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	01/28/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48226 Based on record review and interview, the facility failed to notify the physician of not administering medications as ordered for 2 of 5 Residents reviewed for unnecessary medications (Residents 76 and 74). Findings include: 1. On 1/23/25 at 10:00 a.m., the medical record of Resident 76 was reviewed. Diagnoses included but not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), dilated cardiomyopathy (disease of the heart muscle), heart failure (a condition in which your heart's main pumping chamber becomes stiff and unable to fill properly), hypertension (high blood pressure), anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), hyperlipidemia (high cholesterol), chronic pain, seasonal allergies, and urinary retention (a condition in which urine cannot empty from the bladder). A quarterly Minimum Data Set (MDS) assessment, dated 11/12/24, indicated the resident was mildly cognitively impaired and received psychotropic medications. The MDS indicated the resident required minimal assistance with daily care needs. A physician order, dated 8/11/24, indicated staff were to administer 1 tablet of Ativan (lorazepam) 0.5 mg (milligram) orally twice daily for diagnosis of schizophrenia. Review of the Electronic Medication Administration Record (EMAR) indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/11/24, indicated staff were to administer 1 tablet of Atorvastatin administer 20 mg orally once per day for diagnosis of hyperlipidemia. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 8/11/24, indicated staff were to administer 1 tablet of Buspirone 15 mg orally three times per day for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/11/24, indicated staff were to adminster 1 capsule of Tamsulosin 0.4 mg orally once a day for diagnosis of urinary retention. Review of the EMAR indicated the medication was not administered on 11/9/24, 11/10/24, and 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/11/24, indicated staff were to adminster 1 tablet of Tizanidine 2 mg three times a day for diagnosis of generalized pain. Review of the EMAR indicated the medication was not administered on 11/28/24, 12/26/24, and 12/27/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/16/24, indicated staff were to adminster 3 tablets of Depakote ER (divalproex) extended release 24-hour 500 mg orally for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/18/24, indicated staff were to adminster 1 tablet of Metoprolol succinate extended release 24-hour 50 mg orally twice daily for diagnosis of hypertension. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/28/24, indicated staff were to adminster 1 tablet of Melatonin 5 mg daily for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 8/29/24, indicated staff were to adminster 1 tablet of Senna 8.6 mg, orally twice daily for diagnosis of constipation. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 9/5/24, indicated staff were to adminster 1 capsule Cymbalta (duloxetine) delayed release 30 mg orally once a day for diagnosis of pain. Review of the EMAR indicated the medication was not administered on 1/6/25. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 10/16/24, indicated staff were to adminster 1 tablet Olanzapine 20 mg orally twice daily for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 12/1/24, 12/2/24, 12/4/24, 12/26/24, and 1/19/25. The record lacked documentation of physician notification or resident refusal of medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 11/19/24, indicated staff were to inject 1.5 milliliter (ml) of Invega Sustenna (paliperidone palmitate) 234 mg/1.5 ml into the intramuscular (in the muscle) for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 11/21/24 and 11/29/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 11/26/24, indicated staff were to adminster 2 ml of Risperdal Consta (risperidone microspheres) 12.5 mg/2 mL in Intramuscular once a day for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 11/26/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/1/24, 12/2/24, and 12/17/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 12/18/24, indicated staff were to adminster 1 spray of Fluticasone propionate spray suspension 50 mcg (micrograms) into each nostril twice daily for diagnosis of seasonal allergies. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A physician order, dated 12/21/24, indicated staff were to adminster 1 tablet of Perphenazine 8 mg orally three times daily for diagnosis of schizophrenia. Review of the EMAR indicated the medication was not administered on 12/26/24. The record lacked documentation of physician notification or resident refusal of medication. A care plan, dated 1/27/25, indicated the resident had health related complications. Interventions included but not limited to administer medication as ordered by physician. On 1/24/25 at 11:47 a.m., during an interview, the Signature Clinical Consultant (SCC) indicated, if a medication was not available to administer, the nurse should contact the physician each time. She indicated the nurse should check in the emergency drug kit (EDK) and if it is not available there, the nurse should notify the physician for an alternate medication or an alternate order. 34525 2. Resident 74's record was reviewed on 1/23/25 at 11:02 a.m. The profile indicated the resident's diagnoses included, but were not limited to, brief psychotic disorder (a short-term mental health condition that involves a sudden onset of psychotic symptoms such as delusions, hallucinations, or disorganized speech) and major depressive disorder (a mental health condition that causes persistent feelings of sadness, hopelessness, and a lack of interest in activities). An admission Minimum Data Set (MDS) assessment, dated 12/24/24, indicated the resident had no cognitive deficit and received routine antipsychotic medication (a class of drugs that treat symptoms of psychosis, such as hallucinations and delusions). A physician's order, dated 12/26/24, indicated to administer 1 tablet of 0.5 milligrams (mg) of risperidone (antipsychotic medication) two times a day. Review of the January 2025 Medication Administration Record (MAR) indicated the following: a. On 1/9/25 at 8:27 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 1/9/25 at 8:27 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. c. On 1/14/25 at 7:45 p.