STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Terre Haute	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on interview, and record review, the facility failed to timely report an allegation of suspected resident-to-resident abuse for 1 of 7 residents reviewed for resident abuse (Resident F). Findings include: A facility reportable incident (FRI), dated [DATE] at 11:51 a.m., indicated Resident F was attempting to ambulate in her room in the memory care and fell . Resident F complained of right shoulder and bilateral lower extremities pain. The resident was transported by ambulance to the emergency room (ER) where she was diagnosed with a non-displaced acute distal right clavicle fracture, diffuse osteopenia, and a subdural hematoma with mild midline shift. A confidential concern during the survey indicated that local police responded to a nearby hospital to speak with Resident F who was being treated for injuries that occurred at the nursing home. The resident died on [DATE]. There was concern that the deceased resident had been beaten by another resident. A concern from a local hospital employee, dated [DATE], indicated Resident F had been brought into the ER for an unwitnessed fall via emergency medical services (EMS). She had been admitted to the hospital for injuries and uncontrolled pain associated with this event. A physician's note indicated that the resident presented to the hospital with a suspected unwitnessed fall and was taking Eliquis (a blood thinner). The Hospitalist Nurse Practitioner (NP) talked with the resident who maintained that a nurse at the nursing home twisted her arm behind her back, causing her to fall. The resident reiterated the recollection of events multiple times. The NP noted the resident had a clavicle fracture, brain bleed (subdural hematoma), scattered bruises, and skin tears from the event. Resident F's family made the decision not to have the resident return to the facility. A confidential interview during the survey process indicated, on [DATE], CNA 8 had reported having seen Resident J walk out of Resident F's room holding her arm, with fresh scratches on her arm. When police arrived at the facility on [DATE], QMA 5 indicated, staff thought there had been a resident-to-resident altercation between Residents F and J, causing Resident F to fall. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:03 p.m. Certified Nursing Assistant (CNA) 7 indicated, on the night of [DATE] she had been at the nurse's station and had seen Resident J walking around/pacing. Five minutes later CNA 8 had jumped up and said she had heard Resident F say ouch. As both CNAs walked into Resident F's room, Resident J walked out. Resident F was observed sitting on the floor in the doorway of the bathroom next to a footboard of a bed. During an interview on [DATE] at 11:26 a.m., the Nurse Consultant indicated, on [DATE], staff had been doing rounds and Resident J was pacing, they were on opposite ends of the hallway. The CNAs had their eyes off Resident J for approximately 3 minutes while they changed another resident. The CNAs then sat down to chart at the nurse's station and heard someone say ouch. Resident J was witnessed exiting Resident F's room, who was witnessed on the floor in her room. The CNAs denied hearing any indication of a fall. During an interview on [DATE] at 2:10 p.m., CNA 8 indicated, on [DATE], she had been doing bed checks with CNA 7, when she heard Resident F say ouch. She observed Resident J exit Resident F's room frowning and holding her right arm, and Resident F was observed sitting on the floor in front of the bathroom door. Resident J was to be watched, and staff were to keep eyes on her, but the CNAs had been providing care in another resident room for about 1 minute and then went to the nurse's station to chart. During an interview on [DATE] at 3:10 p.m., LPN 6 indicated, on [DATE], she had been summoned to the 900 hallways by QMA 5 who reported a fall. LPN 6 had observed Resident F on the floor in the doorway to the hallway, sitting on her buttocks with her legs outstretched, which was within ,d+[DATE] feet of the bathroom. Resident F had skin tears on both lower shins, her leg looked abnormal, she had skin tears and scratches on the right forearm, there was slight penny sized bleeding on the floor, and she complained of pain in her right shoulder, so they did not move it. 911 was called and Resident F was transported to the hospital for evaluation and treatment. CNA 7 indicated she had seen Resident J come out of Resident F's room. Resident J had been assessed and found with purple/blue bruising and fresh scratches with blood on the forearm. When asked what had happened, Resident F indicated her and pointed to Resident J. The Administrator (ADM) was notified, and she told LPN 6 to put Resident J on 15-minute checks. LPN 6 instructed the CNAs to keep an eye on Resident J and assure she was not wandering in other residents' rooms. LPN 6 indicated in the past Resident J had been monitored related to wandering, taking down other residents' stop