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	06/12/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility staff failed to administer scheduled doses of comfort medication per physician order without nursing assessment and physician notification for 1 of 8 resident reviewed for quality of care (Resident B). The deficient practice was corrected by 6/5/25 prior to the start of the survey and was therefore Past Noncompliance. Findings include: During a telephone interview on 6/12/25 at 3:20 p.m., Resident B's family member indicated the staff were not able to explain needs or symptoms that would be managed with the hospice ordered medications. They appeared confused about the administration of the medications and when they were to be given. The residents breathing would become rapid at times and he would begin to move his shoulders and grunt as if he were uncomfortable. When the medications were given, he seemed more comfortable and seemed to breath easier. One Qualified Medication aide (QMA) had entered the room and attempted to administer his medications, but indicated he was clenching his teeth and she was not able to administer the dose. She felt he looked calm and comfortable so she indicated she would skip it. We agreed only because we were relying on the staff to know what was best. It was very uncomfortable to watch him seem to struggle occasionally. The clinical record for Resident B was completed on 6/12/25 at 9:52 a.m. Diagnoses included dementia, chronic obstructive pulmonary disease, atrial fibrillation, heart disease and anxiety disorder. A nursing progress note, dated 5/19/25 at 7:13 p.m., indicated the resident had increased pain and agitation. The physician was notified for palliative treatment and changed the order for morphine (to treat pain and shortness of breath) from as needed to scheduled every four hours. A physician's order, dated 5/19/25, indicated to administer morphine concentrate 20 mg (milligram) per 1 ml (milliliter), 0.25 ml/5 mg, every four hours for pain and agitation. The medication was scheduled to be provided at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. QMA 2 failed to administer the ordered medication on the following dates and with explanations: a. On 5/20/25 at 12:00 p.m., the note indicated the resident had no pain and was sleeping. b. On 5/20/25 at 4:00 p.m., the note indicated the resident had no pain. c. On 5/21/25 at 4:00 p.m., the note indicated the resident was sleeping, had no pain, and had no agitation. (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
	155426	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 5/22/25 at 12:00 p.m., the note indicated the resident had no agitation or pain. e. On 5/27/25 at 12:00 p.m., the note indicated the resident was sleeping. During an interview on 6/12/25 at 4:08 p.m., QMA 2 indicated Resident B's family was present when she came into the room to administer his morphine. She observed he was not in any distress and decided to hold the medication. She asked the family if they needed anything and if he seemed comfortable then left the room. She felt there was no issue and he did not need that dose. She held the scheduled medication because she observed no grimacing or signs and symptoms of pain. She indicated if the medication had been for high blood pressure or something like that, she would have administered the medication even without outward signs of need. QMA 4 failed to administer the ordered medication on the following dates with explanations: a. On 5/26/25 at 12:00 a.m., the note indicated unable to arouse resident. b. On 5/26/25 at 4:00 a.m., the note indicated unable to arouse resident. During an interview on 6/12/25 at 4:31 p.m., QMA 4 indicated she had put the dropper into the resident's mouth, and he clenched his teeth tightly making it difficult to administer. The family were at bedside and indicated they thought he may not have needed or wanted it at the time. QMA 4 indicated she held the dose. The clinical record lacked progress notes indicating completed assessments to hold the scheduled morphine or documentation of physician notification. During an interview on 6/12/25 at 4:34 p.m., the DON indicated QMA's and nurses should not skip doses of scheduled medications unless they contact the physician. A current facility policy, revised 1/31/25, titled, Physicians Orders, provided by the Nurse Consultant on 6/12/25 at 5:17 p.m., included the following: Policy Statement It is the standard of this facility that physician orders are followed Guideline: .2. Licensed Nurses and Medication Aides are expected to follow physician's orders. The deficient practice was corrected by 6/5/25 after the facility implemented a systemic plan that included re-education of nursing staff. On 6/12/25 at 4:28 p.m., the Nurse Consultant provided two documents of completed inservices. The In-Service Sign in Sheet, dated 5/30/25, indicated the training provided as assessments, notifying the physician for out of range vitals, documentation, fall prevention, and QMA scope of practice. The In-Service Sign in Sheet, dated 6/5/25, indicated the training provided as out of range vitals required physician be made aware and noted by nurse, and QMA's may not hold medications without nurse assessment and physician notification. QMA 2 and QMA 4 had signed each inservice record sheet. This citation relates to Complaint IN00460686. 3.1-48(c)(2)