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. d. On 1/15/25 at 8:37 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. e. On 1/16/25 at 7:16 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. f. On 1/17/25 at 7:41 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. g. On 1/18/25 at 7:05 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. h. On 1/19/25 at 7:24 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. i. On 1/20/25 at 8:12 a.m., documentation on the MAR indicated the medication was not administered because the drug was unavailable. The MAR lacked documentation that the physician had been notified. The progress notes lacked documentation of any physician notification of the medications not being available. A late entry of a physician progress note, dated 1/20/25, the physician indicated he had been notified by the staff, at the time of his 1/20/25 visit, that the pharmacy had been out of stock of the risperidone, days prior to that visit. During an interview, on 1/23/25 at 11:53 a.m., the Director of Nursing (DON) indicated it was the expectation that a Situation, Background, Assessment, and Recommendation (SBAR) form be completed, and the physician be notified for the times when medications were not available to administer. 3.1-5(a)(3)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34525 Based on record review and interview, the facility failed to ensure the Notice of Transfer/Discharge forms were completed and provided to residents and/or their representatives for 4 of 4 residents reviewed for hospitalization (Residents 18, 165, 138, and 54). Findings include: 1. Resident 18's record was reviewed on [DATE] at 2:25 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a brain disorder that slowly damages memory and thinking skills, eventually leading to dementia). A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had no cognitive deficit and had exhibited behavioral symptoms directed towards others. A discharge, return anticipated MDS, dated [DATE], indicated the resident had been discharged to an inpatient psychiatric hospital. The census indicated that the resident had been hospitalized from [DATE] through [DATE]. A progress note, dated [DATE] at 10:46 a.m., indicated the resident had been diagnosed with a urinary tract infection (UTI) and had increased altered mental status (AMS-a change in mental function). The resident was placed on 1 on 1 observation. The physician was notified and ordered the resident be sent to the hospital for evaluation and treatment. The record lacked documentation of the Notice of Transfer/Discharge forms being completed and provided to the resident and/or her representative. During an interview, on [DATE] at 10:34 a.m., the Administrator (ADM) indicated no Notice of Transfer/Discharge forms had been found. The expectation was that the forms should be completed, and copies provided to the resident/representative, for all transfers. 2. Resident 165's closed record was reviewed on [DATE] at 11:27 a.m. The profile indicated the resident's diagnoses included, but were not limited to, complete traumatic amputation of left lower leg (the loss of a body part, usually a finger, toe, arm, or leg, that occurs as the result of an accident or injury). A discharge, return anticipated Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had been discharged to an acute care hospital. The census indicated that the resident had been sent out to the hospital on [DATE]. The resident had expired at the hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hospital transfer document, dated [DATE], indicated the resident had been sent out to the hospital, per physician order, for evaluation and treatment related to altered mental status (AMS-a change in mental function), hypoxia (a condition where there is a lack of oxygen in the body's tissues or in an environment), and edema (swelling caused by excess fluid in the body's tissues). The form lacked documentation of the Notice of Transfer/Discharge forms being completed and provided to the resident and/or her representative. The record lacked documentation of the Notice of Transfer/Discharge forms being completed and copies provided to the resident and/or her representative. During an interview, on [DATE] at 1:50 p.m., the State Signature Care Consultant (SCC) indicated they had been unable to find the Notice of Transfer/Discharge forms for the resident's transfer. The expectation was that the forms should be completed, and copies provided to the resident or representative for every hospital transfer. 35317 3. During an interview, on [DATE] at 3:01 p.m., Resident 138 indicated she had been transferred to the hospital several times in the last few months. Resident 138's record was reviewed on [DATE] at 10:13 a.m. The profile indicated the resident's diagnosis included, but were not limited to, encephalopathy (a medical condition that affects the brain's function), malignant neoplasm of upper lobe, right bronchus or lung (a cancerous tumor that has developed in the upper lobe of the right bronchus or lung tissue), and acute on chronic systolic heart failure a (a type of heart failure that occurs when the heart struggles to compensate for a decline in function that has developed over time). Resident 138's census information indicated she was transferred to the hospital on [DATE] and returned later that evening, was transferred on [DATE] and returned on [DATE], and was transferred on [DATE] and returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. A progress note, dated [DATE] at 5:58 p.m., indicated Resident 138 had returned to the facility from the hospital with no new orders . The record lacked documentation that the Notice of Transfer/Discharge form was completed for the resident's transfer to the hospital on [DATE]. A progress note, dated [DATE] at 7:23 a.m., indicated Resident 138 was transferred to the hospital per physician order. The record lacked documentation that the Notice of Transfer/Discharge form was completed for the resident's transfer to the hospital on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated [DATE] at 11:59 p.m., indicated Resident 138 was transferred to the hospital from the facility due to change of condition. The record lacked documentation that the Notice of Transfer/Discharge form was completed for the resident's transfer to the hospital on [DATE]. During an interview, on [DATE] at 10:28 a.m., the Administrator indicated she was unable to provide documentation that the Notice of Transfer/Discharge form was completed for Resident 138 for the months of December and January. She indicated the form should have been completed by the nurse anytime a resident is transferred out to the hospital. 