signs, and hitting at staff, but she thought that might have ended. During an interview on [DATE] at 7:48 a.m., QMA 5 indicated, on [DATE], she had given Resident F her evening medications on [DATE] between 7:30 p.m.and 8:00 p.m. and had not seen the resident after she was helped to bed by the CNAs. QMA 5 had been sitting on a couch charting, where she did not have a view of Residents F and J's rooms. CNA 7 had come and told her someone was on the floor, and she went and found LPN 6 before going to Resident F's room. Upon entering Resident F's room, the resident was observed on the floor near the end of the roommate's bed, sitting up, facing the doorway. Resident J had been seen exiting Resident F's room. Resident J had a history of aggression, would smack, kick, etc. toward staff, and her behavior got worse at night. CNA 8 had heard Resident F say ouch, and being as her room was approximately 100 feet from the nurse's station it had to have been at a high volume. QMA 5 indicated she had not seen Resident J in bed asleep, but had seen the CNA's take her to her room, and they said she had been asleep. Staff did not see Resident J go into Resident F's room. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:19 a.m., CNA 7 indicated she had worked [DATE] from 6:00 p.m. to 6:00 a.m. and made resident rounds every 30 minutes to 1 hour. She had last checked Resident F about 15 minutes before she was found on the floor, and at the time the resident had been sitting in bed awake with the television (TV) off. CNA 7 indicated that she had then sat down at the nurse's station to chart. Resident J had been observed around 12:00 a.m. and 12:30 a.m., walking in the hallways. Resident J was known to wander, and did not sit or lay in bed for long. Resident J used to be a housekeeper and would wander in and out of other residents' rooms, made other residents' beds, would take their bedding to the laundry room, and would pick up cups. CNA 7 indicated Resident J was violent towards staff, was unpredictable going from pleasant to violent, and staff were still learning her behaviors. CNA 7 indicated recently upon redirection from getting into another resident's bed, Resident J tried to backhand her. On [DATE], she had seen Resident J come out of Resident F's room. Resident J seemed calm, walked to the nurse's station and sat down, and showed the CNA that she had scratches on her left arm. Resident J denied knowing what had happened to Resident F. CNA 7 indicated she had reported the backhand incident to the DON a few days before [DATE], and was told the facility would send the resident for psychiatric help. Staff initially thought Resident J might have been involved in Resident F's fall because she could be mean but later thought due to Resident J's calm demeanor at the time, she was most likely not involved. CNA 7 indicated she had not known Resident J had been put onto 15-minute checks prior to [DATE]. If a resident was on 15-minute checks, staff would document seeing the resident every 15 minutes. A confidential interview held during the survey process indicated Resident F's family had called the police in response to events that happened on [DATE]. A staff member heard a scream coming from Resident F's room where she was found on the floor injured, and Resident J was observed leaving Resident F's room while holding her own arm. At the hospital Resident F made statements about a staff member holding her arm behind her back causing the accident. The press had then found out about the incident and details had been aired in a local newspaper and on-line formats. A police detective had notified staff he and the Attorney General's office would be setting up times to interview staff. During an interview on [DATE] at 12:51 p.m. the Administrator (ADM) and Nurse Consultant indicated a family member had reported the fall and subsequent death of Resident F to the media. The family member had also posted videos of Resident F taken while she was in the hospital with details of how she fell , her injuries, and death on a major social platform. On [DATE] Resident F was sent to the ER for evaluation and treatment after a fall. The fall incident was State reported by the facility on [DATE] after a hospital report was obtained showing the resident had a broken clavicle and subdural hematoma. The Nurse Consultant indicated that an investigation was initiated on [DATE] after the family member had called and spoken to the Director of Nursing (DON). The family member indicated that she had called the police after being told by someone at the hospital that an EMT reported to them CNA 7 told the EMT's Resident J had potentially caused Resident F's fall. The Nurse Consultant indicated Resident F's fall had initially been a two-part investigation, resident to resident abuse, and fall with injury. After the DON had spoken with the family member on [DATE] around 8:00 a.m. to 9:00 a.m., the family member seemed to be on the same page of no abuse, so it was not reported. When interviewed, CNA 7 denied making that remark to the EMT of Resident