

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  09/27/2024
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34129</p> <p>Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from sexual abuse by a resident residing on the same locked unit for 2 of 3 residents reviewed for abuse (Residents B and C) resulting in an Immediate Jeopardy when the facility failed to keep the residents separated and prevent further abuse.</p> <p>The immediate jeopardy began on 9/22/24 when a cognitive impaired resident (Resident B) was observed by staff touching another cognitively impaired resident (Resident C) in the genital region in the common area after breakfast. Later that same day, Residents B and C were found together in bed with Resident B's hand was on Resident C's bare stomach and legs intertwined. In the afternoon, Residents B and C were observed in another resident's room with Resident B's pants down without a brief and his back turned towards the door and his hands on Resident C's shoulders. The Administrator (ADM) was notified of the immediate jeopardy at 4:45 p.m. on 9/25/24. The immediate jeopardy was removed on 9/27/24 at 4:37 p.m., 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.</p> <p>Findings include:</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/24/24 at 10:29 a.m., the Director of Nursing (DON) indicated she had an incident that she was trying to input into the Indiana Department of Health (IDOH) facility reported incident record (FRI) system about Resident B and Resident C. Resident B was going around and leading Resident C by the hand. Resident C had on a gold belt buckle that Resident B kept trying to touch the buckle. Certified Nursing Aide (CNA) 5 and CNA 6, thought Resident B was being inappropriate with Resident C and Resident B was touching Resident C's private area. DON contacted the Administrator (ADM), Social Services (SS), and the behavioral health services. The behavioral health services staff called back and changed Resident B's medication order for Xanax (medication used to treat anxiety and panic disorders) and increased the medication from 0.25 milligram (mg) twice daily (BID) to 0.5 mg BID. The DON indicated, she had requested the CNAs to write statements and neither CNA wrote a statement. On 9/22/24, a Qualified Medication Aide (QMA) and two CNAs worked on the 500 locked unit. The QMA had told the DON that she did not see anything. CNA 5 told the DON Resident B kept touching Resident C at the belt buckle and taking Resident C's hand and walking around the unit. The DON told CNA 5 to separate Resident B and Resident C, and she went back to the 500 locked unit and watched the residents for about 15 minutes. She had asked the three staff members on the locked unit to write statements about the incident. The DON indicated Resident B kept leading Resident C around the unit hand in hand. CNA 6 kept telling CNA 5 that Resident B kept touching Resident C's private area. The DON indicated she had requested CNA 5 to stay with Resident B. There were other residents and residents' family members on the 500 locked unit, but no one had said anything to the DON about Resident B or Resident C.</p> <p>On 9/24/24 at 11:44 a.m., CNA 9, observed working on the 500 hall locked unit, indicated the night shift staff had reported to the day shift staff to keep Resident B and Resident C separated, because there was sexual tension, like Resident B rubbing on Resident C. Resident B was on 15-minute checks and staff were to keep them separated, because Resident B was rubbing all over Resident C. Resident B nor Resident C had any care plan interventions besides keeping them separated. Resident B had the 15-minute checks, but no other interventions other than to keep the residents separated.</p> <p>On 9/24/24 at 12:47 p.m., Resident C was observed being fed lunch by CNA 9. Resident C was wearing clothes and nonskid socks. After Resident C was finished eating his lunch, he stood up out of the wheelchair, unassisted, and walked around the dining room area. CNA 9 directed Resident C to sit back down in his wheelchair. Resident C sat down in a regular chair at the dining room table by himself.</p> <p>On 9/24/24 at 12:52 p.m. Resident B was observed to eat his lunch at a dining table, unassisted by staff. Then Resident B stood up from the dining room chair and went over and sat in a recliner in the television area by himself.</p> <p>The DON, on 9/24/24 at 12:59 p.m., indicated Resident B was touching people and was put on 15-minute checks, on 9/22/24, and staff would continue the 15-minute checks to ensure Resident B's medication adjustment was working and until psychiatric services came, on 9/26/24, to assess Resident B.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an anonymous interview during the survey, Anonymous 1 indicated Resident B kept trying to get close to Resident C. In the morning after breakfast on 9/22/24, Anonymous 1 observed Resident B and Resident C sitting in recliners next to each other in the television area. Resident B put his hand inside Resident C's pants under his brief and rubbed Resident C's genitals. Anonymous 1 asked Resident B to remove his hand from Resident C's pants. Resident C was assisted to his room, by another staff member to get dressed. In the afternoon, Resident C was observed lying flat on his roommate's bed with Resident B lying on his side, next to Resident C with Resident B's hand on Resident C's bare stomach with the residents' legs intertwined. Anonymous 1 asked Resident B to remove his hand from Resident C's stomach and Resident B was escorted out of Resident C's room. About 5:50 to 6:00 p.m. on 9/22/24, Anonymous 1 assisted Resident C to the bathroom and the DON came into the bathroom and assessed Resident C's bottom. No one asked Anonymous 1 to write a statement about the incident and Anonymous 1 was told by another staff member on the 500 locked unit that the DON had told them not to document about the incident in the residents' medical records.</p> <p>During an anonymous interview during the survey, Anonymous 2 indicated, after breakfast on the morning of 9/22/24, Resident B and Resident C were sitting next to each other in recliners in the television area. Resident B had his hand in the slit of Resident C's boxer pants and was rubbing Resident C's thigh. Another staff member asked Resident B to stop touching Resident C. Resident C was moved from the recliner in the television room, because he was easier to remove from the situation. Resident C was assisted by Anonymous 2 to his room to get dressed. Anonymous 2 then went and told the DON about the incident with Resident B and Resident C. Resident B was put on 15-minute checks by the DON. The DON instructed staff to keep the two residents separated. There was no additional staff called to watch Resident B, so staff tried to keep Resident B within their sight, while providing care to the other residents. But Resident B kept going back to Resident C, touching him and grabbing Resident C's hand to walk with him. Anonymous 2 indicated Anonymous 2 had found the two residents laying in Resident C's roommate's bed with Resident C laying on his back and Resident B laying on his side next to Resident C with Resident B's hand on Resident C's bare stomach. At about 2:00 p.m., Anonymous 2 indicated, they observed the two residents in another resident's room with Resident B standing in the room with his back to the door, without a brief and his pants were down to his ankles and his hands were on Resident C's shoulders. Resident C was taken out of the room by another staff member and Resident B was taken by Anonymous 2 to his room to put on a brief. At about 4:00 p.m., Resident B had his hand down Resident C's pants, while the residents were sitting in recliners in the television area. Staff tried to keep Resident C by the nurses' desk. Anonymous 2 indicated they saw the two residents in another resident's room, laying on the bed together with Resident B's arm around Resident C, but no hands were observed on any genitals. Later in the afternoon on 9/22/24, Resident C was observed having a hard time sitting down. Anonymous 2 informed the DON that it was painful for Resident C to sit down. The DON and another staff member assessed Resident C. Resident C had no problem earlier in the day sitting down but had a problem sitting down toward the end of the shift, 6:00 a.m. to 6:00 p.m. Anonymous 2 indicated they were not asked to write a statement about the incidents, and the DON had told them not to chart the incident in the residents' medical records.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an anonymous interview during the survey, Anonymous 3 indicated, on 9/22/24, in the morning after breakfast, Resident B and Resident C were observed seated next to each other in recliners and Resident B had his hand down Resident C's pants. Anonymous 3 went over and told Resident B that he could not have his hand down Resident C's pants. Resident B's hand was assisted out of Resident C's pants by staff. Resident B said, okay. Both residents got up from the recliners and Resident B held Resident C's hand and they walked around the unit, hand in hand. Resident C followed along with Resident B, hand in hand or they walked beside each other. At about 9:00 a.m. on 9/22/24, Anonymous 3 went to the DON and told the DON they had found Resident B had his hand down Resident C's pants. DON told Anonymous 3 to put Resident B on 15 minutes checks. The DON came back to the unit later and observed Resident B and Resident C hand in hand and the DON told Resident B that he could not be holding Resident C's hand. Resident B let go of Resident C's hand. The two residents walked around the unit together, but not holding hands any longer. Resident B did not normally hold hands with any of the residents and was quiet, not causing any problems on the unit. Resident C went along with Resident B and did not normally get up and down as much until Resident B guided Resident C to walk together. Resident C liked to sit in a recliner in the television room area throughout the day. Resident B would not leave Resident C alone and kept coaxing Resident C to go walk around the unit. When it was time to eat lunch, the residents were seated at different tables. After lunch, Resident B slept most of the afternoon on the couch in the television room area and Resident C was up and down and wandering around the unit. After lunch, Resident C had a difficult time of sitting down, almost like he was scared or fearful to sit down. Resident C had peripheral vision problems and was always super careful when sitting down. Resident C, by the afternoon, was very tired from all the walking and roaming around the unit. The DON did a skin assessment on Resident C in the bathroom and did not find any skin issues. The DON had asked the staff to not document on the incident in the Residents' medical records and to keep it quiet.