4. During an interview, on [DATE] at 11:47 a.m., Resident 54 indicated he had been hospitalized recently in [DATE]. Resident 54's record was reviewed, on [DATE] at 1:26 p.m. The profile indicated the resident's diagnosis included, but were not limited to, acute and chronic respiratory failure with hypoxia (a condition where the lungs have difficulty exchanging oxygen and carbon dioxide with the blood, resulting in low oxygen levels in the body), type II diabetes mellitus with diabetic polyneuropathy (a complication of type II diabetes that occurs when multiple nerves in the body are damaged), and schizophrenia (a disorder that affects a person's ability to think, fell , and behave clearly). Resident 154's census information indicated she was transferred to the hospital on [DATE] and returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. A progress note, dated [DATE] at 4:00 a.m., indicated Resident 54 was transferred to the hospital from the facility due to a change of condition. The record lacked documentation that the Notice of Transfer/Discharge form was completed for the resident's transfer to the hospital on [DATE]. During an interview, on [DATE] at 3:29 p.m., the Signature Clinical Consultant indicated she was unable to provide documentation that the Notice of Transfer/Discharge form was completed for Resident 54 for [DATE], transfer to the hospital. She indicated they have identified a system failure, and they would need to implement a new process and re-educate staff on completing the form every time a transfer takes place. On[DATE] at 10:26 a.m., the Administrator provided a document with a revised date of [DATE], titled, Transfer/Discharge Notice, and indicated it was the policy currently being used by the facility. The policy indicated, .2 . the facility will notify resident/resident representative in writing of: The reason the facility has initiated the involuntary transfer/discharge to another legally responsible institutional or noninstitutional setting, The effective date of transfer or discharge. The address of the location to which the resident if being transferred or discharged 3XXX,d+[DATE](a)(6)(A)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34525 Based on record review and interview, the facility failed to ensure the Ombudsman (a person who serves as an advocate for patients and consumers) had been notified of resident transfers from the facility, in the month of [DATE], for 3 of 4 residents reviewed for hospitalization (Residents 18, 165, and 138). Findings include: 1. Resident 18's record was reviewed on [DATE] at 2:25 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a brain disorder that slowly damages memory and thinking skills, eventually leading to dementia). The census indicated that the resident had been hospitalized from [DATE] through [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had no cognitive deficit and had exhibited behavioral symptoms directed towards others. A discharge, return anticipated MDS, dated [DATE], indicated the resident had been discharged to an inpatient psychiatric hospital. The record lacked documentation that the Ombudsman had been notified of the resident's transfer to the hospital in [DATE]. During an interview, on [DATE] at 10:34 a.m., the Administrator (ADM) indicated no documentation that the Ombudsman had been notified of any resident's transferred in [DATE] had been found. The Ombudsman should be notified of all resident transfers and discharges monthly. 2. Resident 165's closed record was reviewed on [DATE] at 11:27 a.m. The profile indicated the resident's diagnoses included, but were not limited to, complete traumatic amputation of left lower leg (the loss of a body part, usually a finger, toe, arm, or leg, that occurs as the result of an accident or injury). The census indicated that the resident had been sent out to the hospital on [DATE]. The resident expired at the hospital. A discharge, return anticipated Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had been discharged to an acute care hospital. The record lacked documentation that the Ombudsman had been notified of the resident's transfer to the hospital in [DATE]. During an interview, on [DATE] at 1:50 p.m., the State Signature Care Consultant (SCC) indicated they had been unable to find any documentation that the Ombudsman had been notified of any resident transfers for the month of [DATE]. The expectation was that the Ombudsman would be notified monthly of all residents transferred from the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	35317 3. During an interview, on [DATE] at 3:01 p.m., Resident 138 indicated she had been transferred to the hospital several times in the last few months. Resident 138's record was reviewed on [DATE] at 10:13 a.m. The profile indicated the resident's diagnosis included, but were not limited to, encephalopathy (a medical condition that affects the brain's function), malignant neoplasm of upper lobe, right bronchus or lung (a cancerous tumor that has developed in the upper lobe of the right bronchus or lung tissue), and acute on chronic systolic heart failure a (a type of heart failure that occurs when the heart struggles to compensate for a decline in function that has developed over time). Resident 138's census information indicated she was transferred to the hospital on [DATE] and returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. A discharge assessment return anticipated (MDS) was initiated on [DATE] and an entry assessment was initiated on [DATE] when the resident returned from the hospital. The record lacked documentation that the ombudsman was notified of the resident's transfer to the hospital in November of 2024. During an interview, on [DATE] at 1:50 p.m., the Signature Care Consultant (SCC) indicated they had been unable to find any documentation that the Ombudsman had been notified of any resident transfers for the month of [DATE] due to staffing changes. On [DATE] at 10:26 a.m., the Administrator provided a document with a revised date of [DATE], titled, Transfer/Discharge Notice, and indicated it was the policy currently being used by the facility. The policy indicated, .4. Notification to the office of the State LTC (long term care) Ombudsman: when the facility provides written notice to the resident and or resident representative, the facility must also notify the Ombudsman of a facility- imitated transfer or discharge by sending a copy of the transfer notice to a representative of the Office of the State LTC Ombudsman 3XXX,d+[DATE](a)(6)(A)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34525 Based on record review and interview, the facility failed to ensure bed hold forms were completed and provided to residents and/or their representatives for 3 of 4 residents reviewed for hospitalization (Residents 18, 165, and 138). Findings include: 1. Resident 18's record was reviewed on [DATE] at 2:25 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a brain disorder that slowly damages memory and thinking skills, eventually leading to dementia). A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had no cognitive deficit and had exhibited behavioral symptoms directed towards others. A discharge, return anticipated MDS, dated [DATE], indicated the resident had been discharged to an inpatient psychiatric hospital. The census indicated that the resident had been hospitalized from [DATE] through [DATE]. A progress note, dated [DATE] at 10:46 a.m., indicated the resident had been diagnosed with a urinary tract infection (UTI) and had increased altered mental status (AMS-a change in mental function). The resident was placed on 1 on 1 observation. The physician was notified and ordered the resident be sent to the hospital for evaluation and treatment. The record lacked documentation of a bed hold form being completed and provided to the resident and/or her representative. During an interview, on [DATE] at 10:34 a.m., the Administrator (ADM) indicated no bed hold form had been found. The expectation was that the bed hold form should be completed, and copies provided to the resident/representative. 