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	09/23/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure informed consent was obtained for psychotropic medications for 5 of 5 residents reviewed for unnecessary medications (Resident 8, 11, 5, 99, and 103). The deficient practice was corrected on 9/9/25, prior to the start of the survey, and was therefore past noncompliance. Findings include:1. Resident 8's record was reviewed on 9/18/25 at 11:48 a.m. Census information indicated the resident was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 8/20/25, indicated the resident had a moderate cognitive impairment and received an antipsychotic (treats psychosis), antianxiety (treats anxiety), anticonvulsant (treats seizures and can be used as mood stabilizers), and antidepressant (treats depression) medication during the look-back period. Diagnoses on the resident's profile included, but were not limited to, anxiety disorder unspecified, major depressive disorder recurrent and mild, and bipolar disorder (extreme shifts in mood, energy, thinking, and behavior, ranging from periods of high energy to periods of low mood) unspecified. A physician's order, dated 6/21/25 and discontinued on 9/6/25, indicated alprazolam (antianxiety) 1 milligram (mg) by mouth daily for anxiety. A physician's order, dated 6/24/25, indicated bupropion (antidepressant) sustained release 150 mg by mouth once daily for bipolar disorder. A physician's order, dated 6/24/25, indicated Rexulti (antipsychotic) 2 mg daily for bipolar disorder. A physician's order, dated 6/25/25, indicated doxepin (antidepressant) 50 mg by mouth daily for depression. A physician's order, dated 6/25/25, indicated lamotrigine (anticonvulsant that can be used as a mood stabilizer) 200 mg daily for bipolar disorder. A physician's order, dated 9/6/25, indicated alprazolam 0.25 mg by mouth three times daily for anxiety. A consent for the use of psychotropic medications, dated 8/11/25, indicated informed consent was obtained from the resident for the use of bupropion and alprazolam. The consent lacked documentation an informed consent was obtained for Rexulti, doxepin, or lamotrigine. A consent for the use of psychotropic medications, dated 9/9/25, indicated informed consent was obtained from the resident for the use of Rexulti, doxepin, and lamotrigine. (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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's electronic record lacked documentation an informed consent, for the use of psychotropic medications, was obtained from the resident, or the resident's representative, prior to 8/11/25. 2. Resident 11's record was reviewed on 9/19/25 at 10:51 a.m. A 5-day Minimum Data Set (MDS) assessment, dated 8/27/25, indicated the resident was cognitively intact and received an antipsychotic (treats psychosis), antianxiety (treats anxiety), and antidepressant (treats depression) medication during the look-back period. Diagnoses on the resident's profile included, but were not limited to, anxiety disorder unspecified and depression unspecified. The resident's electronic record contained the following physician's orders for quetiapine (antipsychotic). -A physician's order, dated 4/24/25 and discontinued on 6/10/25, indicated quetiapine 100 milligrams (milligrams) by mouth daily for major depressive disorder and anxiety. -A physician's order, dated 6/10/25 and discontinued on 6/18/25, indicated quetiapine 25 mg by mouth daily for major depressive disorder and anxiety. -A physician's order, dated 6/18/25 and discontinued on 6/29/25, indicated quetiapine 25 mg by mouth daily for major depressive disorder and anxiety. -A physician's order, dated 7/17/25 and discontinued on 8/6/25, indicated quetiapine 25 mg by mouth once daily. -A physician's order, dated 8/22/25, indicated quetiapine 25 mg by mouth once daily. The resident's electronic record contained the following physician's orders for buspirone (antianxiety). -A physician's order, dated 4/24/25 and discontinued on 6/10/25, indicated buspirone 15 mg by mouth three times daily for anxiety. -A physician's order, dated 6/10/25 and discontinued on 6/29/25, indicated buspirone 15 mg by mouth three times daily for anxiety. -A physician's order, dated 7/17/25 and discontinued on 8/6/25, indicated buspirone 15 mg by mouth three times daily. -A physician's order, dated 8/22/25, indicated buspirone 15 mg by mouth once daily for anxiety. The resident's electronic record contained the following physician's orders for duloxetine (antidepressant). -A physician's order, dated 4/24/25 and discontinued on 6/10/25, indicated duloxetine 30 mg by mouth daily in the morning for depression. