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	05/21/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, and interview, a facility staff member failed to follow a resident's plan-of-care intervention requiring the use of a gait belt for transfers, which resulted in a resident fall with fracture that required a hospital visit and follow-up care for 1 of 3 residents reviewed for accidents (Resident C). The deficient practice was corrected by 5/11/26 after the facility implemented a systemic plan and was therefore Past Noncompliance. Findings include: During an interview on 5/20/26 at 1:09 p.m., Resident C indicated he fell during a transfer when CNA 2 snatched him up by the back of his pants, real quick. She did not use a gait belt as other staff had done. He lost his balance and fell to the floor, landing on his left side. He indicated he had no use of that arm afterward and was in pain. The resident's clinical record was reviewed on 5/20/26 at 11:25 a.m. Diagnoses included hemiparesis (neurological condition caused by brain damage that causes partial weakness or loss of strength on one side of the body) affecting left non-dominant side, need for assistance with personal care, and pain in left ankle and joints of left foot. An annual Minimum Data Set (MDS) assessment, dated 3/17/26, indicated Resident C was cognitively intact and required substantial/maximum assistance with toileting, dressing, transferring, and personal hygiene. He used a manual wheelchair for mobility and was frequently incontinent of bowel and bladder. A current health care plan, created on 2/28/26 and edited on 3/19/26, indicated Resident C was at risk for injury related to falls due to left eye blindness, left-side hemiplegia related to a stroke, left foot drop, weakness, incontinence, and a history of falls. An intervention, dated 3/31/26, indicated staff were to use a gait belt with all transfers. The clinical record lacked a valid progress note regarding the fall on 5/1/26. A late entry note, dated 5/2/26 at 6:17 a.m., indicated a progress note, dated 5/1/26 at 6:15 p.m., as invalid. A nursing progress note, dated 5/2/26 at 4:39 p.m., indicated Resident C was on fall follow-up and reported left shoulder pain rated at five of ten. Staff noted no swelling. They notified the medical provider, who gave an order for an X-ray of the left should and arm. A nursing progress note, dated 5/3/26 at 1:19 p.m., included that the resident's left shoulder Xray had showed an acute left distal clavicle fracture. The medical provider ordered staff to send Resident C to the emergency department at an acute care hospital for further evaluation. The resident left the facility at 1:57 p.m. An Interdisciplinary Team progress note, dated 5/4/26 at 9:17 a.m., included Resident C lost his balance while transferring to the restroom with staff. An intervention was added to the resident's care plan for the assistance of two staff while transferring to the restroom. During a telephone interview on 5/21/26 at 11:11 a.m., CNA 2 indicated she did not use a gait belt when transferring Resident C. She indicated she lifted him by placing one arm under his right arm and grabbing the back of his pants with her other hand. His knees buckled, and he fell to the floor. She acknowledged she was aware of care sheets but could not say whether Resident C's care sheet included the use of a gait belt. She had not reviewed it. She indicated she would need to complete re-education regarding proper transfers before returning to work. During an interview on 5/21/26 at 11:00 a.m., the Corporate Nurse Consultant indicated Resident C had an intervention to use a gait belt during transfers on his care plan and on the care guides that were updated daily. CNA 2 should have used a gait belt when transferring Resident C. CNA 2 was receiving re-education prior to returning to work. The facility (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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(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 - Actual harm Residents Affected - Few	re-educated staff and audited all care plans for accuracy following the fall. The facility had no specific gait belt or transfer policy but expected staff to follow each resident's care plan. A current facility policy, revised 1/31/25, titled, Falls, provided by the Corporate Nurse Consultant on 5/21/26 at 11:29 a.m., included the following: Policy Statement The intent of this policy is to ensure the facility provides an environment that is as free from accident hazards, as possible, over which the facility has control to prevent avoidable falls.Guideline:.2. A Comprehensive Care Plan will be implemented based on the resident's risk for falls with an individual goal and interventions specific to each resident to attempt to reduce the risk of avoidable falls, to the extent possible. This deficient practice was corrected by 5/11/26 prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included review of all resident care plans, staff education, and auditing of three resident transfers, two times per week for two weeks, then weekly, to ensure safety interventions are in place. All falls since the last clinical meeting will be reviewed during clinical meetings to ensure care plan interventions were in place at the time of the fall. The Quality Assurance and Performance Improvement (QAPI) meetings will be held weekly for four weeks to monitor audits and continued education. The deficient practice was corrected by 5/15/26 after the facility implemented a systemic plan and was therefore Past Noncompliance. This deficient practice was corrected on 5/11/26 before the survey, and therefore past noncompliant. The facility reviewed falls for current residents to ensure care plan interventions were in place; audited care guides for fall interventions, and re-educated staff including return demonstrations for safe transfers was completed. This citation relates to Intake 3016193. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)