2. Resident 165's closed record was reviewed on [DATE] at 11:27 a.m. The profile indicated the resident's diagnoses included, but were not limited to, complete traumatic amputation of left lower leg (the loss of a body part, usually a finger, toe, arm, or leg, that occurs as the result of an accident or injury). A discharge, return anticipated Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had been discharged to an acute care hospital. The census indicated that the resident had been sent out to the hospital on [DATE]. The resident had expired at the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hospital transfer document, dated [DATE], indicated the resident had been sent out to the hospital, per physician order, for evaluation and treatment related to altered mental status (AMS-a change in mental function), hypoxia (a condition where there is a lack of oxygen in the body's tissues or in an environment), and edema (swelling caused by excess fluid in the body's tissues). The form lacked documentation of a bed hold form being completed and provided to the resident and/or her representative. During an interview, on [DATE] at 1:50 p.m., the State Signature Care Consultant (SCC) indicated they had been unable to find the bed hold form for the resident's transfer. The expectation was that the forms should be completed, and copies provided to the resident or representative for every hospital transfer. 35317 3. During an interview, on [DATE] at 3:01 p.m., Resident 138 indicated she had been transferred to the hospital several times in the last few months. Resident 138's record was reviewed on [DATE] at 10:13 a.m. The profile indicated the resident's diagnosis included, but were not limited to, encephalopathy (a medical condition that affects the brain's function), malignant neoplasm of upper lobe, right bronchus or lung (a cancerous tumor that has developed in the upper lobe of the right bronchus or lung tissue), and acute on chronic systolic heart failure (a type of heart failure that occurs when the heart struggles to compensate for a decline in function that has developed over time). Resident 138's census information indicated she was transferred to the hospital on [DATE] and returned later that evening, [DATE] and returned on [DATE], and [DATE] and returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. A progress note, dated [DATE] at 5:58 p.m., indicated Resident 138 had returned to the facility from the hospital with no new orders. The record lacked documentation that the Bed Hold Agreement form was completed for the resident's transfer to the hospital on [DATE]. A progress note, dated [DATE] at 7:23 a.m., indicated Resident 138 was transferred to the hospital per physician order. The record lacked documentation that the Bed Hold Agreement form was completed for the resident's transfer to the hospital on [DATE]. A progress note, dated [DATE] at 11:59 p.m., indicated Resident 138 was transferred to the hospital from the facility due to change of condition. The record lacked documentation that the Bed Hold Agreement form was completed for the resident's transfer to the hospital on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on [DATE] at 10:28 a.m., the Administrator indicated she was unable to provide documentation that the Bed Hold Agreement form was completed for Resident 138 for the months of December and January. She indicated the form should have been completed by the nurse anytime a resident is transferred out to the hospital. 4. During an interview, on [DATE] at 11:47 a.m., Resident 54 indicated he had been hospitalized recently in [DATE]. Resident 54's record was reviewed, on [DATE] at 1:26 p.m. The profile indicated the resident's diagnosis included, but were not limited to, acute and chronic respiratory failure with hypoxia (a condition where the lungs have difficulty exchanging oxygen and carbon dioxide with the blood, resulting in low oxygen levels in the body), type II diabetes mellitus with diabetic polyneuropathy (a complication of type II diabetes that occurs when multiple nerves in the body are damaged), and schizophrenia (a disorder that affects a person's ability to think, fell , and behave clearly). Resident 154's census information indicated she was transferred to the hospital on [DATE] and returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. A progress note, dated [DATE] at 4:00 a.m., indicated Resident 54 was transferred to the hospital from the facility due to a change of condition. The record lacked documentation that the Bed Hold Agreement form was completed for the resident's transfer to the hospital on [DATE]. During an interview, on [DATE] at 3:29 p.m., the Signature Clinical Consultant indicated she was unable to provide documentation that the Bed Hold Agreement form was completed for Resident 54 for [DATE], transfer to the hospital. She indicated they have identified a system failure, and they would need to implement a new process and re-educate staff on completing the form every time a transfer takes place. On[DATE] at 10:26 a.m., the Administrator provided a document with a revised date of [DATE], titled, Facility Bed-Hold, and indicated it was the policy currently being used by the facility. The policy indicated, .The facility will notify the resident and/or resident representative of the facility's bed-hold policy at admission and anytime the resident is transferred to the hospital or goes out on therapeutic leave . 