

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 03/05/2025
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 - Minimal harm or potential for actual harm</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>38847</p> <p>Based on record review and interview, the facility failed to protect the resident's right to be free from verbal abuse when a resident was called a derogatory name by a staff member for 1 of 6 residents reviewed for abuse (Resident E). The deficient practice was corrected on 12/28/24, prior to the start of the survey, and was therefore past noncompliance.</p> <p>Findings include:</p> <p>An Indiana Department of Health (IDOH) Incident Report was dated 12/27/24 at 4:33 a.m. The report indicated the staff called the Administrator and alleged verbal abuse by contract staff Licensed Practical Nurse (LPN) 4 towards Resident E. LPN 4 and Resident E exchanged inappropriate remarks. Immediate actions included resident separated from LPN 4 and taken to her room with another staff member, another staff nurse notified, Administrator notified, Administrator suspended LPN 4 via phone, LPN 4 left the facility without incident, the resident's physician, responsible party, and Director of Nursing (DON) were notified.</p> <p>The facility's incident investigation file included the following witness statements.</p> <p>A witness statement from Certified Nursing Aide (CNA) 6, dated 12/27/24, indicated, [Resident E] was having a bad night with behaviors. [Resident E] kept going up and down hall and getting people upset. Agency nurse stated she was not staff and not dealing with [Resident E]. People were asking for meds [medications] and asking nurse for things. Then [Resident E] came to nurse's station and nurse said, 'I will handle this I am the nurse.' [Resident E] called the nurse a b---- and the nurse called [Resident E] a b----. Then the nurse antagonized [Resident E] by saying, 'I am a good n----- b----.' This only upset [Resident E] more. One aide was also present and heard it as well, both aides were shocked</p> <p>A witness statement from CNA 7, dated 12/27/24, indicated, For the past 2 days [Resident E] who has mental health issues has had behaviors. [CNA 7] and [CNA 6] were at nurse's station charting. [Resident E] and [LPN 4] approached nurse's station. [Resident E] called nurse a b----. The nurse immediately called [Resident E] a b----. This ramped up [Resident 4] more. The nurse said, 'Keep it going.' Then she said, 'Call me a n----- b----'</p> <p>A witness statement from LPN 8, dated 12/27/24, indicated, [CNA 7] and [CNA 6] came to report verbal abuse by agency nurse to [Resident E]</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 155426
		If continuation sheet Page 1 of 5

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A witness statement from Resident E, dated 12/27/25, indicated, [Resident E] asked for thyroid medication. The nurse told her to get out of the way. [Resident E] asked for a cigarette. The nurse got mad. [Resident E] denies yelling, cussing, or causing any problems. She feels she was unfairly picked on</p> <p>Resident E's record was reviewed on 3/5/25 at 10:44 a.m. Diagnoses on the resident's profile included, but were not limited to, schizoaffective disorder bipolar type (symptoms of schizophrenia and bipolar disorder), bipolar disorder (chronic mental health condition with extreme mood swings), unspecified dementia, and anxiety disorder.</p> <p>A care plan, initiated on 11/16/22, indicated the resident had behaviors including, but not limited to, screaming at others, cursing at others, and making repetitive statements to others causing negative responses. Interventions included, but were not limited to, observe for triggers of inappropriate behaviors and alter environment as needed, avoid over stimulation, and maintain a calm environment and approach to the resident.</p> <p>A Progress Note, dated 12/27/24, indicated the resident and an agency nurse exchanged inappropriate comments that morning.</p> <p>A quarterly Minimum Data Set (MDS) Assessment, dated 2/6/25, indicated the resident had a moderate cognitive impairment.</p> <p>During an interview, on 3/4/25 at 11:54 a.m., the Assistant Administrator indicated LPN 4 was an agency nurse, and she was not allowed to work in the facility anymore.</p> <p>During an interview, on 3/4/25 at 12:21 p.m., Resident E indicated she remembered the incident on 12/27/24, but she did not want to talk about it.</p> <p>During an interview, on 3/4/25 at 12:25 p.m., CNA 6 indicated she witnessed the incident between LPN 4 and Resident E on 12/27/24. Resident E was having behaviors, which was not unusual for her. CNA 6 tried to explain this to LPN 4, but LPN 4 told CNA 6 she was not going to deal with it because she was not actually staff at the facility. LPN 4 told CNA 6 to go tell someone who was actually facility staff. CNA 6 notified LPN 8 that Resident E was having behaviors. Later, Resident E became increasingly aggressive and called LPN 4 a b----. LPN 4 looked at Resident E and said, You're a b----. CNA 6 reported it to LPN 8.</p> <p>During an interview, on 3/4/25 at 3:00 p.m., the Clinical Support Nurse indicated Resident E's safety was ensured, LPN 4 was immediately removed from the building, and she was not allowed to work at the facility again.