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A physician's order, dated 4/24/25 and discontinued on 6/10/25, indicated duloxetine 60 mg by mouth daily in the evening for depression. -A physician's order, dated 6/10/25 and discontinued on 6/26/25, indicated duloxetine 30 mg by mouth daily for depression. -A physician's order, dated 6/26/25 and discontinued 6/29/25, indicated duloxetine 30 mg by mouth daily for depression. -A physician's order, dated 7/17/25 and discontinued on 8/6/25, indicated duloxetine 30 mg by mouth daily for depression. -A physician's order, dated 8/22/25, indicated duloxetine 30 mg by mouth daily for depression. A consent for the use of psychotropic medication, dated 8/11/25, indicated informed consent was obtained from the resident for the use of buspirone. The consent lacked documentation informed consent was obtained for the use of quetiapine or duloxetine. A consent for the use of psychotropic medication, dated 9/9/25, indicated informed consent was obtained from the resident for the use of duloxetine, buspirone, and quetiapine. The resident's electronic record lacked documentation an informed consent, for the use of psychotropic medications, was obtained from the resident, or the resident's representative, prior to 8/11/25. During an interview, on 9/19/25 at 10:32 a.m., the Regional Clinical Consultant indicated there had been issues with the psychotropic medication consents. They got consents for all residents initially in August but then realized the consents did not include all of the required medications. They completed all required consents for psychotropic medications in September 2025. 3. On 9/19/25 at 10:16 a.m., the medical record of Resident 5 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but not limited to, depression (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), 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), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). Physician orders, dated 12/13/24 and 4/17/25, indicated to administer amitriptyline one 100 mg (milligram) tablet by mouth for depression. The record lacked documentation of consent for psychotropic medication. 4. On 9/18/25 at 1:47 p.m., the medical record of Resident 99 was reviewed. The record indicated the resident had been admitted and discharged five times since first admission on [DATE]. The record indicated the most recent admission was on 7/6/25. admission diagnosis included but was not limited to, depression (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), and dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extent that it interferes with a person's daily life and activities). A physician order, dated 9/5/25, indicated to administer quetiapine 150 mg (milligram) orally once a day for dementia. The record lacked documentation of consents for psychotropic medications from 2/12/25 to 8/8/25. 5. Resident 103's record was reviewed on 9/18/25 at 3:38 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia (occurs when a person's cognitive impairment is unclear), anxiety disorder (intense, persistent worry or feat that interferes with daily life), and unspecified psychosis not due to a substance or known physiological condition (a mental state characterized by a loss of touch with reality and may involve hallucinations, delusions, disordered thinking, and behavioral changes). Census information indicated Resident 103 was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 7/4/25, indicated the resident was cognitively intact and had received anti-psychotic (used to primarily reduce the symptoms of psychosis) and anti-depressant (used for depression symptoms) medications. A physician order, dated 6/30/25, indicated to administer olanzapine (anti-psychotic) 5milligrams (mg) orally twice a day. A physician order, dated 6/30/25, indicated to administer Zoloft (anti-depressant) 50 mg orally once a day. A physician order, dated 6/20/35 with a discontinue date of 9/5/25, indicated to administer Paxil (anti-depressant) 20 mg orally once a day. A consent for the use of psychotropic medications, dated 8/10/25, indicated informed consent was obtained from the resident for the use of olanzapine. The informed consent lacked documentation on the use of Paxil and Zoloft was obtained. The resident's electronic record lacked documentation the informed consent for the use of psychotropic medications was obtained from the resident, or the resident's representative, prior to 8/10/25. During an interview, on 9/19/25 at 11:41 a.m., the Regional Clinical Consultant indicated they had obtained consents for all residents initially in August but then realized the consents did not include all the required medications. The original consents that were completed in August only included anti-psychotic medications which did not meet the required guidelines of all psychotropic medications. They completed all required consents for psychotropic medications in September 2025. She indicated that the psychotropic medication consents should be completed on admission and with any new initiation of a new psychotropic medication. On 9/19/25 at 3:20 p.m., the Regional Clinical Consultant provided a document with a revised date of 2/23/25, titled, Psychotropic Medications Policy, and indicated