1. The facility's bed-hold policy will be discussed with the resident and/or resident representative and the facility will provide written notice of the bed-hold policy 3XXX,d+[DATE](a)(25) 3XXX,d+[DATE](a)(26)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 35317 Based on record review and interview, the facility failed to ensure the QMAs (qualified medication aides) followed proper standards of practice for 1 of 28 residents reviewed (Resident 92). Findings include: Resident 92's record was reviewed, on 1/23/25 at 11:06 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), pressure ulcer (injury to skin an underlying tissue resulting from prolonged pressure on skin) of right buttock, sacral region, left buttock, stage 3, and skin tear/laceration to left heel. An annual Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident had severe cognitive impairment and had 3 stage 3 pressure ulcers. A care plan, dated 8/1/22, indicated the resident is at risk for alteration in skin integrity related to self-performance of bed mobility and incontinence. Interventions included but were not limited to, observe for further open areas with each bathing and incontinence episode, turn and reposition every 2 hours, notify medical doctor as needed. A physician order, dated 11/7/24 with a discontinued date of 12/2/24, indicated to cleanse wound on left heel with normal saline, pat dry, apply xeroform (a sterile non adherent gauze dressing), apply abd (a medical dressing used to treat wounds that are moderately to heavily draining) and wrap with Kerlix (absorbent, breathable, and protective gauze) daily and as needed for soilage and dislodgement. A Treatment Medication Record (TAR) for November 2024 indicated Qualified Medication Aide (QMA) 3 documented she completed the treatment on 11/8, 11/11, 11/12, 11/14, 11/18, and 11/19/24. QMA 13 documented that she completed the treatment on 11/9, 11/16, and 11/24/24. Certified Medication Aide (CMA) 14 documented that she completed the treatment on 11/13, 11/15, 11/27, and 11/28/24. A physician order, dated 11/18/24 with a discontinued dated of 12/2/24, indicated to cleanse wound on left gluteal fold with wound cleanser, pat dry, skin prep to peri wound (the skin surrounding a wound) apply Medi honey (a medical grade wound care dressing made from honey) to wound bed, apply border foam daily, and as needed for soilage and dislodgement. A TAR for November 2024 indicated Qualified Medication Aide (QMA) 3 documented that she completed the treatment on 11/19/24. QMA 14 documented that she completed the treatment on 11/24/24. CMA 14 documented she completed the treatment on 11/27 and 11/28/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 11/25/24 with a discontinued date of 12/2/24, indicated to cleanse wound on coccyx with normal saline, pat dry, apply zinc oxide (an soluble white solid medical ointment) twice daily, leave open to air. A TAR for November 2024, indicated CMA 14 documented she had completed the treatment on 11/27 and 11/28/24. A physician order, dated 11/9/24 with a discontinued date of 12/26/24 indicated to cleanse area to right buttock, apply skin prep, cover with foam dressing, change daily and as needed. A TAR for November 2024, indicated QMA 3 documented she completed the treatment on 11/11, 11/12, 11/14, 11/18, and 11/19/24. QMA 13 documented that she completed the treatment on 11/10, 11/16, and 11/24/24. CMA 14 documented that she completed the treatment on 11/13, 11/15, 11/27, and 11/28/24. A physician order, dated 11/7/24 with a discontinued date of 12/27/24, indicated to cleanse area to left heel with normal saline, apply foam dressing, change daily and as needed. A TAR for December 2024, indicated QMA 3 documented that she had completed the treatment on 12/20/24. QMA 13 documented that she had completed the treatment on 12/5, and 12/14/24. CMA 14 documented that she had completed the treatment on 12/4, 12/6, and 12/13/24. The TAR also lacked documentation of the treatment being completed on 12/11 and 12/19/24. A TAR for December 2024, indicated the treatment to right buttock was documented by QMA 3 as competed on 12/20/24. QMA 13 documented she completed the treatment on 12/5, 12/14, and 12/15/24. CMA 14 documented she completed the treatment on 12/4 and 12/13/24. The TAR also lacked documentation of the treatment being completed on 12/6, 12/11, and 12/19/24. A TAR for December 2024, indicated the treatment to coccyx was documented by QMA 13 as competed on 12/1/24. A physician order, dated 12/19/24 with a discontinued date of 12/24/24, indicated to cleanse wound to coccyx with wound cleanser, pat dry, skin prep to peri wound, apply Medi Honey to wound bed, apply boarder gauze daily and as needed for soilage and dislodgement. A TAR for December 2024, indicated the treatment to coccyx was documented by QMA 3 as competed on 12/20/24. A TAR for December 2024, indicated the treatment to left gluteal fold was documented by QMA 13 as completed on 12/5 and 12/14/24. CMA 14 documented the treatment as completed on 12/4 and 12/13/24. Review of wound note, dated 12/26/24, indicated the following wounds had healed: a. Skin tear/laceration to left heel b. Stage 3 pressure ulcer to left gluteal fold c. Stage 3 pressure ulcer to right buttock (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Stage 3 pressure ulcer to coccyx During an interview, on 1/23/25 at 1:30 p.m., QMA 3 indicated they were only allowed to do treatments on intact skin. They could not do treatments on any skin areas that were opened. During an interview, on 1/27/25 at 10:00 a.m., QMA 9 indicated they could only place ointments and creams on intact skin. They were not allowed to do treatments on any open areas on the resident's skin. During an interview, on 1/27/25 at 1:20 p.m., the Signature Clinical Consultant indicated QMAs must practice within their scope. Their QMAs follow the state guidelines. QMAs were only allowed to do treatments on intact skin. They may not provide treatments to open areas. By signing off the treatment on the TAR that would indicate that the staff member completed the treatment. Review of an undated document titled, Qualified Medication Aide, Scope of Practice, was retrieved on 1/29/25 from the IN.gov website at https://www.in.gov. The guidance included: .The following tasks shall NOT be included in the QMA scope of practice, .