</p> <p>During an anonymous interview during the survey, Anonymous 4 indicated, on 9/22/24, there was a situation where Resident B sexually abused Resident C. The staff reported it to the nurse who reported it to the DON who came in on her day off and did a rectal exam on Resident C. Since the DON did not see any skin impairment on Resident C, the DON told the staff not to document the abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/25/24 12:06 p.m., Social Services Assistant (SSA) indicated she did not personally know Resident B nor Resident C. She was home on Sunday, when she got a call from the DON. The DON requested SSA call psychiatric services for a medication review for Resident B. The psychiatric services on-call physician increased Resident B's Xanax medication to 0.5 mg twice daily (BID). Resident B did not have any behavior monitoring but had the behaviors of exit seeking and bowel movements and urinating in the hallways. She did not understand what happened on 9/22/24, the DON was trying to tell the SSA about Resident C's pants and a shiny belt buckle. SSA indicated she was at home and was confused about the situation. Resident B was wanting to touch shiny things such as a shiny belt buckle and shiny name tags. SSA indicated she was doing psychosocial follow ups for Resident B and Resident C and was documenting the follow ups in the residents' electronic medical records in the progress notes. SSA indicated she was following up for the behavior of a shiny buckle. SSA also was following up on Resident C, since he was the resident being touched. This morning, on 9/25/24, she had visited with Resident C's wife when she came to the facility. Resident C's wife indicated Resident C was tearful until his wife gave him a stuffed animal that seemed to cheer him up. SSA indicated, she needed to add a care plan intervention for Resident B about inappropriately touching other residents and add a care plan intervention for Resident C's tearfulness. Staff were making sure Resident B and Resident C were staying separated. The Corporate Social Services Director (SSD) indicated Resident B should have a care plan with interventions for touching others inappropriately with an intervention to separate the residents immediately, change rooms, and 15-minute checks for Resident B and psychosocial follow ups for Resident C. The SSD indicated the Interdisciplinary (IDT) team should have met Monday morning, 9/23/24, to discuss the incident and put care plan interventions to keep Resident B from touching other residents and an intervention to keep Resident C safe. SSA indicated, she had just now, on Resident B's electronic medical record, put in a new care plan intervention for Resident B to separate residents immediately for the care plan of resident makes sexually inappropriate advances towards female staff and other residents.</p> <p>On 9/25/24 at 1:25 p.m., DON provided a copy of the Indiana Department of Health (IDOH) facility reported incident record (FRI) about Resident B and Resident C and indicated she had spoken to the IDT on Monday, 9/23/24, about the incident but did not document the IDT meeting. She had 15-minute checks continue for Resident B.</p> <p>The DON, on 9/25/24 at 2:50 p.m., indicated she had contacted the three staff working on 9/22/24 from 6:00 a.m. to 6:00 p.m. shift on the 500-hall locked unit to get witness statements, but she had not gotten any responses. QMA 7 never came to the DON and told her there was any inappropriate touching between the Resident B and Resident C. CNA 5 came to her, on 9/22/24, and told her Resident B was touching inappropriately Resident C and that was the only staff member who had spoken to her about the inappropriate touching. CNA 5 had come to her about Resident B's inappropriate touching at least three times from 10 a.m. to 2 p.m. The DON had gone back to the 500-hall locked unit at least 3 times, on 9/22/24, and she had not seen any inappropriate touching.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/26/24 at 8:05 a.m., CNA 6 indicated, on 9/25/24 at 9:30 p.m., the Administrator in Training (AIT) texted and asked if CNA 6 was able to send the statement over to the facility. The AIT indicated, We can transcribe a verbal statement of the incident over the phone. CNA 6 could call the AIT or the DON, and they would create the statement and CNA 6 texted, she would feel much more comfortable, providing a handwritten statement, written and signed by herself. She was willing to come in earlier and provide a written statement. CNA 6 indicated, they had handwritten the incident statement of three pages, written on lined paper, that they were providing to the facility, dated 9/25/24, which indicated, on the day of 9/22/24, they had worked on the 500 men's unit from 6 a.m. to 6 p.m. After breakfast at approximately between the times of 8 a.m. and 9 a.m., CNA 6 was sitting at the nurses' station charting. CNA 5 was also sitting at the nurses' station charting, when QMA 7 came to the nurses' station and indicated, come look at Resident B and Resident C. Resident B and Resident C were sitting in recliners next to each other facing the wall/television and Resident B's hand in and down Resident C's pants and brief, rubbing Resident C's genitals. At that time, CNA 6 assisted Resident C from the recliner and relocated him to another recliner. At the same time, CNA 5 redirected Resident B. QMA 7, CNA 5, and CNA 6, discussed what the best plan of action was moving forward. They all agreed/decided, to notify the DON and let her make the decision. CNA 5 offered to go find the DON and inform her of the situation/incident. CNA 5 then left the locked 500 unit and came back to the unit approximately 10 to 15 minutes later, and said, The DON said to not document the incident because it was a State offense, but to keep a close eye on Resident C. Throughout the shift, staff kept a close eye on Resident C. During our rounds and answering call lights, we lost track of both Resident B and Resident C. When we found both gentlemen, which was after lunch time, between 4:00 p.m. and 5:00 p. m., we found Resident B and Resident C laying perpendicularly in Resident C's roommate's bed. Resident B had his legs intertwined with Resident C's legs. Resident B's head was nuzzled into Resident C's neck region. Resident B also had his left hand was resting on Resident C's bare belly button region with Resident C's shirt slightly raised, but his brief/pants were not disturbed. Concerning the second incident, QMA 7, offered and spoke with the DON. CNA 6 was not informed of any further instructions pertaining to this incident. At approximately between 5:00 p.m. to 6:00 p.m. on 9/22/24, the DON came to the locked unit and had noticed how slowly Resident C was at sitting down in a chair. DON requested Resident C be taken to his private bathroom. CNA 6 indicated to the DON that Resident C had sat down like that since the first day he was admitted to the facility. The DON made the remark that they needed to make sure we do not actually have a reportable. Resident C was assisted from the chair and into his private restroom. Resident C's brief was removed, and his pants were pulled down. The DON walked into the bathroom and assessed Resident C's buttocks and genital region. The DON cleaned Resident C, then removed her gloves and exited the bathroom. Resident C was assisted on putting on a new brief and pulling up his pants. CNA 6 indicated, CNA 5 found Resident B and Resident C in another resident's room. CNA 5 called for CNA 6 to assist Resident C out of the room with CNA 5 telling CNA 6 that Resident B's pants had been pulled down and his brief was off. CNA 5 had taken Resident B to his room to get a new brief put on him. CNA 6 observed Resident C standing by the television in another resident's room and Resident C was escorted back to the dining room area and CNA 6 had tried to get Resident C to sit down, but Resident C was reluctant to sit down and walked around the dining room area. CNA 6 gathered their belongings and clocked out at 6:09 p.m. on 9/22/24 and was never asked to provide a written statement to the facility. The first time CNA 6 was asked to provide a statement to the facility about the incident between Resident B and Resident C was on 9/25/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 12:40 p.m. the Administrator provided a typed statement from QMA 7, dated 9/26/24, indicated QMA 7 observed Residents B and C walking down the hall and noticed Resident B had his hands down Resident's C pants. QMA 7 assisted Resident B with getting his hand out of Resident C's pants and was redirected and separated. The DON was notified, and fifteen-minute checks were implemented. Residents were not observed in bed together. QMA 7 indicated that nothing more was reported to her the rest of the day. QMA 7 indicated she did not believe that Resident B and C were able to get into a bed by themselves without help.</p> <p>On 9/26/24 at 6:24 p.m. the Administrator provided a copy of a handwritten statement from QMA 7 dated 9/25/24. QMA 7 indicated Residents B and C were never alone in a room by themselves at all.</p> <p>On 9/26/24 at 6:24 p.m. the Administrator provided a handwritten statement from CNA 5, dated 9/25/24. The statement indicated it was written by the DON and was a telephone statement from CNA 5. CNA 5 indicated he was told by CNA 6 around breakfast of that Resident B's hands were in Resident C's pants. Both CNAs went and separated the residents. After breakfast Resident B had his hand in Resident C's pants while sitting in the recliners by the television. CNA 5 reported to QMA 7 and the DON. The statement indicated that the DON had Resident B stay with CNA 5 and place the resident on fifteen- minute checks. After lunch Resident B went in a room and CNA 5 saw Resident B's pants and brief down with Resident C in the same room dressed.