it was the current policy being used by the facility. The policy indicated, .Psychotropic medications will be used appropriately for residents with mental illness and/or related disorders.These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic.1. The (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility will make every effort to comply with state and federal regulations related to the use of psychotropic medications in the long-term care facility to include regular reviews for continued need.5. Resident and/or resident representative will have informed consent on the risks vs benefits of any psychotropic medication initiation or increase including any black box warnings. The deficient practice was corrected by 9/9/25 after the facility implemented a systemic plan that included the following actions: auditing resident records for antipsychotic medications, educating staff, and continued monitoring of resident antipsychotic medications to meet regulations. 3.1-3(n)(2)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on interview and record review, the facility failed to ensure the residents were informed of the contact information regarding how to file a complaint with the State (the government entity responsible for inspecting and certifying long-term care facilities to ensure they meet federal and state health and safety standards for resident care) for 1 of 1 Resident Council interview and 3 of 3 months of Resident Council meeting minutes reviewed. Findings include:On 9/22/25 at 11:18 a.m., the Resident Council meeting minutes for June, July, and August 2025 were reviewed. The minutes lacked documentation that the Resident Council members had been informed of where to locate the information on how to file a complaint with the State. During the Resident Council interview, on 9/22/25 at 2:23 p.m., the President of the Resident Council indicated she was not sure what the process was for contacting the State if she had a complaint. She could not remember ever discussing that topic at the Resident Council meetings. At the same time, Resident 76 indicated he had never been informed about how to contact the State if he had a complaint to file. On 9/22/25 at 2:30 p.m., the Activity Director indicated they had not covered how to file a complaint with the State in the resident council meetings. She just assumed that the members knew where the information was located. The Resident Council President's record was reviewed on 9/23/25 at 1:37 p.m. An annual Minimum Data Set (MDS) assessment, dated 7/7/25, indicated the resident had no cognitive deficit. Resident 76's record was reviewed on 9/23/25 at 1:47 p.m. An admission MDS assessment, dated 7/2/25, indicated the resident had no cognitive deficit. On 9/23/25 at 8:45 a.m., the Regional Clinical Consultant indicated that she was unable to find a specific policy related to the topics that were supposed to be discussed during the Resident Council meetings. The facility would follow the State regulations. 3.1-4(j)(3)(A)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessment for 4 of 27 residents MDS assessments reviewed (Residents 14, 15, 16, and 145). Findings include: 1. Resident 14's record was reviewed on 9/18/25 at 8:28 a.m. The profile indicated the resident's diagnoses included, but were not limited to, neuromuscular dysfunction of bladder (occurs when damage to the brain, spinal cord, or nerves disrupts the signals between bladder and the brain, leading to problems with bladder control) and urinary retention (difficulty urinating and completely emptying the bladder). A quarterly Minimum Data Set (MDS) assessment, dated 6/12/25, indicated the resident had an indwelling catheter and was always incontinent of urine. A quarterly MDS assessment, dated 6/24/25, indicated the resident had an indwelling catheter and was always incontinent of urine. A quarterly MDS assessment, dated 8/22/25, indicated the resident had severe cognitive impairment, had an indwelling catheter, and was always incontinent of urine. A physician's order, dated 8/7/25, indicated to anchor a Foley catheter size 16 Fr (French) (diameter of catheter tubing) 10cc (cubic centimeter) balloon to straight drainage. During an interview, on 9/18/25 at 2:34 p.m., the MDS Coordinator indicated if a resident had an indwelling catheter the MDS assessment should be marked as not rated. She was unsure why the assessments were marked as always incontinent. She indicated sometimes staff would mark them incontinent if a catheter was leaking. The record lacked any documentation of the resident having a catheter that leaked urine. During an interview, on 9/18/25 at 3:22 p.m., the Regional Clinical Consultant indicated the MDS assessments were not coded correctly for Resident 14, and the resident had not had any leaking from her indwelling catheter. She further indicated the MDS assessments would need to be amended since they were not coded correctly. Section H of the CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2024, indicated, .H0300: Urinary incontinence .Coding Instructions .9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days. 2. Resident 15's record was reviewed on 9/22/25 at 9:31 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive brain disorder and the most common form of dementia, characterized by a gradual decline in memory and thinking skills that eventually affects daily life) and gastrostomy status (refers to medical diagnosis indicating the presence of a gastrostomy tube which is surgically created opening into the stomach for feeding). A significant change in status Minimum Data Set (MDS) assessment, dated 5/28/25, indicated the resident was severely cognitively impaired and was marked no for a terminal prognosis. A quarterly MDS assessment, dated 8/28/25, indicated the resident was marked no for a terminal (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prognosis. A physician order, dated 5/21/25, indicated to admit Resident 15 to hospice care. Review of a statement from the hospice agency, dated 5/28/25 indicated the hospice physician had certified the patient's prognosis was less than 6 months or less if the disease runs its normal course. The statement indicated the hospice nurse had received verbal consent from the physician on 5/22/25 at 10:00 a.m. and was signed by the physician on 5/28/25 electronically. Review of a statement from the hospice agency, dated 8/6/25 indicated the hospice physician had certified the patient's prognosis was less than 6 months or less if the disease runs its normal course. The statement indicated the physician electronically signed it on 8/6/25. During an interview, on 9/22/25 at 10:00 a.m., the Regional Clinical Consultant indicated the MDS assessments were not coded correctly and should have been marked as yes, because the resident had a terminal prognosis and was on hospice services. Section J of the CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2024, indicated, .J1400: Prognosis.Does the resident have a condition or chronic illness that may result in a life expectancy of less than 6 months? .1.Yes. 3. Resident 16's record was reviewed on 9/23/25 at 11:32 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 8/26/25, indicated the resident had a diagnosis of Schizophrenia (a chronic brain disorder that affects how a person thinks, feels, and behaves, often involving hallucinations, delusions, and disorganized thinking). The option to code a diagnosis of psychotic disorder, other than schizophrenia, was not indicated. Diagnoses on the resident's profile included, but were not limited to, psychotic disorder (a state where a person loses contact with reality) with delusions due to a known physiological condition. The profile lacked documentation the resident had a diagnosis of Schizophrenia. A psychiatric progress note, dated 10/16/24, indicated the resident had a diagnosis of psychotic disorder but lacked documentation of a Schizophrenia diagnosis. During an interview, on 9/23/25 at 2:07 p.m., the Regional Clinical Consultant indicated the resident did not have a diagnosis of schizophrenia, and the MDS assessment was coded incorrectly. The facility used the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) manual for coding guidance. The CMS RAI Version 3.0 Manual, last revised in October 2024, indicated, .Section I: Active Diagnoses.Active Diagnoses in the Last 7 Days. ACTIVE DIAGNOSES Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. 4. On 9/23/2025 10:24 AM reviewed the medical record of Resident 145. The resident was admitted to the facility on [DATE]. admission diagnosis included but was not limited to, osteomyelitis (infection in the bone), non-pressure chronic ulcer of other part of left foot (a persistent, non-healing open sore that is caused by an underlying medical condition), and open wound of left great toe with damaged (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toenail. A physician order, dated 9/15/25, indicated to cleanse wound with wound cleanser, pat dry, apply betadine to area on left great toe, and cover with small border gauze daily and as needed for soilage and dislodgement once a day. A quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was mildly cognitively impaired and required assistance from the staff for care needs. The MDS indicated the resident had a dressing to foot. The MDS lacked documentation of a non-pressure wound. On 9/18/25 at 3:22 p.m., the Director of Nursing (DNS) provided a document titled, Resident Assessment, dated 9/15/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Guideline.7. If data is conflicting, appears in error or requires further clarification, Minimum Data Set Coordinator (MDSC) will verify with the resident, resident representative, licensed and non-licensed staff, and or physician to ensure data is accurate.15. The Assessment Coordinator will be responsible for ensuring that all required resident assessments are completed and submitted in accordance with current federal and state guidelines outlined in the RAI manual.