(6) Administer a treatment that involves advanced skin conditions, including stage II, stage III, stage IV decubitus ulcers 3.1-35(g)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on observation, record review, and interview, the facility failed to prevent new pressure wounds on 1 of 4 residents reviewed for pressure wounds (Resident 131). Findings include: On 1/21/25 at 3:13 p.m., during an initial observation Resident 131 was lying in bed on the right side on a low air loss mattress. No off-loading heel boots were observed on bilateral feet. On 1/22/25 at 9:48 a.m., during a routine observation the resident was lying in bed on her right side on a low air loss mattress. No offloading boots were observed. Boots were in the wheelchair next to the bed. On 1/23/25 at 11:00 a.m., the resident was observed lying in bed on her right side on a low air loss mattress. No offloading boots were observed on bilateral feet. On 1/24/25 at 11:30 a.m., the resident was observed lying in bed on her right side. No offloading boots to bilateral feet observed. Boots were in the wheelchair next to the bed. On 1/24/25 at 12:10 p.m., the medical record of Resident 131 was reviewed. Diagnosis included but was not limited to, osteomyelitis (an inflammation or swelling that occurs in the bone. It can result from an infection somewhere else in the body that has spread to the bone, or it can start in the bone), muscle weakness, pressure ulcer of sacral region (pressure ulcers that appear on the skin over a bony region of the spine called the sacrum), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), unspecified severe protein-calorie malnutrition (obvious significant muscle wasting, loss of subcutaneous body fat), and functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord). A physician order, dated 6/24/21, ordered med pass 120 milliliter (ml) orally twice a day for supplement. A physician order, dated 4/18/24, ordered mirtazapine 7.5 milligram (mg) 1 tablet orally daily for appetite stimulant. A care plan dated 7/9/2024, indicated resident had a diagnosis of malnutrition related to symptoms. (i.e. weight loss, acute illness. Interventions included Supplements as ordered, Notify MD with significant changes. A care plan, dated 4/16/2024, indicated refusal of care, such as not eating meals. Interventions included but were not limited to offer and encourage medications as ordered. Observe the effectiveness and side effects of medications and resident exercises right to decline treatment and services. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record lacked documentation of an updated care plan reflecting the deep tissue injuries to the bilateral feet and heels. The record lacked documentation of resident refusal to wear heel boots or to be repositioned and turned when in bed. A physician order, dated 10/23/24, ordered centrum (multivitamin-iron-folic acid) 18-400 mg-mcg (milligram-microgram) administer 1 tablet orally once a day for malnutrition. A quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was cognitively impaired and required total assistance for care needs. The MDS indicated the resident was admitted with a sacral wound. A physician order, dated 1/13/25, indicated to ensure bilateral heels were floating while in bed every shift. A physician order, dated 1/20/25, indicated to cleanse wound on right heel medial with normal saline, pat dry, apply skin prep twice daily and as needed. Apply heel boots. On 1/20/25 a wound care note was entered by the Nurse Practitioner (NP) indicated the following. Skin and wound assessment completed. Wound vac was not in place upon assessment. Sacral wound was chronic, had good granulation. Patient had new areas on both heels. Strongly recommended heel boots be applied. Educated staff on continuing strict offloading to area and keeping patient clean and dry. Strongly recommended patient wear heel boots for offloading. The patient to continue with Nutritional Consult for presence of a wound and delayed wound healing. Education was provided to the staff regarding the patient's wound, dressing care, and general treatment recommendations. On 1/28/25 at 9:00 a.m., observed the resident being transferred to wheelchair with assistance of two Certified Nurse Aides (CNA). Observed heel boots were on bilateral feet. On 1/28/25 at 9:03 a.m., during interview CNA 15 indicated she applied the offloading heel boots at times. If the resident was in bed she would give the resident a break and leave the heel boots off. She indicated when not in use she kept the boots in the resident's chair. On 1/28/25 at 10:08 a.m., during interview the Director of Nursing Services (DNS) indicated wound care services provided recommendations for wound care. When they provided a recommendation the nurse would contact the physician and obtain orders. If the resident had a low air loss mattress they considered it as an offloading measure, unless recommendations from wound care services were added. She indicated if the resident was refusing to follow the plan of care it was usually in the care plan. On1/28/25 at 10:52 a.m., the Administrator provided a document titled, Physician Orders, dated 11/16/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy statement .It is the standard of this facility that physician orders are followed, reviewed to ensure delivery of care . Guideline .2. Licensed Nurse and Medication Aides are expected to follow physician's orders 3.1-40

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on observation, record review, and interview, the facility failed to provide adequate hydration for 2 of 32 residents reviewed for hydration and nutrition (Residents 131 and 109). Findings include: 1. On 1/21/25 at 3:14 p.m., during an initial observation, Resident 131 was lying in bed on her right side. Skin and mouth were observed dry. A styrofoam cup with a small amount of brown liquid was observed inside on the overbed table next to the wall, which was outside of the resident's reach. On 1/22/25 at 9:48 a.m., during a routine observation, Resident 131 was lying in bed on her right side. An empty styrofoam cup was on the bedside overbed table. Resident tried to drink from the cup. On 1/24/25 at 2:00 p.m., during a general observation, Resident 131 was lying in bed on her right side. A partially melted cup of ice cream and a styrofoam cup with a small amount of water were on the overbed table. On 1/27/25 at 3:17 p.m., Resident 131 was lying in bed. Overbed table was next to the wall on the far side of her bed. No water glass on table or near the resident. On 1/24/25 at 12:10 p.m., the medical record of Resident 131 was reviewed. Diagnosis included but was not limited to, osteomyelitis (an inflammation or swelling that occurs in the bone. It can result from an infection somewhere else in the body that has spread to the bone, or it can start in the bone), muscle weakness, pressure ulcer of sacral region (pressure ulcers that appear on the skin over a bony region of the spine called the sacrum), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), unspecified severe protein-calorie malnutrition (obvious significant muscle wasting, loss of subcutaneous body fat), and functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord). A Physician order, dated 6/24/21, ordered med pass 120 milliliters (ml) orally twice a day for supplement. A care plan, dated 4/16/24, indicated refusal of care, such as not eating meals. Interventions included but were not limited to offer and encourage