J potentially causing the accident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:51 p.m. the Administrator (ADM) and Nurse Consultant indicated after Resident F left the faciity on [DATE] an investigation was initiated, Resident J was placed on one on one (1:1), interviews were conducted with staff, and a policeman came in response to the family member's call. A facility State Reportable Incident report was sent on [DATE] in response to the fall with injury. Staff found a smear of blood on the foot board of the roommate's bed and 2 small drops of blood on the floor at the end of the bed to indicate where the resident had fallen, and the policeman had requested to view the crime scene. The Interdisciplinary team (IDT), Quality Assurance (QA), Quality Assurance and Performance Improvement (QAPI) teams all met to discuss Resident F's fall, and did not believe the incident was a resident-to-resident altercation. A facility decision was made at that time to not report resident-to-resident abuse. The Nurse Consultant indicated, if they had thought the fall was related to an altercation, they would have reported the incident within 2 hours, but this was not the situation. During an interview on [DATE] at 12:51 p.m. the Nurse Consultant indicated a family member had called the DON on [DATE] around 8:00 a.m. to 9:00 a.m. and indicated she had called the police in response to hearing in the ER of a potential resident to resident interaction, and Resident F kept saying someone had pulled on her arm causing her to fall. The family member had also thought the gash on the front of Resident F's left shin happened during the altercation. A policeman had come into the facility on [DATE] around 9:30 a.m., looked at the scene, and left. The situation had not been State reported as abuse after the family member called, but it was state reported on [DATE] in reaction to the fall with injury. The Nurse Consultant indicated the facility was unable to get a response in calls to the EMTs, had not attempted to speak with anyone at the hospital, and had not attempted to speak with the family member after the resident had discharged to the hospital. The Nurse Consultant indicated that the incident had not been reported as abuse due to the family member having seemed to be on the same page of the incident being an accident by the end of the phone conversation with the DON on [DATE]. A detective was now interviewing night staff that were present on [DATE], he had asked for the facility attorney information to speak with legal counsel (who had asked for the facility soft file), as it was the process. The Nurse Consultant indicated the police were following up the situation as a whole; circumstances related to the fall incident, Resident F's hospitalization , and Resident F's death at the hospital. The Nurse Consultant indicated at no time had the police indicated they thought the situation was abuse or a suspicious death. The Nurse Consultant and the ADM indicated at no time since the police, a detective, the family, hospital, EMT's, and media were involved, had any further investigation been completed as the facility felt a thorough investigation had already been completed. On [DATE] at 12:10 a.m., the Nurse Consultant provided a local newspaper article, dated [DATE]. The article indicated, A death investigation is underway involving a resident at a [name of city] long-term rehabilitation facility, authorities have confirmed On [DATE] at 12:10 a.m., the Nurse Consultant provided a local television station newscast and on-line blog, dated [DATE], indicated, A death investigation is underway in [name of city]. On [DATE], the [name of city] police department responded to [a local hospital] to speak with a patient who was being treated for injuries believed to have occurred at a local long term rehabilitation facility. While the investigation was underway, the victim passed away (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation from the skilled nursing home Resident J had transferred from on [DATE], indicated Resident J had initiated 2 prior resident-to-resident altercations by hitting other residents in the 4 months prior to admission to the current skilled nursing home, the most recent incident had occurred on [DATE]. A progress note, dated [DATE] at 12:16 a.m., indicated Resident J had been admitted on the day shift of [DATE]. On the evening shift the resident had been exit seeking and walked fast in the halls. The resident attempted to exit with someone else's family member, but staff assisted, and Resident J was returned from outside the door area to the hall. The resident came back willingly but at times when staff talked to the resident, she got verbally aggressive and called staff curse words. Resident J spit at staff and attempted to throw things at them several times. She targeted resident rooms with stop signs on them and ripped the signs down and threw them on the floor. This behavior caused an issue with another resident (Resident F). Resident J was verbally aggressive toward others, and the