</p> <p>On 9/24/24 at 1:05 p.m., the DON provided copies of the fifteen-minute monitoring for Resident B dated 9/22/24. The document was blank from 12:00 a.m. until 10:00 a.m. Starting at 10:00 a.m. until 6:00 p.m., in every fifteen-minute slot were initials for the location the resident was found and initials for the staff member recording the fifteen-minute check. The document lacked documentation of what Resident B was doing or if Resident B was with another resident.</p> <p>On 9/26/24 at 12:40 p.m., the Administrator provided copies of the fifteen-minute monitoring for Resident B dated 9/22/24. This document differed from the document with the same date provided on 9/24/24. The document was blank from 12:00 a.m. until 10:30 a.m. Starting at 10:30 a.m. until 6:00 p.m. in every fifteen-minute slot were initials for the location the resident was found and the initials for the staff member recording the fifteen-minute check. The recorded initials for the locations and staff member were different than the record provided on 9/24/24. The document lacked documentation of what Resident B was doing or if Resident B was with another resident. Starting at 6:15 p.m. until 11:00 p.m. the fifteen-minute slots indicated what the resident was doing but lacked staff initials and if Resident B was with another resident. The monitoring tool was blank from 11:00 p.m. on 9/22/24 until 6:00 a.m. on 9/23/24.</p> <p>a. Resident B's record was reviewed, on 9/24/24 at 10:01 a.m. Diagnoses included, but not limited to, unspecified dementia, unspecified severity without behavioral disturbance (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, reasoning, and remembering, that interferes with daily life) and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A quarterly Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident B had a severe cognitive impairment, no impairments in upper extremity nor lower extremities, without mobility devices usage, supervision or touching assistance for eating, partial to moderate assistance for oral hygiene, substantial to maximal assistance for toileting hygiene and bathing, with partial to moderate assistance for upper and lower dressing and personal hygiene, and supervision or touching assistance with helper provided verbal cues or touching/steadying as resident completed activity of sit to stand, chair/bed-to-chair transfers, and toilet transfers.</p> <p>A care plan, started on 11/8/23, indicated Resident B had behavioral care plan for refusing care, such as showers and personal hygiene. Resident makes sexually inappropriate advances towards female staff and other residents with interventions included, but were not limited to, approach resident in a calm and unhurried manner to deliver provide services; explain care process prior to delivery of care as needed; offer choices in hands-on care and contact; resident chooses to sleep on couch and chooses to stay up late; and resident exercises right to decline treatment and services.</p> <p>A nursing progress note written by the DON, dated 9/22/24 at 10:30 a.m., indicated Resident B was wandering in the unit, following residents and reaching out to staff and residents for shiny items such as name badges and belt buckles. When the DON spoke to the resident about keeping his hands to himself, Resident B was naming all kinds of body parts to the DON. The DON had the unit staff keep redirecting and had a staff CNA stay with resident to redirect.</p> <p>A nursing progress note written by the DON, dated 9/22/24 at 10:57 a.m., indicated staff noted to the DON that Resident B was following another resident and holding his hand and leading resident to different areas on the unit. Staff continued to redirect and separate the residents. Resident B was put on 15-minute checks to redirect from other residents and to engage in other activities. Resident B was toileted and redirected to the bathroom with assistance of staff. The resident was redirected from urinating in the unit hallway corner.</p> <p>On 9/26/24 at 12:40 p.m., the Administrator provided Resident B's Point of Care History for September 2024. The Point of Care History indicated on 9/21/24 Resident B needed limited assistance getting dressed and on 9/22/24 Resident B only needed supervision to get dressed. The Point of Care History indicated on 9/21/24 Resident B was independent with movement in bed in the morning and limited assistance at night. On 9/22/24, Resident B was independent with movement in bed in the morning and needed supervision at night.</p> <p>A Social Services progress note, written by the SSA, dated 9/23/24 at 2:08 p.m., indicated Social Services follow up. Resident had been asleep on the couch in the residents' common area intermittently though out the day so far. Staff reported resident had been pleasant and had healthy appetite, with no signs or symptoms of psychosocial distress at this time.</p> <p>A Social Services progress note, written by the SSA, dated 9/24/24 at 1:56 p.m., indicated Social Services follow up. Resident has been sitting in a chair intermittently though out the shift. Staff reported resident has had pleasant mood with no signs or symptoms of psychosocial distress at this time.</p> <p>A nursing progress note, dated 9/24/24 at 7:47 p.m., indicated Resident B was observed standing in other resident's room while they were resting. Resident B was redirected to the day room, took all medications, and continued 15-minute checks.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Signature Healthcare of Terre Haute		STREET ADDRESS, CITY, STATE, ZIP CODE  3500 Maple Ave Terre Haute, IN 47804	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Social Services progress note, written by the SSA, dated 9/25/24 at 10:36 a.m., indicated Social Services follow up. Resident was currently sitting in the residents' common area. SSA sat with resident a while. Resident B declined to speak the SSA. The resident preferred to sit and observe. No signs or symptoms of psychosocial distress at this time.</p> <p>Resident B's care plans and medical record lacked documentation of interventions for when Resident B made sexually inappropriate advances towards female staff and other residents and lacked documentation Resident B's family was notified of the incident on 9/22/24.</p> <p>No written statements were provided from Occupational Therapy or Physical Therapy for Resident B.</p> <p>b. Resident C's record was reviewed on 9/24/24 at 11:12 a.m. The resident was admitted to the facility, on 9/6/24, with diagnoses included, but not limited to, vascular dementia (brain condition that affects thinking, memory, and behavior, and is caused by damaged blood vessels in the brain) and anxiety.</p> <p>A care plan, dated 9/6/24, indicated the resident had a self-care deficit related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of activities of daily living (ADL) cares with interventions included, but not limited to, be alert for changes or declines in ability to participate in ADL cares. Notify Nurse if noting any changes in abilities, encourage resident to participate if they are able, and provide frequent encouragement, along with prompting and assistance.</p> <p>A Brief Interview for Mental Status assessment, dated 9/9/24, indicated the resident had a severe cognitive impairment.</p> <p>On 9/26/24 at 12:40 p.m., the Administrator provided Resident B's Point of Care History for September 2024. The Point of Care History indicated on 9/21/24 Resident C needed limited assistance with dressing. On 9/22/24 Resident C needed supervision one time and was totally dependent the second time with dressing. The Point of Care History indicated on 9/21/24 Resident C needed limited assistance one time and extensive assistance the second time with bed mobility. On 9/22/24 Resident C needed supervision one time and extensive assistance the second time with bed mobility.</p> <p>A Social Services progress note, written by the SSA, on 9/24/24 at 2:01 p.m., indicated SSA follow up. Resident C had visit with his wife today. Wife reported the resident was tearful briefly during the visit but cheered up when the wife brought out a stuffed [NAME] toy. Staff reported resident has had a pleasant mood with no signs or symptoms of psychosocial distress at this time.</p> <p>A written statement by the Registered Occupational Therapist (OTR), dated 9/26/24 and provided by the Administrator on 9/26/24 at 12:40 p.m., indicated Resident C needed partial or moderate assistance with verbal and/or tactile cueing for all activities of daily living.</p> <p>A written statement by the Physical Therapist (PT), dated 9/26/24 and provided by the Administrator on 9/26/24 at 12:40 p.m., indicated Resident C had been able to walk with PT on 9/25/24. Resident C needed verbal or visual cueing to start but was able to do task after cueing. The statement indicated that Resident C . was at a good level of following verbal cues yesterday as compared to the previous therapy sessions</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A written statement dated 9/27/24 and signed by the ADM was provided by the ADM on 9/27/24 at 4:25 p.m. The statement indicated the DON notified the ADM by phone on 9/22/24 at 11:08 a.m. that two CNAs reported potential resident to resident interactions on the 500 hall between two cognitively impaired residents. The DON asked the staff to do 15-minute checks and would assess the residents. The DON was working as the nurse that day and would enter the incident into the Indiana Department of Health report system.</p> <p>Cross reference F609 and F610.</p> <p>On 9/24/24 at 9:35 a.m., the ADM provided and identified a document as a current facility policy, titled Abuse, Neglect and Misappropriation of Property, dated 9/15/23. The policy indicated, .Policy Statement .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 .Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain, or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse .Sexual abuse is defined as non-consensual sexual contact of any type with a resident</p> <p>The immediate jeopardy that began on 9/22/24 was removed on 9/27/24 at 4:37 p.m., when the facility ensured a systemic plan to include education, assessment, and monitoring for all cognitively impaired residents to prevent resident to resident abuse. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring.</p> <p>This citation relates to Complaint IN00443846.