438294.</p> <p>3.1-43(a)(1)</p> | | |