administration was notified of the resident to be on 15-minute checks. Staff were educated that 1 staff member was to be up alternating to have eyes on Resident J to detour her from other residents' rooms to decrease resident to resident risk of incident. An event entered into the electronic medical record (EMR) by Licensed Practical Nurse (LPN) 6, on [DATE] at 3:40 a.m., indicated Resident J had new or worsening behaviors including wandering into other residents' rooms, not able to sleep, and hitting staff at times. LPN 6 indicated the resident wandered frequently and aimlessly, and at times when redirected she hit at staff. Psychiatric services had seen the resident. Interventions to alleviate behaviors included 15-minute checks, and a SBAR (situation, background, assessment and recommendation) had been sent to the physician requesting an order for psychiatric medication and medication to help the resident sleep. An Abuse, Neglect and Misappropriation of Property policy, dated [DATE], indicated, Allegation of Abuse. This means a report, complaint, grievance, statement, incident, or other facts that a reasonable person would understand to mean that abuse, as defined in this policy, is occurring, has occurred, or plausibly might have occurred .All alleged violations involving abuse, neglect .are reported immediately, but no later than 2 hours after the allegation is made . Cross reference tag F744. This citation relates to Complaint IN00458972. 3XXX,d+[DATE](a)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on observation, interview, and record review, the facility failed to ensure resident specific interventions were implemented for a dementia resident who was known to have behaviors upon admitting to the facility and intrusive wandering for 1 of 6 residents reviewed for dementia care (Resident J). This deficient practice resulted in harm when Resident J wandered into Resident F's room unsupervised and then exited with three circular bruises on the right lower arm and scratches with fresh blood on them. Resident F was found on the ground of her room with skin tears, and was diagnosed at the hospital with a non-displaced acute distal right clavicle fracture, and a subdural hematoma with mild midline shift. Findings include: A confidential interview during the survey indicated that local police responded to a nearby hospital to speak with Resident F who was being treated for injuries that occurred at the nursing home. The resident died on [DATE]. There was concern that the deceased resident had been beaten by Resident J. Resident J's record was reviewed on [DATE] at 2:30 p.m. Diagnoses on Resident J's profile included, early onset Alzheimer's disease (a progressive disease that destroys memory and other mental functions), and anxiety disorder (stress that was out of proportion to the impact of the event, inability to set aside a worry, and restlessness). On [DATE] at 9:35 a.m., Resident J was observed in an activity/dining room on the secured memory care unit, at a table with a peer, and their seating was spaced apart. The resident was calm and looking around. On [DATE] at 9:35 a.m., an observation of the secured memory care unit with the Nurse Consultant was completed. Resident J's room was at the end of a hallway near the outside exit doors, four resident rooms down from the nurse's desk. Resident F's room was observed to be directly next door on the same side of the hallway. The nurse's desk was located in the middle where the 3 separate hallways intersected on the 900 hallway. The Nurse Consultant indicated that a couch had previously been in an alcove in front of the nurse's desk on the hallway leading towards the exit into the main part of the facility, where QMA 5 who was in charge of the 900 hallways on [DATE] had been sitting while she charted and would not have been able to view Residents J and F's rooms at the end of the hallway. During a continuous observation of the 900 hallways, on [DATE] from 11:05 a.m. to 11:25 a.m., Resident J was observed walking swiftly towards the exit door upon entry of a visitor to the unit. The resident was observed to turn and follow the visitor to the nurse's desk, where she watched but did not engage the four unidentified staff members standing and sitting around the desk. At 11:17 a.m., Resident J was persuaded to enter the dining/activity room and sit at the end of a long table where peers were sitting during an activity, the resident actively watched activity around her, but maintained a flat affect and did not engage with those around her. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Review of documentation from the skilled nursing home Resident J had transferred from on [DATE], indicated Resident J had initiated two prior resident-to-resident altercations by hitting other residents in the four months prior to admission to the current skilled nursing home. The most recent incident occurred on [DATE]. Physician's orders dated [DATE], included: a. Admit to a gated community due to Alzheimer's dementia. b. Resident may see psychiatrist as needed. The resident record lacked a physician's order to monitor target behaviors of wandering, cursing, yelling, until [DATE]. A progress note, dated [DATE] at 12:16 a.m., indicated Resident J had been admitted on the day shift of [DATE]. On the evening shift the resident had been exit seeking and walked fast in the halls. The resident attempted to exit with someone else's family member, but staff assisted, and Resident J was returned from outside the door area to the hall. The resident came back willingly but at times when staff talked to the resident, she got verbally aggressive and called staff curse words. Resident J spit at staff and attempted to throw things at them several times. She targeted resident rooms with stop signs on them and ripped the signs down and threw them on the floor. This behavior caused an issue with another resident (Resident F). Resident J was verbally aggressive toward others, and the administration was notified of the resident to be on 15-minute checks. Staff were educated that one staff member was to be up alternating to have eyes on Resident J to detour her from other residents' rooms and to decrease the risk of resident to resident incident. A 48-Hour Baseline Care Plan, dated [DATE], indicated a history of impaired daily decision making, dementia, Alzheimer's disease, short or long-term memory loss were not triggered. Interventions related to Alzheimer's or dementia were not added to the baseline care plan. A care plan for Resident J, dated [DATE], indicated the resident was placed in the locked unit as a least restrictive approach to protect the resident and assure her health and safety. Approaches included encouraging the family to place familiar objects, and pictures in the resident room for cueing, encouraging the resident to participate in activities, and to provide access and visitation by family, resident representative, and/or other individuals. Staff were to be alert to psychosocial needs and conduct ongoing periodic review for the continued need for placement on the unit. The care plan lacked documentation of individualized interventions for Resident J and did not mention the history of altercations with staff or another resident. A care plan for Resident J, dated [DATE], indicated the resident was at risk for injury or adverse outcomes related to wandering behaviors. Approaches included encouraging the resident's representative / family to visit as needed, encourage the resident to participate in activities of interest / choice, observe the resident's wandering patterns and escort her away from other residents or other resident rooms as needed, and observe for signs of increasing fatigue and offer rest periods. The care plan lacked documentation of individualized interventions for Resident J and did not mention the history of altercations with staff or another resident. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	The resident record lacked documentation of the care plans having been updated with behaviors to include exit seeking, physical and verbally combative behaviors, or the resident having been placed on 15-minute checks An admission MDS assessment, completed on [DATE], assessed Resident J as usually having the ability to make herself understood and to usually understand others. A BIMS score ,d+[DATE] indicated moderately impaired cognition. The resident had no signs or symptoms of delirium, behaviors, or rejection of care, but did displayed wandering behaviors daily. The resident was independent with bed mobility and required supervision with transfers and ambulation. The resident had no skin conditions to include pressure wounds, skin tears, or bruises. The MDS lacked documentation of behaviors. An event entered into the electronic medical record (EMR) by Licensed Practical Nurse (LPN) 6, on [DATE] at 3:40 a.m., indicated Resident J had new or worsening behaviors including wandering into other residents' rooms, not able to sleep, and hitting staff at times. LPN 6 indicated the resident wandered frequently and aimlessly, and at times when redirected she hit at staff. Psychiatric services had seen the resident. Interventions to alleviate behaviors included 15-minute checks, and a SBAR (situation, background, assessment and recommendation) had been sent to the physician requesting an order for psychiatric medication and medication to help the resident sleep. An event entered by LPN 6 on [DATE] at 4:19 a.m., indicated the resident had 3 circular dark purple bruises on the right arm, each measuring 1-centimeter (cm) by (x) 1 cm x 0 cm with scratches. At the time of the bruises occurrence the resident was wandering into another resident's (Resident F's) room. A possible contributing factor was combative/resistive behavior. A progress note, dated [DATE] at 4:13 a.m., indicated Resident J was observed leaving Resident F's room. Resident J had new bruises, three approximate 1 cm x 1 cm circular bruises on the right lower arm, and scratches as well that had fresh blood on them. Administration was notified, and the resident was placed on 15-minute checks. A progress note, dated [DATE] at 2:25 p.m., indicated Resident J was sent by ambulance to an in-house Geri-psychiatric (Geri-psych) hospital for admission. A progress note, dated [DATE] at 5:36 p.m., indicated Resident J returned from Geri-psych for readmission to the facility. A progress note, dated [DATE] at 4:45 p.m., indicated Resident J was seen by a visiting psychiatric group for a routine psychiatric follow up with no new concerns or orders. On [DATE] at 1:15 p.m., the Nurse Consultant indicated psychiatric services had seen Resident J in the facility on [DATE] for an initial visit, the facility had not yet received documentation of the visit. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	A confidential interview during the survey process indicated Resident F's family member had come through the locked memory care unit doors for a visit, and when she would not let Resident J out, Resident J became violent with her and staff had to intervene. Resident F's family member had reported Resident J having been found in Resident F's room at least 6 different times prior to the incident on [DATE]. On [DATE], CNA 8 had reported having seen Resident J walk out of Resident F's room holding her arm, with fresh scratches on her arm. When police arrived at the facility on [DATE], QMA 5 indicated staff thought there had been a resident to resident altercation between Residents F and J, causing Resident F to fall. During an interview on [DATE] at 2:03 p.m. Certified Nursing Assistant (CNA) 7 indicated, on the night of [DATE] she had been at the nurse's station and had seen Resident J walking around/pacing. Five minutes later CNA 8 had jumped up and said she had heard Resident F say ouch. As both CNAs walked into Resident F's room, Resident J walked out. Resident F was observed sitting on the floor in the doorway of the bathroom next to a footboard of a bed. During an interview on [DATE] at 11:26 a.m., the Nurse Consultant indicated, on [DATE] staff had been doing rounds and Resident J was pacing, they were on opposite ends of the hallway. The CNAs had their eyes off Resident J for approximately 3 minutes while they changed another resident. The CNAs then sat down to chart at the nurse's station and heard someone say ouch. Resident J was witnessed exiting Resident F's room, who was witnessed on the floor in her room. The CNAs denied hearing any indication of a fall. During an interview on [DATE] at 2:10 p.m., CNA 8 indicated, on [DATE], she had been doing bed checks with CNA 7, when she heard Resident F say ouch. She observed Resident J exit Resident F's room frowning and holding her right arm, and Resident F was observed sitting on the floor in front of the bathroom door. Resident J was to be watched and staff were to keep eyes on her, but the CNAs had been providing care in another resident room for about 1 minute and then went to the nurse's station to chart. During an interview on [DATE] at 12:51 p.m. the Administrator (ADM) and Nurse Consultant indicated after Resident F left the faciity on [DATE] an investigation was initiated, Resident J was placed on one on one (1:1), interviews were conducted with staff, and a policeman came in response to the family member's call. A facility State Reportable Incident report was sent on [DATE] in response to the fall with injury for Resident F. Resident J had been on 1:1, and after the fall became aggressive, more than her routine pacing, and was sent to Geri-psych. Resident J had not been viewed by staff as being escalated the night of the incident, but after being put on 1:1 her behaviors escalated. On the night shift of the incident on [DATE], two staff CNAs had been caring for another resident at the end of the hallway, and QMA 5 was sitting at the nurse's desk. Staff thought they heard a help, saw Resident J leave Resident F's room, and staff entered the resident's room to find Resident F on the floor. The Nurse Consultant indicated staff found a smear of blood on the foot board of the roommate's bed and 2 small drops of blood on the floor at the end of the bed to indicate where Resident F had fallen, and the policeman had requested to view the crime scene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Terre Haute	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 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:10 p.m., LPN 6 indicated on [DATE] she had been working on the 700 and 800 hallways, and covering the 2 secured hallways, each of which had a Qualified Medication Aide (QMA). LPN 6 indicated she had been summoned to the 900 hallways by QMA 5 who reported a fall. LPN 6 had observed Resident F on the floor in the doorway to the hallway, sitting on her buttocks with her legs outstretched, which was within ,d+[DATE] feet of the bathroom. Resident F had skin tears on both lower shins, her leg looked abnormal, she had skin tears and scratches on the right forearm, there was slight penny sized bleeding on the floor, and she complained of pain in her right shoulder, so they did not move it. 911 was called and Resident F was transported