medications as ordered. Observe the effectiveness and side effects of medications and resident exercises right to decline treatment and services. A care plan, dated 7/9/2024, indicated resident had a diagnosis of malnutrition related to symptoms, i.e. weight loss, acute illness. Interventions included supplements as ordered. A Physician order, dated 9/11/24, ordered to monitor intake and output, care assist, ordered tasks, evening snack, and fluids. A quarterly Minimum Data Set (MDS) assessment, dated 1/8/25, indicated the resident was cognitively impaired and required total assistance for care needs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 1/22/25 at 10:16 a.m., during an initial observation, Resident 109 was sitting in a recliner in her room. An empty styrofoam cup was on the overbed table in front of her. The resident's skin was thin and dry. The resident could not recall when the staff had filled her water cup last. On 1/24/25 at 2:10 p.m., during a routine observation, Resident 109 was sitting in her room in a recliner. An empty styrofoam cup was on the overbed table in front of the resident. On 1/25/25 at 2:15 p.m., during a routine observation, the resident was sitting in her room in a recliner. An unopened bottle of orange soda was on the overbed table with an empty styrofoam cup. The resident could not recall when the staff had provided ice water to her. The resident indicated she was thirsty. On 1/25/24 at 2:30 p.m., the medical record of Resident 109 was reviewed. Diagnosis included but were not limited to, protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A care plan, dated 3/21/2023, indicated the resident was at nutritional risk related to dementia due to the resident requiring a mechanically altered diet and having weight loss. Interventions included but not limited to, encourage resident to have good fluid intake and assist as needed with beverage set up. A physician order, dated 7/13/24, ordered to monitor meals intake for breakfast, lunch, am snack, and fluids daily. A physician order, dated 10/23/24, ordered to administer med pass 60 ml orally three times a day for malnutrition. A quarterly MDS, dated [DATE], indicated the resident was moderately cognitively impaired and required extensive assistance with care. A physician order, dated 12/27/24, ordered a regular diet. On 1/24/25 at 2:11 p.m., during an interview, Qualified Medication Aide (QMA) 17 indicated the CNAs passed ice water at least once a shift. She indicated the staff passed ice water after breakfast and again in the afternoon and indicated the residents would ask if they want more water. On 1/25/25 at 2:16 p.m., during interview Certified Nurse Aide (CNA) 16 indicated she filled water glasses at least twice per day and when the resident asked for more. If a glass was empty she would refill it then as well. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/2025 at 3:16 p.m., the Administrator provided a document titled, Hydration, dated 1/31/24, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement . Residents will be provided sufficient amounts of fluid to maintain proper hydration to the extent possible . Guidelines .1. Facility staff shall offer fluids to residents throughout their shift (unless contraindicated) .2. Fluids are made available at mealtimes, between mealtimes, at the bedside as needed and as requested (unless contraindicated) 3.1-46

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34525 Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was dated when changed and was maintained and stored in a sanitary manner for 1 of 3 residents reviewed for respiratory (Resident 26). Findings include: During an observation, on 1/22/25 at 9:36 a.m., Resident 26 was asleep in his bed. His oxygen concentrator (a medical device that separates nitrogen from the air to provide oxygen-enriched air for breathing) was on, and his nasal cannula (a medical device that supplies oxygen to a patient through their nose) was in his nose. The resident's oxygen tubing was undated, and no storage bag was observed. During an observation, on 1/23/25 at 2:17 p.m., the resident was sleeping in his bed. The oxygen concentrator was running, and his nasal cannula was observed out of his nose, un-bagged, and laying inside of his trash can next to his bed. There was visible trash items in the trash can along with his nasal cannula. His oxygen tubing was undated, and no storage bag was observed. During an observation, on 1/24/25 at 10:02 a.m., the resident was in his bed with his oxygen concentrator running and his nasal cannula in his nose. The tubing was not dated and no storage bag was observed. The trash can remained in the same position next to his bed. Resident 26's record was reviewed on 1/23/25 at 1:20 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic systolic heart failure (a serious condition that occurs when the left side of the heart can't pump blood properly) and atherosclerotic heart disease (a condition where plaque builds up in the arteries of the heart, narrowing them and making it difficult for blood to flow). A quarterly Minimum Data Set (MDS) assessment, dated 12/5/24, indicated the resident had moderate cognitive deficit. The MDS assessment lacked documentation that the resident received oxygen therapy. A physician's order, dated 9/26/24, indicated to administer 2 liters (L) of oxygen as needed. A care plan, dated 1/20/25, indicated the resident had impaired oxygen gas exchanged and was at risk for complications. Interventions included, but were not limited to, oxygen as ordered. The January 2025 Treatment Administration Record (TAR) indicated the resident's oxygen tubing had been changed on 1/1/25. The TAR lacked documentation that the tubing had been changed after being in the resident's trash can. During an interview, on 1/24/25 at 10:04 a.m., Qualified Medication Aide (QMA) 7 indicated the oxygen tubing should be dated and a bag should be in place for the nasal cannula to be put in when not in use. If the nasal cannula comes into contact with the floor or in the trash can, it should be changed, and the tubing dated, before the resident used the oxygen and nasal cannula again. (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	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Terre Haute	3500 Maple Ave Terre Haute, IN 47804