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, record review, and interview, the facility failed to ensure interventions were initiated after falls for 1 of 2 residents reviewed for falls (Resident 16). B. Based on observation, interview, and record review, the facility failed to ensure safe transport residents on the facility bus for 4 of 4 residents reviewed for accidents (Residents 132, 76, 145, and 65). Findings include:A. On 9/22/25 at 11:53 a.m., Resident 16 was observed lying in bed. The resident had a bariatric (wide) bed with borders on the mattress and the head and the foot with a gap in the middle of the mattress. There were non-skid strips on the floor at the head and foot of the bed, however there were no non-skid strips in the center area, where the gap in the mattress borders was located. A body pillow was on a table. On 9/22/25 at 11:58 a.m., the Regional Clinical Consultant observed Resident 16's room. At the same time, the Regional Clinical Consultant acknowledged the non-skid strips were missing in the middle area of the bed where the mattress border gapped. The resident's body pillow was on the table, but sometimes he refused it. Resident 16's record was reviewed on 9/22/25 at 10:42 a.m. Diagnoses on the resident's profile included, but were not limited to, blindness in right eye, mild cognitive impairment of unknown etiology, and fracture of the neck of an unspecified femur (thigh bone). A quarterly Minimum Data Set (MDS) assessment, dated 8/26/25, indicated the resident was cognitively intact and required substantial/maximal assistance from staff for transfers. A fall event, dated 4/15/25, indicated the resident fell out of bed, and the fall was unwitnessed. The area to select a new intervention to prevent further falls was left blank. A progress note, dated 4/15/25, indicated the resident had on and off confusion and was talking like drunk. The resident fell out of bed and appeared to be confused. The resident refused to be sent to the hospital and said he was faking all of his confusion. The note lacked documentation of a root cause analysis or new intervention put in place to prevent further falls. A fall event, dated 4/17/25, indicated the resident fell out of bed, and the fall was unwitnessed. The area to select a new intervention to prevent further falls was left blank. A progress note, dated 4/17/25, indicated the resident had an unwitnessed fall with no physical injuries. The resident was observed to be confused, disoriented, and combative with staff with a continued decline in status. The resident's altered mental status persisted but he continued to refuse hospitalization. The note lacked documentation of a root cause analysis or new intervention put in place to prevent further falls. A fall event, dated 5/8/25, indicated the resident fell out of bed, and the fall was unwitnessed. The area to select a new intervention to prevent further falls was left blank. A progress note, dated 5/8/25, indicated the resident was found on the floor on the right side of the bed. The fall was unwitnessed. The resident appeared to be at his baseline level of confusion and thought he was getting off the truck. The note lacked documentation of a root cause analysis or an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervention to prevent further falls. A progress note, dated 5/9/25, indicated the resident had continuously climbed out of bed. The resident's bed was moved against the wall. An interdisciplinary team (IDT) note, dated 5/9/25, indicated the resident had a witnessed fall out of bed on 5/8/25, and experienced baseline confusion. The intervention was to place the resident's bed against the wall. The note did not address the prior documentation which indicated the fall was unwitnessed. A fall event, dated 5/14/25, indicated the resident fell out of bed, and the fall was unwitnessed. The resident complained of right hip pain and was sent to the emergency room (ER). The area to select a new intervention to prevent further falls was left blank. A progress note, dated 5/14/25, indicated the staff heard the resident yelling from his room. The staff found the resident on the floor next to his bed. The resident's right leg was rotated outward, 911 was called, and the resident was transported to the hospital for further evaluation. An IDT note, dated 5/20/25, indicated the resident had a recent fall on 5/14/25. The resident was found on the floor after attempting a self-transfer. The resident was sent to the ER for further evaluation of injuries. Non-skid strips were placed on the floor. Census information indicated the resident was hospitalized from [DATE] to 5/22/25. A fall event, dated 6/22/25, indicated the resident fell out of bed, and the fall was unwitnessed. The area to select a new intervention to prevent further falls was left blank. An IDT note, dated 6/23/25, indicated the