to the hospital for evaluation and treatment. CNA 7 indicated, she had seen Resident J come out of Resident F's room. Resident J had been assessed and found with purple/blue bruising and fresh scratches with blood on the forearm. When asked what had happened Resident F indicated her and pointed to Resident J. The Administrator (ADM) was notified, and she told LPN 6 to put Resident J on 15-minute checks. LPN 6 instructed the CNAs to keep an eye on Resident J and assure she was not wandering in other residents' rooms. LPN 6 indicated, in the past Resident J had been monitored related to wandering, taking down other residents' stop signs, and hitting at staff, but she thought that might have ended. During an interview on [DATE] at 7:48 a.m., QMA 5 indicated, on [DATE], she had worked the night shift passing medications from 6:00 p.m. to 6:00 a.m. QMA 5 had given Resident F her evening medications on [DATE] at 7:30 p.m. and had not seen the resident after she was helped to bed by the CNAs. QMA 5 had been sitting on a couch charting, where she did not have a view of Residents F and J's rooms. CNA 7 had come and told her someone was on the floor, and she went and found LPN 6 before going to Resident F's room. Upon entering Resident F's room, the resident was observed on the floor near the end of the roommate's bed, sitting up, facing the doorway. Resident J had been seen exiting Resident F's room. Resident J had a history of aggression, would smack, kick, etc. toward staff, and her behavior got worse at night. QMA 5 indicated staff had been made aware that Resident J could be violent to staff with care, redirection, and did not like to be told what to do. QMA 5 indicated the Director of Nursing was aware of Resident J's behaviors, but to her knowledge she was not aware of Resident J having been placed on 1:1 monitoring related to her known behaviors. Resident J was known to enter other residents' rooms and take their stuff, and she frequently wandered into all other residents' rooms on the unit. QMA 5 indicated the CNAs had been able to see all 3 of the 900 hallways from the nurse's station. CNA 8 had heard Resident F say ouch, and being as her room was approximately 100 feet from the nurse's station it had to have been at a high volume. QMA 5 indicated she had not seen Resident J in bed asleep, but had seen the CNA's take her to her room, and they said she had been asleep. Staff did not see Resident J go into Resident F's room. (continued on next page)

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	155426	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 8:19 a.m., CNA 7 indicated, she had worked [DATE] from 6:00 p.m. to 6:00 a.m. and made resident rounds every 30 minutes to 1 hour. Resident J had been observed around 12:00 a. m. and 12:30 a.m., walking in the hallways. Resident J was known to wander, and did not sit or lay in bed for long. Resident J used to be a housekeeper and would wander in and out of other residents' rooms, made other residents' beds, would take their bedding to the laundry room, and would pick up cups. CNA 7 indicated Resident J was violent towards staff, was unpredictable going from pleasant to violent, and staff were still learning her behaviors. CNA 7 indicated recently upon redirection from getting into another resident's bed, Resident J tried to backhand her. On [DATE], she saw Resident J come out of Resident F's room. Resident J seemed calm, walked to the nurse's station and sat down, and showed the CNA that she had scratches on her left arm. Resident J denied knowing what had happened to Resident F. CNA 7 indicated, her bosses knew Resident J was being violent towards staff, and staff had been told that if an incident was resident to staff, the staff were on their own. CNA 7 indicated she had reported the backhand incident to the DON a few days before [DATE], and was told the facility would send the resident for psychiatric help. Staff initially thought Resident J might have been involved in Resident F's fall because she could be mean but later thought due to Resident J's calm demeanor at the time, she was most likely not involved. CNA 7 indicated she had not known Resident J had been put onto 15-minute checks prior to [DATE]. If a resident was on 15-minute checks, staff would document seeing the resident every 15 minutes. Increased Monitoring - 15 minute check reports for Resident J, dated [DATE] - [DATE], were unavailable at the time of the survey exit. Handwritten copies of the reports were received via e-mail from the Nurse Consultant on [DATE] at 12:10 a.m. During the exit conference on [DATE] at 4:43 p.m., the Nurse Consultant indicated it was the right of all residents on the memory care unit to wander where they wanted, any time they wanted, and that included allowing Resident J to wander into other residents' rooms during the night on the unit. That was the purpose of a secured memory care wing. A behavior management policy was requested but not provided during the survey process. This citation relates to Complaint IN00458972. 3XXX,d+[DATE](a)