</p> <p>3.1-27(a)(1)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34129</p> <p>Based on interview and record review, the facility failed to ensure allegations of resident abuse were reported immediately to the Administrator and/or designee and to the Indiana Department of Health for 2 of 3 residents reviewed for reporting allegations of abuse (Resident B and C).</p> <p>Findings include:</p> <p>On 9/24/24 at 10:29 a.m., the Director of Nursing (DON) provided the Indiana Department of Health (IDOH) help desk email correspondence with the DON, dated 9/19/24, 9/23/24, and 9/24/24. The DON indicated she had an abuse incident about Resident B and Resident C that she was trying to input into the Indiana Department of Health (IDOH) facility reported incident record (FRI) system but kept getting an error message. She had emailed the IDOH help desk, on 9/19/24 and emailed the help desk again on 9/24/24 at 10:05 a.m., and indicated in the email, .My updates from last 3 reportables and reportable from Sunday (9/22/24) is not even on my list today to follow up on. When I sent my reply, I thought they were complete and it wasn't when I reviewed the 1st 3 are missing the 2nd residents and follow ups are missing. But my last reportable is not showing up at all The DON indicated, the 9/22/24 abuse allegation incident was still not showing up in the IDOH FRI system and she was not aware of alternative ways to report the incident into IDOH survey report system about Resident B and Resident C. Resident B was going around and leading Resident C by the hand. Resident C had on a gold belt buckle that Resident B kept trying to touch the buckle. Certified Nursing Aide (CNA) 5 and CNA 6, thought Resident B was being inappropriate with Resident C and Resident B was touching Resident C's private area. DON contacted the Administrator (ADM), Social Services (SS), and the behavioral health services. The behavioral health services staff called back and changed Resident B's medication order for Xanax (medication used to treat anxiety and panic disorders) and increased the medication from 0.25 milligram (mg) twice daily (BID) to 0.5 mg BID. On 9/22/24, a Qualified Medication Aide (QMA) and two CNAs worked on the 500 locked unit. The QMA had told the DON that she did not see anything. CNA 5 told the DON Resident B kept touching Resident C at the belt buckle and taking Resident C's hand and walking around the unit. The DON told CNA 5 to separate Resident B and Resident C, and she went back to the 500 locked unit and watched the residents for about 15 minutes. The DON indicated Resident B kept leading Resident C around the unit hand in hand. CNA 6 kept telling CNA 5 that Resident B kept touching Resident C's private area. The DON indicated she had requested CNA 5 to stay with Resident B. There were other residents and residents' family members on the 500 locked unit, but no one had said anything to the DON about Resident B or Resident C.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an anonymous interview during the survey, Anonymous 1 indicated Resident B kept trying to get close to Resident C. In the morning after breakfast on 9/22/24, Anonymous 1 observed Resident B and Resident C sitting in recliners next to each other in the television area. Resident B put his hand inside Resident C's pants under his brief and rubbed Resident C's genitals. Anonymous 1 asked Resident B to remove his hand from Resident C's pants. Resident C was assisted to his room, by another staff member to get dressed. In the afternoon, Resident C was observed lying flat on his roommate's bed with Resident B lying on his side, next to Resident C with Resident B's hand on Resident C's bare stomach with the residents' legs intertwined. Anonymous 1 asked Resident B to remove his hand from Resident C's stomach and Resident B was escorted out of Resident C's room. About 5:50 to 6 p.m. on 9/22/24, Anonymous 1 assisted Resident C to the bathroom and the DON came into the bathroom and assessed Resident C's bottom. No one asked Anonymous 1 to write a statement about the incident and Anonymous 1 was told by another staff member on the 500 locked unit that the DON had told them not to document about the incident in the residents' medical records. Anonymous 1 did not specify if staff reported each incident to the DON.</p> <p>During an anonymous interview during the survey, Anonymous 2 indicated, after breakfast on the morning of 9/22/24, Resident B and Resident C were sitting next to each other in recliners in the television area. Resident B had his hand in the slit of Resident C's boxer pants and was rubbing Resident C's thigh. Another staff member asked Resident B to stop touching Resident C. Resident C was moved from the recliner in the television room, because he was easier to remove from the situation. Resident C was assisted by Anonymous 2 to his room to get dressed. Anonymous 2 then went and told the DON about the incident with Resident B and Resident C. Resident B was put on 15-minute checks by the DON. The DON instructed staff to keep the two residents separated. There was no additional staff called to watch Resident B, so staff tried to keep Resident B within their sight, while providing care to the other residents. But Resident B kept going back to Resident C, touching him and grabbing Resident C's hand to walk with him. Anonymous 2 indicated Anonymous 2 had found the two residents laying in Resident C's roommate's bed with Resident C laying on his back and Resident B laying on his side next to Resident C with Resident B's hand on Resident C's bare stomach. At about 2:00 p.m., Anonymous 2 indicated, they observed the two residents in another resident's room with Resident B standing in the room with his back to the door, without a brief and his pants were down to his ankles and his hands were on Resident C's shoulders. Resident C was taken out of the room by another staff member and Resident B was taken by Anonymous 2 to his room to put on a brief. At about 4:00 p.m., Resident B had his hand down Resident C's pants, while the residents were sitting in recliners in the television area. Staff tried to keep Resident C by the nurses' desk. Anonymous 2 indicated they saw the two residents in another resident's room, laying on the bed together with Resident B's arm around Resident C, but no hands were observed on any genitals. Later in the afternoon on 9/22/24, Resident C was observed having a hard time sitting down. Anonymous 2 informed the DON that it was painful for Resident C to sit down. The DON and another staff member assessed Resident C. Resident C had no problem earlier in the day sitting down but had a problem sitting down toward the end of the shift, 6:00 a.m. to 6:00 p.m. Anonymous 2 indicated they were not asked to write a statement about the incidents, and the DON had told them not to chart the incident in the residents' medical records. Anonymous 2 did not specify if staff reported each incident to the DON.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an anonymous interview during the survey, Anonymous 3 indicated, on 9/22/24, in the morning after breakfast, Resident B and Resident C were observed seated next to each other in recliners and Resident B had his hand down Resident C's pants. Anonymous 3 went over and told Resident B that he could not have his hand down Resident C's pants. Resident B's hand was assisted out of Resident C's pants by staff. Resident B said, okay. Both residents got up from the recliners and Resident B held Resident C's hand and they walked around the unit, hand in hand. Resident C followed along with Resident B, hand in hand or they walked beside each other. At about 9:00 a.m. on 9/22/24, Anonymous 3 went to the DON and told the DON they had found Resident B had his hand down Resident C's pants. DON told Anonymous 3 to put Resident B on 15 minutes checks. The DON came back to the unit later and observed Resident B and Resident C hand in hand and the DON told Resident B that he could not be holding Resident C's hand. Resident B let go of Resident C's hand. The two residents walked around the unit together, but not holding hands any longer. Resident B did not normally hold hands with any of the residents and was quiet, not causing any problems on the unit. Resident C went along with Resident B and did not normally get up and down as much until Resident B guided Resident C to walk together. Resident C liked to sit in a recliner in the television room area throughout the day. Resident B would not leave Resident C alone and kept coaxing Resident C to go walk around the unit. When it was time to eat lunch, the residents were seated at different tables. After lunch, Resident B slept most of the afternoon on the couch in the television room area and Resident C was up and down and wandering around the unit. After lunch, Resident C had a difficult time of sitting down, almost like he was scared or fearful to sit down. Resident C had peripheral vision problems and was always super careful when sitting down. Resident C, by the afternoon, was very tired from all the walking and roaming around the unit. The DON did a skin assessment on Resident C in the bathroom and did not find any skin issues. The DON had asked the staff to not document on the incident in the Residents' medical records and to keep it quiet.</p> <p>During an anonymous interview during the survey, Anonymous 4 indicated, on 9/22/24, there was a situation where Resident B sexually abused Resident C. The staff reported it to the nurse who reported it to the DON who came in on her day off and did a rectal exam on Resident C. Since the DON did not see any skin impairment on Resident C, the DON told the staff not to document the abuse.</p> <p>On 9/25/24 at 1:25 p.m., DON provided a copy of the Indiana Department of Health (IDOH) facility reported incident record (FRI) about Resident B and Resident C and indicated she had spoken to the IDT on Monday, 9/23/24, about the incident but did not document the IDT meeting. She had 15-minute checks continue for Resident B.</p> <p>The DON, on 9/25/24 at 2:50 p.m., indicated QMA 7 never came to the DON and told her there was any inappropriate touching between the Resident B and Resident C. CNA 5 came to her, on 9/22/24, and told her Resident B was touching inappropriately Resident C and that was the only staff member who had spoken to her about the inappropriate touching. CNA 5 had come to her about Resident B's inappropriate touching at least three times from 10 a.m. to 2 p.m. DON had gone back to the 500-hall locked unit at least 3 times, on 9/22/24, and she had not seen any inappropriate touching.