</p> <p>During an interview, on 3/5/25 at 10:14 a.m., LPN 8 indicated she was working on a unit near LPN 4's unit on 12/27/25. Resident E was having behaviors, and LPN 8 had contacted the Administrator and DON. The aides were keeping her informed on what was going on with the resident. Around 4:00 a.m., LPN 8 was passing medications on her unit when two CNAs came to her and told her LPN 4 called Resident E a b----. LPN 8 sent a staff member to stay with the resident, and they reported the incident to the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 3/5/25 at 12:48 p.m., CNA 7 indicated she witnessed the incident on 12/27/24. Resident E was having behaviors, and this was not unusual for her. LPN 4 was an agency nurse. Sometimes the resident would go back and forth talking with the staff. Resident E called LPN 4 a b---- and LPN 4 called Resident E a b---- in return. LPN 4 antagonized Resident E and told Resident E to say other inappropriate things. LPN 4 told Resident E to call her a n----- b----. They ensured Resident E's safety and reported the incident.</p> <p>On 3/4/25 at 12:10 p.m., the Assistant Administrator provided a document titled, Abuse, Neglect and Misappropriation of Property, last reviewed 1/31/25, and indicated it was the policy currently being used by the facility. The policy indicated, .It is the organization's intention to prevent occurrences of abuse .Verbal abuse is the use of any oral, written or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability</p> <p>The deficient practice was corrected by 12/28/24 after the facility implemented a systemic plan that included the following actions: immediate assurance of the resident's safety, reporting the incident to the Administrator, removal of the nurse from the facility and not allowing her to return, abuse investigation completed, staff members educated on the facility's abuse policy, and a Quality Assurance and Performance Improvement (QAPI) plan implemented with the completion of an audit tool for ongoing scaled monitoring.</p> <p>This citation relates to complaints IN00454858 and IN00454449.</p> <p>3.1-27(b)</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>38847</p> <p>Based on record review and interview, the facility failed to ensure an incident of verbal abuse from a nurse to a resident was reported to the Indiana Department of Health (IDOH) accurately for 1 of 6 residents reviewed for abuse (Resident E).</p> <p>Findings include:</p> <p>An Indiana Department of Health (IDOH) Incident Report was dated 12/27/24 at 4:33 a.m. The report indicated the staff called the Administrator and alleged verbal abuse by contract staff Licensed Practical Nurse (LPN) 4 towards Resident E. LPN 4 and Resident E exchanged inappropriate remarks. Immediate actions included resident separated from LPN 4 and taken to her room with another staff member, another staff nurse notified, Administrator notified, Administrator suspended LPN 4 via phone, LPN 4 left the facility without incident, the resident's physician, responsible party, and Director of Nursing (DON) were notified. The follow-up, dated 1/2/25, indicated upon investigation the abuse allegation was unsubstantiated.</p> <p>The facility's incident investigation file included the following witness statements.</p> <p>A witness statement from CNA 7, dated 12/27/24, indicated, For the past 2 days [Resident E] who has mental health issues has had behaviors. [CNA 7] and [CNA 6] were at nurse's station charting. [Resident E] and [LPN 4] approached nurse's station. [Resident E] called nurse a b----. The nurse immediately called [Resident E] a b----. This ramped up [Resident 4] more. The nurse said, 'Keep it going.' Then she said, 'Call me a n----- b----'</p> <p>A witness statement from LPN 8, dated 12/27/24, indicated, .[CNA 7] and [CNA 6] came to report verbal abuse by agency nurse to [Resident E]</p> <p>A witness statement from Resident E, dated 12/27/25, indicated, [Resident E] asked for thyroid medication. The nurse told her to get out of the way. [Resident E] asked for a cigarette. The nurse got mad .[Resident E] denies yelling, cussing, or causing any problems. She feels she was unfairly picked on</p> <p>An investigation summary, dated 12/27/24, indicated the resident was at the nurse's station having behaviors, and the staff attempted to de-escalate the situation. The resident called the agency nurse a b---- and the agency nurse called the resident a b----. The Administrator was notified, the nurse was suspended, and an investigation was initiated. Staff interviews confirmed the agency nurse used foul language towards the resident. The allegation of verbal abuse was substantiated, and the incident was reported to IDOH.</p> <p>Resident E's record was reviewed on 3/5/25 at 10:44 a.m. Diagnoses on the resident's profile included, but were not limited to, schizoaffective disorder bipolar type (symptoms of schizophrenia and bipolar disorder), bipolar disorder (chronic mental health condition with extreme mood swings), unspecified dementia, and anxiety disorder.</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 Progress Note, dated 12/27/24, indicated the resident and an agency nurse exchanged inappropriate comments that morning.</p> <p>During an interview, on 3/4/25 at 11:54 a.m., the Assistant Administrator indicated she had not completed the verbal abuse investigation so she was not sure why the final report said the allegation was unsubstantiated.</p> <p>During an interview, on 3/4/25 at 3:00 p.m., the Clinical Support Nurse indicated the verbal abuse allegation was substantiated upon completion of the investigation, but there was an error made when the final report was submitted.</p> <p>On 3/4/25 at 12:10 p.m., the Assistant Administrator provided a document titled, Abuse, Neglect, and Misappropriation of Property, last revised 1/31/25, and indicated it was the policy currently being used by the facility. The policy indicated, .It is the organization's intention to prevent the occurrence of abuse .and to assure that all alleged violations of federal or State laws which involve abuse .are investigated, and reported immediately to the Facility Adminsitrator, State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law</p> <p>This citation relates to complaints IN00454858 and IN00454449.</p> <p>3.1-28(c)</p>