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/24/25 at 2:14 p.m., the State Signature Care Consultant (SCC) indicated the expectation was that all oxygen supplies should be bagged when not in use and that the tubing be dated when changed. On 1/24/25 at 11:47 a.m., the SCC provided a document, with a revision date of 5/30/24, titled, Oxygen Administration Policy, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: .Change the O2 (oxygen) tubing monthly and as needed 3.1-47(a)(6)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35317 Based on record review and interview, the facility failed to ensure AIMS (abnormal involuntary movement scale) assessments were completed for 1 of 5 residents were reviewed for unnecessary medications (Resident 92). Findings include: Resident 92's record was reviewed, on 1/23/25 at 11:06 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder (a mental health disorder characterizer by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). An annual Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident had severe cognitive impairment and was on anti-psychotic and anti- depressant medication. A care plan, dated 8/15/22, indicated the resident had a diagnosis of insomnia and anxiety and is at risk for drug related symptoms due to use of psychotropic medication. Interventions included, but were not limited to, monitor the resident's mood and response to medication. A physician order, dated 10/9/24, with an original start date of 11/22/23, indicated to administer Zyprexa (used to treat mental disorders) 10mg (milligrams) one table via gastric tube (a flexible tube that's inserted into the stomach to provide nutrition, fluids, and medication) once a day at bedtime. A care plan, dated 12/12/24, indicated the resident had a diagnosis of psychosis. Interventions included, but were not limited to, consult with psychiatry/psychology as needed and notify the medical doctor with medication side effects as needed. Review of Resident 92's record indicated an AIMS assessment had been completed on 1/21/25 but the record lacked documentation of an AIMS assessment being completed between 10/15/23 and 1/21/25. During an interview, on 1/24/25 at 9:27 a.m., the Director of Nursing (DON) indicated she had recently updated a lot of AIMS assessments for residents because they were behind on some people. During an interview, on 1/24/25 at 10:17 a.m., the DON indicated she was unable to provide documentation that AIMS assessments were completed for Resident 92 during the dates of 10/15/23 to 01/21/25. She further indicated they were aware of the issue, and they had started a new process for these to be completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/24/25 at 11:47 a.m., the Signature Clinical Consultant (SCC) indicated she was unable to find a specific policy regarding AIMS assessments, but they should be completed every 6 months when a resident was on anti-psychotic medication. On 1/24/25 at 2:13 p.m., the SCC provided a document with a revised date of 5/7/24, titled, Psychotropic Medications Policy, and indicated it was the policy currently being used by the facility. The policy indicated, . 1. The facility will make every effort to comply with state and federal regulations related to use of psychotropic medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects (including psychosocial), risks and/or benefits 3.1-48(b)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48226 Based on observation, record review, and interview, the facility failed to ensure medications were dated with the date medications were opened and stored in 4 of 5 medication administration carts observed for medication storage and labeling. Findings include: 1. On 1/27/25 at 9:00 a.m., an observation of the medication administration cart on 400 hall with QMA 18. The following was observed. Resident 66 had a physician order, dated 10/18/24, for Admelog U-100 Insulin lispro (insulin lispro) solution; 100 unit/mL (milliliter) administer injection per sliding scale before meals and at bedtime for diagnosis of diabetes. Multi dose insulin vial was opened and undated. 2. On 1/27/25 at 9:10 a.m., the 300-hall medication administration cart was observed with the Director of Nursing (DNS). Resident 2 had a physician order, dated 12/30/24, for Basaglar KwikPen U-100 Insulin (insulin glargine) administer 30 units subcutaneous (under the skin) once daily for diagnosis of diabetes. Basaglar insulin pen was opened and undated. Resident 111 had a physician order, dated 1/8/25, for Lantus SoloStar U-100 Insulin (insulin glargine) insulin pen, 100 unit/mL (3 mL), administer 35 units subcutaneous once a day for diagnosis of diabetes. The pen was opened and undated. Resident 111 had a physician order, dated 1/8/25, for Humalog KwikPen Insulin (insulin lispro) insulin pen 100 unit/mL administer per sliding scale before meals and at bedtime for diagnosis of diabetes. The pen was opened and undated. Resident 42 had a physician order, dated 1/16/25, for Trulicity (dulaglutide) pen injector 4.5 mg/0.5 mL (milligram) administer 0.5ml subcutaneous once a day on Fri for diagnosis of diabetes. The pen was unopened and stored in med cart. The label on the pen indicated must keep refrigerated till use. Resident 19 had a physician order for Latanoprost drops 0.005 % administer 1 drop ophthalmic (eye) in left eye every evening for diagnosis of glaucoma. The bottle was opened and undated. Manufacture guidelines recommend, once bottle was opened, discard after 6 weeks. 3. On 1/27/25 at 9:20 a.m., the 300-hall medication administration cart #2 observation was completed with the DNS. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10 had a physician order, dated 11/30/23, for Ozempic (Semaglutide) pen injector 0.25 mg or 0.5 mg (2 mg/3 mL) administer 0.5 mg subcutaneous once a day on Monday for diagnosis of diabetes. The pen was opened and undated. Resident 10 had a physician order, dated 7/3/24, for Tresiba U-100 Insulin (insulin Decgludec) solution 100 unit/mL multi dose vial. Administer 40 units subcutaneous twice a day for diagnosis of diabetes. The vial was opened and undated. 4. On 1/27/24 at 9:30 a.m., the 100 Hall medication administration cart was observed with the DNS. Resident 70 had a physician order, dated 11/28/23, for Basaglar KwikPen U-100 Insulin (insulin glargine) insulin pen 100 unit/mL (3 mL) administer 15 units subcutaneous twice daily for diagnosis of diabetes. The pen was opened and undated On 1/27/25 at 9:30 a.m., during an interview the DON indicated the insulin pens should be labeled with a date opened. On 1/27/25 at 1:57 p.m., during an interview the Administrator indicated the facility follows manufacture guidelines for insulin and eye drops date opened and use by recommendations. On 1/28/2025 at 2:00 p.m., the Signature Clinical Consultant provided an undated document, titled, Medications with expiration dates, and indicated it was the policy currently being used by the facility. The policy indicated, .Humalog insulin, Lantus insulin, Basaglar insulin and Lispro insulin must be discarded once opened after 28 days. Tresiba and Ozempic must be discarded once opened after 56 days 3.1-25(j) 3.1-25(m) 3.1-25(n)