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/26/24 at 8:05 a.m., CNA 6 indicated, on 9/25/24 at 9:30 p.m., the Administrator in Training (AIT) texted and asked if CNA 6 was able to send the statement over to the facility. CNA 6 indicated, they had handwritten the incident statement of three pages, written on lined paper, that they were providing to the facility, dated 9/25/24, which indicated, on the day of 9/22/24, they had worked on the 500 men's unit from 6 a.m. to 6 p.m. After breakfast at approximately between the times of 8 a.m. and 9 a.m., CNA 6 was sitting at the nurses' station charting. CNA 5 was also sitting at the nurses' station charting, when QMA 7 came to the nurses' station and indicated, come look at Resident B and Resident C. Resident B and Resident C were sitting in recliners next to each other facing the wall/television and Resident B's hand in and down Resident C's pants and brief, rubbing Resident C's genitals. At that time, CNA 6 assisted Resident C from the recliner and relocated him to another recliner. At the same time, CNA 5 redirected Resident B. QMA 7, CNA 5, and CNA 6, discussed what the best plan of action was moving forward. They all agreed/decided, to notify the DON and let her make the decision. CNA 5 offered to go find the DON and inform her of the situation/incident. CNA 5 then left the locked 500 unit and came back to the unit approximately 10 to 15 minutes later, and said, The DON said to not document the incident because it was a State offense, but to keep a close eye on Resident C. Throughout the shift, staff kept a close eye on Resident C. During our rounds and answering call lights, we lost track of both Resident B and Resident C. When we found both gentlemen, which was after lunch time, between 4:00 p.m. and 5:00 p.m., we found Resident B and Resident C laying perpendicularly in Resident C's roommate's bed. Resident B had his legs intertwined with Resident C's legs. Resident B's head was nuzzled into Resident C's neck region. Resident B also had his left hand was resting on Resident C's bare belly button region with Resident C's shirt slightly raised, but his brief/pants were not disturbed. Concerning the second incident, QMA 7, offered and spoke with the DON. CNA 6 was not informed of any further instructions pertaining to this incident. At approximately between 5:00 p.m. to 6:00 p.m. on 9/22/24, the DON came to the locked unit and had noticed how slowly Resident C was at sitting down in a chair. DON requested Resident C be taken to his private bathroom. CNA 6 indicated to the DON that Resident C had sat down like that since the first day he was admitted to the facility. The DON made the remark that they needed to make sure we do not actually have a reportable. Resident C was assisted from the chair and into his private restroom. Resident C's brief was removed, and his pants were pulled down. The DON walked into the bathroom and assessed Resident C's buttocks and genital region. The DON cleaned Resident C, then removed her gloves and exited the bathroom. Resident C was assisted on putting on a new brief and pulling up his pants. CNA 6 indicated, CNA 5 found Resident B and Resident C in another resident's room. CNA 5 called for CNA 6 to assist Resident C out of the room with CNA 5 telling CNA 6 that Resident B's pants had been pulled down and his brief was off. CNA 5 had taken Resident B to his room to get a new brief put on him. CNA 6 observed Resident C standing by the television in another resident's room and Resident C was escorted back to the dining room area and CNA 6 had tried to get Resident C to sit down, but Resident C was reluctant to sit down and walked around the dining room area. CNA 6 gathered their belongings and clocked out at 6:09 p.m. on 9/22/24.</p> <p>On 9/26/24 at 12:40 p.m. the Administrator provided a typed statement from QMA 7, dated 9/26/24, indicated QMA 7 observed Residents B and C walking down the hall and noticed Resident B had his hands down Resident's C pants. QMA 7 assisted Resident B with getting his hand out of Resident C's pants and was redirected and separated. The DON was notified, and fifteen-minute checks were implemented. Residents were not observed in bed together. QMA 7 indicated that nothing more was reported to her the rest of the day. QMA 7 indicated she did not believe that Resident B and C were able to get into a bed by themselves without help.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 6:24 p.m. the Administrator provided a handwritten statement from CNA 5, dated 9/25/24. The statement indicated it was written by the DON and was a telephone statement from CNA 5. CNA 5 indicated he was told by CNA 6 around breakfast of that Resident B's hands were in Resident C's pants. Both CNAs went and separated the residents. After breakfast Resident B had his hand in Resident C's pants while sitting in the recliners by the television. CNA 5 reported to QMA 7 and the DON. The statement indicated that the DON had Resident B stay with CNA 5 and place the resident on fifteen- minute checks. After lunch Resident B went in a room and CNA 5 saw Resident B's pants and brief down with Resident C in the same room dressed.</p> <p>a. Resident B's record was reviewed, on 9/24/24 at 10:01 a.m. Diagnoses included, but not limited to, unspecified dementia, unspecified severity without behavioral disturbance (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, reasoning, and remembering, that interferes with daily life) and anxiety.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident B had a severe cognitive impairment, no impairments in upper extremity nor lower extremities, without mobility devices usage, supervision or touching assistance for eating, partial to moderate assistance for oral hygiene, substantial to maximal assistance for toileting hygiene and bathing, with partial to moderate assistance for upper and lower dressing and personal hygiene, and supervision or touching assistance with helper provided verbal cues or touching/steadying as resident completed activity of sit to stand, chair/bed-to-chair transfers, and toilet transfers.</p> <p>A nursing progress note, written by the DON, dated 9/22/24 at 10:30 a.m., indicated Resident B was wandering in the unit, following residents and reaching out to staff and residents for shiny items such as name badges and belt buckles. When the DON spoke to the resident about keeping his hands to himself, Resident B was naming all kinds of body parts to the DON. The DON had the unit staff keep redirecting and had a staff CNA stay with resident to redirect.</p> <p>A nursing progress note, written by the DON, dated 9/22/24 at 10:57 a.m., indicated staff noted to the DON that Resident B was following another resident and holding his hand and leading resident to different areas on the unit. Staff continued to redirect and separate the residents. Resident B was put on 15-minute checks to redirect from other residents and to engage in other activities. Resident B was toileted and redirected to the bathroom with assistance of staff. The resident was redirected from urinating in the unit hallway corner.</p> <p>A nursing progress note, dated 9/24/24 at 7:47 p.m., indicated Resident B was observed standing in other resident's room while they were resting. Resident B was redirected to the day room, took all medications, and continued 15-minute checks.</p> <p>b. Resident C's record was reviewed on 9/24/24 at 11:12 a.m. The resident was admitted to the facility, on 9/6/24, with diagnoses included, but not limited to, vascular dementia (brain condition that affects thinking, memory, and behavior, and is caused by damaged blood vessels in the brain) and anxiety.</p> <p>A Brief Interview for Mental Status assessment, dated 9/9/24, indicated the resident had a severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A written statement dated 9/27/24 and signed by the ADM was provided by the ADM on 9/27/24 at 4:25 p.m. The statement indicated the DON notified the ADM by phone on 9/22/24 at 11:08 a.m. that two CNAs reported potential resident to resident interactions on the 500 hall between two cognitively impaired residents. The DON asked the staff to do 15-minute checks and would assess the residents. The DON was working as the nurse that day and would enter the incident into the Indiana Department of Health report system.</p> <p>On 9/24/24 at 9:35 a.m., the ADM provided and identified a document as a current facility policy, titled Abuse, Neglect and Misappropriation of Property, dated 9/15/23. The policy indicated, .Policy Statement .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 Facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law .Immediately all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made .all allegations and incidents of abuse or neglect, as defined in this policy, will be reported 'immediately,' as defined in this paragraph .G. Reporting/Response .1. Every Stakeholder shall immediately report any 'allegation of abuse' . Reporting Guidelines .Any abuse allegation must be reported to State within 2 hours from the time the allegation was received</p> <p>The Indiana Department of Health facility reporting incident record (FRI) system instructed facilities to do the following when the online incident reporting system was down:</p> <ol style="list-style-type: none"> <li>1. Complete the Incident Reporting Form and email it to incidents@health.in.gov.</li> <li>2. Within 24 hours of Gateway being accessible, report the incident through the incident reporting system. Please attach the incident report form to the incident in Gateway.</li> <li>3. Reporting an incident via voicemail is available ONLY when the Incident Reporting System and email are not functioning: <ul style="list-style-type: none"> <li>- Incident reporting secure voicemail line phone number is [PHONE NUMBER].</li> <li>- Please include: <ul style="list-style-type: none"> <li>- Name and title of reporter</li> <li>- Name of facility</li> <li>- Address of facility</li> <li>- Type of incident (examples on Incident Reporting Form)</li> <li>- Description of injury</li> </ul> </li> </ul> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34129</p> <p>Based on interview and record review, the facility failed to ensure an allegation of resident abuse was investigated for 2 of 3 residents reviewed for investigating abuse allegations (Resident B and C).