resident had a recent fall when he attempted to get out of bed. The resident turned himself around in bed and fell off the side. A bariatric bed was provided to give the resident more room in bed. A fall IDT note, dated 6/26/25, indicated a Certified Nurse Aide (CNA) walked past the resident's door, and the resident slid off the bed into a sitting position. The root cause was the resident needed to use the restroom and failed to use the call light. The immediate intervention was to educate the resident on the use of the call light and educate the CNA on to monitor closely. The note lacked documentation of the efficacy of the education considering the resident's prior noted confusion. The resident's events lacked documentation of a fall event which corresponded to a fall on 6/26/25. An IDT note, dated 6/27/25, indicated the resident had a prior fall in which he sat on the edge of the bed and slid off onto the floor. The staff witnessed the fall, and he did not hit his head. The intervention was to encourage the resident to get out of bed and sit in a chair if he wanted to sit up. A fall event, dated 8/11/25, indicated the resident slid out of bed, and the fall was witnessed. The new intervention was a fall mat next to the bed. A progress note, dated 8/11/25, indicated the resident slid off the end of the bed and sat on buttocks on the floor. The note indicated they requested bed to be fixed, unable, switched out a diff [different] bed. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A fall event, dated 8/24/25, indicated the resident fell out of bed, and the fall was witnessed. The intervention was to move the resident's urinal closer to his reach. A progress note, dated 8/24/25, indicated the resident rolled to the right side of the bed and attempted to get his urinal that was hung on the trash can. The resident rolled too far and slid down the bed. It was too late for staff to catch him. The resident landed on his buttocks and hit his right knee on the wheelchair which caused a small cut to the right knee. The call light was placed within reach, and the resident was reeducated to hit the call light for help if he needed assistance. The note lacked documentation of why the resident would hit the call light if staff was already in the room or the efficacy of education considering the resident's prior noted confusion. An IDT note, dated 8/25/25, indicated the resident had a fall when he leaned out of bed to reach the urinal hanging on the trash can. The urinal was moved within reach. A new intervention was enablers to assist with bed mobility. An IDT note, dated 8/29/25, indicated the IDT reviewed the resident's fall interventions and resolved those which were no longer appropriate. The current interventions were reviewed by the IDT. A fall event, dated 9/13/25, indicated the resident was found on the floor next to his bed. The intervention was to get the resident up in the wheelchair when agitated. A progress note, dated 9/13/25, indicated the resident was found sitting on the floor with his legs extended out and the incontinence brief halfway down his legs. The resident stated, I was fishing. An IDT note, dated 9/15/25, indicated the resident had a fall when he believed he was fishing and rolled out of bed. The root cause was the resident being unaware of his boundaries in bed. The intervention was to place a body pillow on the right side of the bed to assist with bed boundaries. Progress notes, dated 9/15/25 to 9/22/25, lacked documentation the resident refused the body pillow. A current care plan indicated the resident was at risk for fall related injury related to right eye blindness, left eye low vision, balance issues, medications, and poor judgement. Interventions included, but were not limited to, body pillow to the right side of the bed to assist with bed boundaries, bed mobility devices as needed/ordered, resident prefers the urinal within reach, encourage the resident to get out of bed and sit in the chair if wanting to sit up, bariatric bed with bolsters, non-skid strips to the floor, bed against the wall on the left side per the resident's preference, call light within reach, and keep the resident's personal items within reach and instruct the resident where items are related to poor vision initiated on 12/24/23. During an interview, on 9/22/25 at 1:52 p.m., the Regional Clinical Consultant indicated there was no IDT note or interventions put in place for the resident's falls on 4/15/25 and 4/17/25 They completed a fall audit in August 2025, after they discovered issues with the fall program. The resident's fall interventions needed to be re-evaluated, and it was possible he did not need the non-skid strips anymore. The resident refused the body pillow at times, but the refusals should have been documented. On 9/22/25 at 2:22 p.m., the Regional Clinical Consultant provided a document titled, Falls, last revised on 1/31/25, and indicated it was the policy currently being used by the facility. The policy (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, .