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 11/13/2024
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35317 Based on record review and interview, the facility failed to ensure post fall assessmetns and vitals were completed for 72 hours post fall for 1 of 3 residents reviewed for accidents (Resident P). Findings include: On 11/13/24 at 1:00 p.m., the facility list of falls was reviewed, it was noted Resident P slid from his wheelchair in his room resulting in the resident being found on the floor next to his wheelchair on 9/3/24. A progress note, dated 9/3/24 at 3:19 p.m., indicated Resident P was observed to be on the floor on the left side of his wheelchair. The resident was found to be incontinent of urine. No injuries noted after skin sweep (skin assessment). Vital signs were obtained, and the resident was lifted off the floor with the assistance of 3 staff. The note indicated that family and doctor were notified. An IDT (interdisciplinary team) note, dated 9/4/24 at 9:56 a.m., indicated they had discussed Resident P's fall and the root cause was determined to be urinary incontinence and an intervention to toilet before and after meals was to be added to the care plan. Resident P's record was reviewed on 11/13/24 at 11:20 a.m. The profile indicated the resident's diagnosis included, but were not limited to, paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), altered mental status (a change in how well the brain is working), and diffuse traumatic brain injury with loss of consciousness of unspecified duration (a widespread brain injury caused by trauma where the person lost consciousness, but exact length of time they were unconscious is unknown). A quarterly Minimum Data Set (MDS) assessment, dated 11/4/24, indicated the resident had severe cognitive impairment and required moderate assistance from staff for transfers and toilet hygiene. A care plan, dated 8/6/24, indicated Resident P was at risk for falling related to prior falls before admission and traumatic brain injury. Interventions included, but were not limited to, staff to offer toileting before and after meals and lay the resident down after meals, keep call light in reach, and keep personal items and frequently used items within reach. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 9/4/24 with a stop date of 9/7/24, indicated a 72 hour follow up assessment related to fall was to be completed. Document skin assessment, vital signs, and pain in progress note every shift. A September medication administration record (MAR) was reviewed, staff had initialed they had completed the 72-hour fall follow up assessment including skin assessment, vital signs, and pain assessment in the progress note for Resident P, but the record lacked any documentation of the assessments. Vitals signs were noted in the computer system for Resident P on 9/3/24 (the date of the fall), the next vital signs documented for the resident were dated 10/13/24. The record lacked documentation of vital signs being obtained between the dates of 9/4/24 to 10/12/24. Review of the fall risk assessment, dated 8/5/24, indicated the resident was a moderate risk for falls. Records lacked documentation that the fall risk assessment had been updated since his admission on 8/5/24. During an interview, on 11/13/24 at 1:26 p.m., the Assistant Administrator indicated they were unable to find where a progress note was documented related to skin assessments, vital signs, and pain assessment being completed for Resident P as ordered. She indicated there was room for improvement regarding documentation by nursing staff. The assistant administrator indicated the order was signed off as completed but they were unable to provide the proof it was done. During an interview, on 11/13/24 at 1:45 p.m., a contracted Registered Nurse (RN) 13 indicated that when a resident falls, staff should first perform a head-to-toe assessment including vital signs, notify family and doctor, and send out to the hospital if injuries are noted. He indicated if there were no injuries, then the resident is monitored by completing a post fall follow up assessment in the progress notes for 72 hours post fall. On 11/13/24 at 1:58 p.m., the Assistant Administrator provided a document, with a revised date of 9/15/23, titled, Falls, and indicated it was the policy currently being used by the facility. The policy indicated, .1. All residents will have a fall risk assessment on admission/readmission, quarterly, annually, and with a significant change of condition to identify risk for falls .2 . The care plan will be reviewed following each fall This citation relates to Complaint IN00446733. 3.1-45(a)

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to assist the resident in transportation from the facility to a physician office appointment for 1 of 1 resident reviewed for transportation (Resident C). Findings include: On 11/12/24 at 11:00 a.m., the medical record of Resident C was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included but not limited to, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), osteomyelitis (a painful bone infection that causes inflammation and swelling in the bone) of bilateral heels (both heels), hypertension (high blood pressure), functional quadriplegia (a condition that causes a person to be completely unable to move due to a severe disability or frailty from another medical condition). An admission Minimum Data Set (MDS) assessment, dated 10/16/24, indicated the resident was cognitively intact and the resident required maximum assistance for daily care needs including physical repositioning and transfers. The medical record indicated the resident was scheduled for a physician office appointment on 10/22/24. The resident was unable to sit up and travel to the appointment. The facility re-scheduled the appointment for 10/24/24. The record indicated the resident was not transported to the appointment. The family of the resident requested the resident be transferred to the hospital due to missed appointments and need for care. The resident was transferred to the emergency room (ER) and admitted to the hospital on 10/24/24. On 11/12/24 at 12:00 p.m., during an interview with the Regional Nurse Consultant, she indicated the facility would arrange for or provide transportation for residents through wheelchair or gurney transfer, based on the needs of the resident. She indicated the facility used multiple companies for transfers. On 11/12/24 at 12:10 p.m., during a phone interview with the resident's physician's office. The receptionist indicated the resident was scheduled for an appointment on 10/22/24 which was cancelled. She indicated the appointment was re-scheduled for 10/24/24. She indicated the resident was a no show for the appointment on 10/24/24. On 11/12/24 at 2:55 p.m., during an interview with Licensed Practical Nurse (LPN) 5, she indicated the Receptionist scheduled appointments for the residents to go out to appointments. She indicated she did not change schedules or make transportation arrangements. On 11/12/24 at 3:00 p.m., during an interview with the Receptionist. She indicated she would make an appointment for a resident to go to appointments by a gurney. She indicated the facility used multiple companies for transportation. She did not recall if transportation had been arranged for the 10/24/24 appointment. She indicated she was not scheduling appointments at that time. (continued on next page)

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 8:45 a.m., during a phone interview with the scheduler of the local ambulance service, she indicated Resident C was not scheduled for a pick-up on October 24, 2024. She indicated they no longer provided service to the facility. On 11/13/24 at 11:27 a.m., during review of the facility events and appointment calendar. The documentation indicated multiple residents were scheduled for physician appointments for each month. The record lacked evidence that an appointment had been scheduled for 10/22/24 or 10/24/24 for Resident C. On 11/13/24 at 11:46 a.m., during an interview with the Assistant Administrator she indicated if an appointment was re-scheduled it would reflect in the nurses notes. She indicated the facility did admit residents who would need gurney assisted transportation. She indicated if the resident needed to be transferred by gurney, the facility would call 24 hours in advance to schedule transportation or to make changes. During review of the progress notes in the medical record, the record lacked evidence of the appointment scheduled for 10/24/24 transportation arrangement. On 11/13/24 at 1:44 p.m., during a phone interview with the Administrator she indicated Resident C had an appointment on 10/22/24. The resident was unable to tolerate sitting up in a wheelchair long enough to be transported to the appointment. She indicated she was not aware if an appointment scheduled for 10/24 had been arranged for gurney transportation. On 11/13/2024 at 2:40 p.m., the Assistant Administrator provided a document, titled, Transportation Policy, dated 7/15/24, and indicated it was the policy currently being used by the facility. The policy indicated, .The facility shall assist residents with arranging transportation for appointments .Policy: 1. The facility in arranging transportation to/from outside care appointments This citation relates to Complaint IN00446006. 3.1-49(j)(3)