</p> <p>Findings include:</p> <p>During an interview, on 9/24/24 at 10:29 a.m., the Director of Nursing (DON) indicated she had an incident that she was trying to input into the Indiana Department of Health (IDOH) facility reported incident record (FRI) system about Resident B and Resident C. Resident B was going around and leading Resident C by the hand. Resident C had on a gold belt buckle that Resident B kept trying to touch the buckle. Certified Nursing Aide (CNA) 5 and CNA 6, thought Resident B was being inappropriate with Resident C and Resident B was touching Resident C's private area. DON contacted the Administrator (ADM), Social Services (SS), and the behavioral health services. The behavioral health services staff called back and changed Resident B's medication order for Xanax (medication used to treat anxiety and panic disorders) and increased the medication from 0.25 milligram (mg) twice daily (BID) to 0.5 mg BID. The DON indicated, she had requested the CNAs to write statements and neither CNA wrote a statement. On 9/22/24, a Qualified Medication Aide (QMA) and two CNAs worked on the 500 locked unit. The QMA had told the DON that she did not see anything. CNA 5 told the DON Resident B kept touching Resident C at the belt buckle and taking Resident C's hand and walking around the unit. The DON told CNA 5 to separate Resident B and Resident C, and she went back to the 500 locked unit and watched the residents for about 15 minutes. She had asked the three staff members on the locked unit to write statements about the incident. The DON indicated Resident B kept leading Resident C around the unit hand in hand. CNA 6 kept telling CNA 5 that Resident B kept touching Resident C's private area. The DON indicated she had requested CNA 5 to stay with Resident B. There were other residents and residents' family members on the 500 locked unit, but no one had said anything to the DON about Resident B or Resident C.</p> <p>On 9/24/24 at 11:44 a.m., CNA 9, observed working on the 500 hall locked unit, indicated the night shift staff had reported to the day shift staff to keep Resident B and Resident C separated, because there was sexual tension, like Resident B rubbing on Resident C. Resident B was on 15-minute checks and staff were to keep them separated, because Resident B was rubbing all over Resident C. Resident B nor Resident C had any care plan interventions besides keeping them separated. Resident B had the 15-minute checks, but no other interventions other than to keep the residents separated.</p> <p>The DON, on 9/24/24 at 12:59 p.m., indicated Resident B was touching people and was put on 15-minute checks, on 9/22/24, and staff would continue the 15-minute checks to ensure Resident B's medication adjustment was working and until psychiatric services came, on 9/26/24, to assess Resident B.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/24/24 at 1:05 p.m., the DON indicated she had initiated an abuse investigation and provided the investigation documentation which included: Resident B's medical record face sheet and skin monitoring assessments, dated 9/22/24 at 3:15 p.m. and 9/23/24 at 8:30 a.m. Resident C's medical record face sheet and skin monitoring assessments, dated 9/22/24 at 2:30 p.m. and 9/23/24 at 8:30 a.m. Increased monitoring - 15 minute checks document, initiated on 9/22/24 at 10:00 a.m. and ended on the document at 6:00 p.m., initialed by QMA 7 with where Resident B was at that time and the QMA's initials, but lacked documentation of what Resident B was doing or if Resident B was with another resident. The DON's written statement document, dated 9/22/24, which indicated, .This writer was notified by [CNA 5's name] that [Resident B's name] BIMS (Brief Interview for Mental Status) 0 was touching another resident and leading him by the hand around the unit. This nurse was giving medication on 600 hall and told staff to immediately place resident on 15-minute checks and to have [CNA 5] stay with the resident providing redirection and companionship. This nurse finished medication pass and went to assess situation. Resident was touching objects at resident's belt level. [Resident C's name] BIMS 0 has a shiny belt latch and belt. Resident touching it. [CNA 5] noted that was what he was touching. Resident saw my badge and grabbed a silver on it. This writer watched resident led [Resident C's name] by the hand around the room . DON did not observe Resident B touching anyone inappropriately other than grabbing at shiny badges or object people were wearing. CNA 5 stated he felt Resident B was being inappropriate with others. He stated CNA 6 stated that Resident B was touching only Resident C in the area of his private areas. DON went with CNA 6 and assessed Resident C head to toe because Resident C was not sitting down well in a chair. CNA 6 was present during head to toe exam and we found no injuries, 15 minutes checks and redirection continued. Notification of behaviors was noted to social services. Psychiatric services was called and medication change given, and families were attempted to be contacted. Resident B was undergoing guardianship and staff left a message for the family member. There was no answer for Resident C's family and staff attempted to recall on 9/24/24. The Physician was notified and there was a follow up conversation on 9/23/24. The incident was reported to the corporate supervisor and state website. The ADM and Administrator in Training (AIT) were notified. At this time, no other investigation documentation was provided by the DON.</p> <p>During an anonymous interview during the survey, Anonymous 1 indicated Resident B kept trying to get close to Resident C. In the morning after breakfast on 9/22/24, Anonymous 1 observed Resident B and Resident C sitting in recliners next to each other in the television area. Resident B put his hand inside Resident C's pants under his brief and rubbed Resident C's genitals. Anonymous 1 asked Resident B to remove his hand from Resident C's pants. Resident C was assisted to his room, by another staff member to get dressed. In the afternoon, Resident C was observed lying flat on his roommate's bed with Resident B lying on his side, next to Resident C with Resident B's hand on Resident C's bare stomach with the residents' legs intertwined. Anonymous 1 asked Resident B to remove his hand from Resident C's stomach and Resident B was escorted out of Resident C's room. About 5:50 to 6 p.m. on 9/22/24, Anonymous 1 assisted Resident C to the bathroom and the DON came into the bathroom and assessed Resident C's bottom. No one asked Anonymous 1 to write a statement about the incident and Anonymous 1 was told by another staff member on the 500 locked unit that the DON had told them not to document about the incident in the residents' medical records.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an anonymous interview during the survey, Anonymous 2 indicated, after breakfast on the morning of 9/22/24, Resident B and Resident C were sitting next to each other in recliners in the television area. Resident B had his hand in the slit of Resident C's boxer pants and was rubbing Resident C's thigh. Another staff member asked Resident B to stop touching Resident C. Resident C was moved from the recliner in the television room, because he was easier to remove from the situation. Resident C was assisted by Anonymous 2 to his room to get dressed. Anonymous 2 then went and told the DON about the incident with Resident B and Resident C. Resident B was put on 15-minute checks by the DON. The DON instructed staff to keep the two residents separated. There was no additional staff called to watch Resident B, so staff tried to keep Resident B within their sight, while providing care to the other residents. But Resident B kept going back to Resident C, touching him and grabbing Resident C's hand to walk with him. Anonymous 2 indicated Anonymous 2 had found the two residents laying in Resident C's roommate's bed with Resident C laying on his back and Resident B laying on his side next to Resident C with Resident B's hand on Resident C's bare stomach. At about 2:00 p.m., Anonymous 2 indicated, they observed the two residents in another resident's room with Resident B standing in the room with his back to the door, without a brief and his pants were down to his ankles and his hands were on Resident C's shoulders. Resident C was taken out of the room by another staff member and Resident B was taken by Anonymous 2 to his room to put on a brief. At about 4:00 p.m., Resident B had his hand down Resident C's pants, while the residents were sitting in recliners in the television area. Staff tried to keep Resident C by the nurses' desk. Anonymous 2 indicated they saw the two residents in another resident's room, laying on the bed together with Resident B's arm around Resident C, but no hands were observed on any genitals. Later in the afternoon on 9/22/24, Resident C was observed having a hard time sitting down. Anonymous 2 informed the DON that it was painful for Resident C to sit down. The DON and another staff member assessed Resident C. Resident C had no problem earlier in the day sitting down but had a problem sitting down toward the end of the shift, 6:00 a.m. to 6:00 p.m. Anonymous 2 indicated they were not asked to write a statement about the incidents, and the DON had told them not to chart the incident in the residents' medical records.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an anonymous interview during the survey, Anonymous 3 indicated, on 9/22/24, in the morning after breakfast, Resident B and Resident C were observed seated next to each other in recliners and Resident B had his hand down Resident C's pants. Anonymous 3 went over and told Resident B that he could not have his hand down Resident C's pants. Resident B's hand was assisted out of Resident C's pants by staff. Resident B said, okay. Both residents got up from the recliners and Resident B held Resident C's hand and they walked around the unit, hand in hand. Resident C followed along with Resident B, hand in hand or they walked beside each other. At about 9:00 a.m. on 9/22/24, Anonymous 3 went to the DON and told the DON they had found Resident B had his hand down Resident C's pants. DON told Anonymous 3 to put Resident B on 15 minutes checks. The DON came back to the unit later and observed Resident B and Resident C hand in hand and the DON told Resident B that he could not be holding Resident C's hand. Resident B let go of Resident C's hand. The two residents walked around the unit together, but not holding hands any longer. Resident B did not normally hold hands with any of the residents and was quiet, not causing any problems on the unit. Resident C went along with Resident B and did not normally get up and down as much until Resident B guided Resident C to walk together. Resident C liked to sit in a recliner in the television room area throughout the day. Resident B would not leave Resident C alone and kept coaxing Resident C to go walk around the unit. When it was time to eat lunch, the residents were seated at different tables. After lunch, Resident B slept most of the afternoon on the couch in the television room area and Resident C was up and down and wandering around the unit. After lunch, Resident C had a difficult time of sitting down, almost like he was scared or fearful to sit down. Resident C had peripheral vision problems and was always super careful when sitting down. Resident C, by the afternoon, was very tired from all the walking and roaming around the unit. The DON did a skin assessment on Resident C in the bathroom and did not find any skin issues. The DON had asked the staff to not document on the incident in the Residents' medical records and to keep it quiet.</p> <p>During an anonymous interview during the survey, Anonymous 4 indicated, on 9/22/24, there was a situation where Resident B sexually abused Resident C. The staff reported it to the nurse who reported it to the DON who came in on her day off and did a rectal exam on Resident C. Since the DON did not see any skin impairment on Resident C, the DON told the staff not to document the abuse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/25/24 12:06 p.m., Social Services Assistant (SSA) indicated she did not personally know Resident B nor Resident C. She was home on Sunday, when she got a call from the DON. The DON requested SSA call psychiatric services for a medication review for Resident B. The psychiatric services on-call physician increased Resident B's Xanax medication to 0.5 mg twice daily (BID). Resident B did not have any behavior monitoring but had the behaviors of exit seeking and bowel movements and urinating in the hallways. She did not understand what happened on 9/22/24, the DON was trying to tell the SSA about Resident C's pants and a shiny belt buckle. SSA indicated she was at home and was confused about the situation. Resident B was wanting to touch shiny things such as a shiny belt buckle and shiny name tags. SSA indicated she was doing psychosocial follow ups for Resident B and Resident C and was documenting the follow ups in the residents' electronic medical records in the progress notes. SSA indicated she was following up for the behavior of a shiny buckle. SSA also was following up on Resident C, since he was the resident being touched. This morning, on 9/25/24, she had visited with Resident C's wife when she came to the facility. Resident C's wife indicated Resident C was tearful until his wife gave him a stuffed animal that seemed to cheer him up. SSA indicated, she needed to add a care plan intervention for Resident B about inappropriately touching other residents and add a care plan intervention for Resident C's tearfulness. Staff were making sure Resident B and Resident C were staying separated. The Corporate Social Services Director (SSD) indicated Resident B should have a care plan with interventions for touching others inappropriately with an intervention to separate the residents immediately, change rooms, and 15-minute checks for Resident B and psychosocial follow ups for Resident C. The SSD indicated the Interdisciplinary (IDT) team should have met Monday morning, 9/23/24, to discuss the incident and put care plan interventions to keep Resident B from touching other residents and an intervention to keep Resident C safe. SSA indicated, she had just now, on Resident B's electronic medical record, put in a new care plan intervention for Resident B to separate residents immediately for the care plan of resident makes sexually inappropriate advances towards female staff and other residents.</p> <p>On 9/25/24 at 1:25 p.m., DON provided a copy of the Indiana Department of Health (IDOH) facility reported incident record (FRI) about Resident B and Resident C and indicated she had spoken to the IDT on Monday, 9/23/24, about the incident but did not document the IDT meeting. She had 15-minute checks continue for Resident B.</p> <p>The DON, on 9/25/24 at 2:50 p.m., indicated she had contacted the three staff working on 9/22/24 from 6:00 a.m. to 6:00 p.m. shift on the 500-hall locked unit to get witness statements, but she had not gotten any responses. QMA 7 never came to the DON and told her there was any inappropriate touching between the Resident B and Resident C. CNA 5 came to her, on 9/22/24, and told her Resident B was touching inappropriately Resident C and that was the only staff member who had spoken to her about the inappropriate touching. CNA 5 had come to her about Resident B's inappropriate touching at least three times from 10 a.m. to 2 p.m. DON had gone back to the 500-hall locked unit at least 3 times, on 9/22/24, and she had not seen any inappropriate touching.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/26/24 at 8:05 a.m., CNA 6 indicated, on 9/25/24 at 9:30 p.m., the Administrator in Training (AIT) texted and asked if CNA 6 was able to send the statement over to the facility. The AIT indicated, We can transcribe a verbal statement of the incident over the phone. CNA 6 could call the AIT or the DON, and they would create the statement and CNA 6 texted, she would feel much more comfortable, providing a handwritten statement, written and signed by herself. She was willing to come in earlier and provide a written statement. CNA 6 indicated, they had handwritten the incident statement of three pages, written on lined paper, that they were providing to the facility, dated 9/25/24, which indicated, on the day of 9/22/24, they had worked on the 500 men's unit from 6 a.m. to 6 p.m. After breakfast at approximately between the times of 8 a.m. and 9 a.m., CNA 6 was sitting at the nurses' station charting. CNA 5 was also sitting at the nurses' station charting, when QMA 7 came to the nurses' station and indicated, come look at Resident B and Resident C. Resident B and Resident C were sitting in recliners next to each other facing the wall/television and Resident B's hand in and down Resident C's pants and brief, rubbing Resident C's genitals. At that time, CNA 6 assisted Resident C from the recliner and relocated him to another recliner. At the same time, CNA 5 redirected Resident B. QMA 7, CNA 5, and CNA 6, discussed what the best plan of action was moving forward. They all agreed/decided, to notify the DON and let her make the decision. CNA 5 offered to go find the DON and inform her of the situation/incident. CNA 5 then left the locked 500 unit and came back to the unit approximately 10 to 15 minutes later, and said, The DON said to not document the incident because it was a state offense, but to keep a close eye on Resident C. Throughout the shift, staff kept a close eye on Resident C. During our rounds and answering call lights, we lost track of both Resident B and Resident C. When we found both gentlemen, which was after lunch time, between 4:00 p.m. and 5:00 p. m., we found Resident B and Resident C laying perpendicularly in Resident C's roommate's bed. Resident B had his legs intertwined with Resident C's legs. Resident B's head was nuzzled into Resident C's neck region. Resident B also had his left hand was resting on Resident C's bare belly button region with Resident C's shirt slightly raised, but his brief/pants were not disturbed. Concerning the second incident, QMA 7, offered and spoke with the DON. CNA 6 was not informed of any further instructions pertaining to this incident. At approximately between 5:00 p.m. to 6:00 p.m. on 9/22/24, the DON came to the locked unit and had noticed how slowly Resident C was at sitting down in a chair. DON requested Resident C be taken to his private bathroom. CNA 6 indicated to the DON that Resident C had sat down like that since the first day he was admitted to the facility. The DON made the remark that they needed to make sure we do not actually have a reportable. Resident C was assisted from the chair and into his private restroom. Resident C's brief was removed, and his pants were pulled down. The DON walked into the bathroom and assessed Resident C's buttocks and genital region. The DON cleaned Resident C, then removed her gloves and exited the bathroom. Resident C was assisted on putting on a new brief and pulling up his pants. CNA 6 indicated, CNA 5 found Resident B and Resident C in another resident's room. CNA 5 called for CNA 6 to assist Resident C out of the room with CNA 5 telling CNA 6 that Resident B's pants had been pulled down and his brief was off. CNA 5 had taken Resident B to his room to get a new brief put on him. CNA 6 observed Resident C standing by the television in another resident's room and Resident C was escorted back to the dining room area and CNA 6 had tried to get Resident C to sit down, but Resident C was reluctant to sit down and walked around the dining room area. CNA 6 gathered their belongings and clocked out at 6:09 p.m. on 9/22/24 and was never asked to provide a written statement to the facility. The first time CNA 6 was asked to provide a statement to the facility about the incident between Resident B and Resident C was on 9/25/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Signature Healthcare of Terre Haute		STREET ADDRESS, CITY, STATE, ZIP CODE  3500 Maple Ave Terre Haute, IN 47804	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 12:40 p.m. the Administrator provided a typed statement from QMA 7, dated 9/26/24, indicated QMA 7 observed Residents B and C walking down the hall and noticed Resident B had his hands down Resident's C pants. QMA 7 assisted Resident B with getting his hand out of Resident C's pants and was redirected and separated. The DON was notified, and fifteen-minute checks were implemented. Residents were not observed in bed together. QMA 7 indicated that nothing more was reported to her the rest of the day. QMA 7 indicated she did not believe that Resident B and C were able to get into a bed by themselves without help.</p> <p>On 9/26/24 at 6:24 p.m. the Administrator provided a copy of a handwritten statement from QMA 7 dated 9/25/24. QMA 7 indicated Residents B and C were never alone in a room by themselves at all.</p> <p>On 9/26/24 at 6:24 p.m. the Administrator provided a handwritten statement from CNA 5, dated 9/25/24. The statement indicated it was written by the DON and was a telephone statement from CNA 5. CNA 5 indicated he was told by CNA 6 around breakfast of that Resident B's hands were in Resident C's pants. Both CNAs went and separated the residents. After breakfast Resident B had his hand in Resident C's pants while sitting in the recliners by the television. CNA 5 reported to QMA 7 and the DON. The statement indicated that the DON had Resident B stay with CNA 5 and place the resident on fifteen- minute checks. After lunch Resident B went in a room and CNA 5 saw Resident B's pants and brief down with Resident C in the same room dressed.</p> <p>On 9/24/24 at 1:05 p.m., the DON provided copies of the fifteen-minute monitoring for Resident B dated 9/22/24. The document was blank from 12:00 a.m. until 10:00 a.m. Starting at 10:00 a.m. until 6:00 p.m., in every fifteen-minute slot were initials for the location the resident was found and initials for the staff member recording the fifteen-minute check. The document lacked documentation of what Resident B was doing or if Resident B was with another resident.</p> <p>On 9/26/24 at 12:40 p.m., the Administrator provided copies of the fifteen-minute monitoring for Resident B dated 9/22/24. This document differed from the document with the same date provided on 9/24/24. The document was blank from 12:00 a.m. until 10:30 a.m. Starting at 10:30 a.m. until 6:00 p.m. in every fifteen-minute slot were initials for the location the resident was found and the initials for the staff member recording the fifteen-minute check. The recorded initials for the locations and staff member were different than the record provided on 9/24/24. The document lacked documentation of what Resident B was doing or if Resident B was with another resident. Starting at 6:15 p.m. until 11:00 p.m. the fifteen-minute slots indicated what the resident was doing but lacked staff initials. The monitoring tool was blank from 11:00 p.m. on 9/22/24 until 6:00 a.m. on 9/23/24.</p> <p>a. Resident B's record was reviewed, on 9/24/24 at 10:01 a.m. Diagnoses included, but not limited to, unspecified dementia, unspecified severity without behavioral disturbance (chronic condition that causes a gradual decline in cognitive abilities, such as thinking, reasoning, and remembering, that interferes with daily life) and anxiety.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident B had a severe cognitive impairment, no impairments in upper extremity nor lower extremities, without mobility devices usage, supervision or touching assistance for eating, partial to moderate assistance for oral hygiene, substantial to maximal assistance for toileting hygiene and bathing, with partial to moderate assistance for upper and lower dressing and personal hygiene, and supervision or touching assistance with helper provided verbal cues or touching/steadying as resident completed activity of sit to stand, chair/bed-to-chair transfers, and toilet transfers.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan, started on 11/8/23, indicated Resident B had behavioral care plan for refusing care, such as showers and personal hygiene. Resident makes sexually inappropriate advances towards female staff and other residents with interventions included, but were not limited to, approach resident in a calm and unhurried manner to deliver provide services; explain care process prior to delivery of care as needed; offer choices in hands-on care and contact; resident chooses to sleep on couch and chooses to stay up late; and resident exercises right to decline treatment and services.</p> <p>A nursing progress note, written by the DON, dated 9/22/24 at 10:30 a.m., indicated Resident B was wandering in the unit, following residents and reaching out to staff and residents for shiny items such as name badges and belt buckles. When the DON spoke to the resident about keeping his hands to himself, Resident B was naming all kinds of body parts to the DON. The DON had the unit staff keep redirecting and had a staff CNA stay with resident to redirect.</p> <p>A nursing progress note, written by the DON, dated 9/22/24 at 10:57 a.m., indicated staff noted to the DON that Resident B was following another resident and holding his hand and leading resident to different areas on the unit. Staff continued to redirect and separate the residents. Resident B was put on 15-minute checks to redirect from other residents and to engage in other activities. Resident B was toileted and redirected to the bathroom with assistance of staff. The resident was redirected from urinating in the unit hallway corner.</p> <p>A nursing progress note, dated 9/24/24 at 7:47 p.m., indicated Resident B was observed standing in other resident's room while they were resting. Resident B was redirected to the day room, took all medications, and continued 15-minute checks.</p> <p>Resident B's care plans and medical record lacked documentation of interventions for when Resident B made sexually inappropriate advances towards female staff and other residents and lacked documentation Resident B's family was notified of the incident on 9/22/24.</p> <p>b. Resident C's record was reviewed on 9/24/24 at 11:12 a.m. The resident was admitted to the facility, on 9/6/24, with diagnoses included, but not limited to, vascular dementia (brain condition that affects thinking, memory, and behavior, and is caused by damaged blood vessels in the brain) and anxiety.</p> <p>A Brief Interview for Mental Status assessment, dated 9/9/24, indicated the resident had a severe cognitive impairment.</p> <p>A Social Services progress note, written by the SSA, on 9/24/24 at 2:01 p.m., indicated SSA follow up. Resident C had visit with his wife today. Wife reported the resident was tearful briefly during the visit but cheered up when the wife brought out a stuffed [NAME] toy. Staff reported resident has had a pleasant mood with no signs or symptoms of psychosocial distress at this time.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/24/24 at 9:35 a.m., the ADM provided and identified a document as a current facility policy, titled Abuse, Neglect and Misappropriation of Property, dated 9/15/23. The policy indicated, .Policy Statement .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's policy is that the Facility Administrator, or his or her designee, will conduct a reasonable investigation of each such alleged violation unless he or she has a conflict of interest or is implicated in the alleged violation. The Facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law . 1. The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute 'allegations of abuse,' .The Facility Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident .2. The investigation should include interviews of involved persons, including the alleged victim, alleged perpetrator, witness, and others who might have knowledge of the allegations .3. To the extent possible and applicable, provide complete and thorough documentation of the investigation .4. The investigation should be documented, and any specific forms required by the State, or as otherwise instructed by legal counsel use (if applicable). These forms are not part of a resident's medical record. The documentation will be kept in the Facility Administrator or Director of Nursing's office in a secure administrative file marked CONFIDENTIAL .5. All investigation documents and materials are to be held in strict confidence and cannot be shared with any unauthorized person .6. The Facility Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents .7. Any affected resident's physician and family/responsible party will be informed of the result of the investigation .8. Every substantiated allegation of abuse will be reviewed by the Facility's Quality Assurance and Performance Improvement Committee to detect potential patterns or trends, and for consideration of further interventions or training opportunities. The medical director should be notified and involved .10. The Governing Body will be informed of the receipt of allegations of abuse, neglect, exploitation, or misappropriation and the results of the investigation via the QAPI process. In the event the investigation of the allegation results in substantiation of abuse, neglect, exploitation, misappropriation or mistreatment, a member of the Governing Body will be advised of the results of the investigation as soon as reasonable suspicion of substantiation has developed .F. Protection .1. Every Stakeholder must intervene immediately, protect the alleged victim, and integrity of the investigation .2. If a Stakeholder observes any form of abuse, the Stakeholder will intervene immediately, remove and/or separate residents involved, and move them to an environment where the residents' safety can be assured .3. Every Stakeholder shall immediately report any 'allegation of abuse,' injury of unknown source,' or 'suspicion of a crime,' as those terms are defined above. All such persons are encouraged to follow these reporting guidelines when they have reason to believe that abuse, neglect, or exploitation is occurring, has occurred, or plausibly may have occurred, but any person who deliberately makes a false allegation of abuse may be subject to discipline .5. If a suspected perpetrator is anyone other than a Stakeholder, the Facility Administrator or designee, will immediately take all appropriate measures to secure the safety and well-being of the affected resident or residents .6. The Facility Administrator will identify, intervene and correct situations in which reported abuse, neglect, exploitation, or misappropriation of resident property may recur</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Cross reference F600 and F609.</p> <p>This citation relates to Complaint IN00443846.</p> <p>3.1-28(d)</p> <p>3.1-28(e)</p>