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. The care plan will be reviewed following each fall.3. Care Plan goals and interventions will be revised as applicable, with each review.5. Falls may be reviewed at the facility Quality Assurance/Performance Improvement [QAPI] Committee. B. During a random observation, on 9/16/25 at 12:45 p.m., the facility bus was observed backing out of the south parking area at an accelerated rate. When the bus had pulled from the parking area, it accelerated down the facility driveway quickly. During a random observation, on 9/19/25 at 12:23 p.m., the facility bus was observed backing out of the south parking area at an accelerated rate. When the bus had pulled from the parking area, it accelerated down the facility driveway quickly. During a random observation, on 9/22/25 at 12:16 p.m., the facility bus was observed to fail to stop at the stop sign at the end of the facility driveway onto the municipal street. a. During an interview, on 9/22/25 at 2:09 p.m., Resident 132 indicated that the facility bus driver had made her feel unsafe at times when she was on the bus. She would sometimes feel that she was jolted back and forth when the driver took off and/or stopped. She had never been hurt when on the bus but had felt unsafe at times. Resident 132's record was reviewed on 9/23/25 at 1:37 p.m. An annual Minimum Data Set (MDS) assessment, dated 7/7/25, indicated the resident had no cognitive deficit and used a motorized wheelchair for ambulation (the act of moving from place to place, either independently or with the use of assistive devices like wheelchairs, walkers, or canes). b. During an interview, on 9/22/25 at 2:11 p.m., Resident 76 indicated the bus driver would sometimes take corners so sharp that he had been tossed back and forth when on the bus. He had never been injured as a result but had not always felt safe. Resident 76's record was reviewed on 9/23/25 at 1:47 p.m. An admission Minimum Data Set (MDS) assessment, dated 7/2/25, indicated the resident had no cognitive deficit and used a manual wheelchair for ambulation (the act of moving from place to place, either independently or with the use of assistive devices like wheelchairs, walkers, or canes). c. On 9/17/25 at 2:16 p.m., during initial observation and interview Resident 145 indicated he would not ride with the bus driver because he drove too fast and he was afraid of getting hurt. On 8/17/25 at 3:00 p.m., the medical record of Resident 145 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but were not limited to, lack of coordination, abnormalities of gait and mobility. A quarterly Minimum Data Set (MDS) assessment, dated 8/19/25, indicated the resident required assistance with daily care needs and was mildly cognitively impaired. d. On 9/17/25 at 2:00 p.m., during an interview Resident 65 indicated he was afraid while riding in the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility transfer bus. He indicated the bus driver drove too fast and once when he was being transported he was afraid he was going to fall out of his wheelchair. He indicated he put out his arm to prevent another resident from falling over at the same time. On 9/17/25 at 3:30 p.m., the medical record of Resident 65 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but were not limited to, acquired absence of right leg below knee, and acquired absence of left leg below knee. A care plan, dated 9/2/25, indicated the resident was at risk for falls and fall related injuries. Interventions included but were not limited to provide a reacher, and call light within reach. The care plan lacked documentation of fall prevention when in wheelchair related to balance issues due to amputation of bilateral lower legs. A quarterly Minimum Data Set (MDS) assessment, dated 8/14/24, indicated the resident was dependent upon the staff for transfers and mobility assistance and was cognitively intact. On 9/23/25 at 1:00 p.m., during an interview the Administrator indicated the facility bus driver should be utilizing safe driving practices at all times when transporting residents. On 9/23/25 at 1:47 p.m., the Director of Nursing (DON) provided a document, titled, Transportation Policy, dated 1/31/25, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy.3. Any staff using facility owned motor vehicle, first must meet criteria for safe driving. 3.1-45(a) 3.1-45(a)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was notified of high blood sugars for 1 of 5 residents reviewed for unnecessary medications (Resident 6). Findings include:On 9/17/25 at 11:04 a.m., during an initial observation and interview, Resident 6 indicated he had elevated blood sugar (BS) levels due to infections and repeated urinary tract infections. On 9/22/25 at 2:30 p.m., during an interview, the Director of Nursing (DNS) indicated prior to 8/24/25 the parameter for notification for Resident 6 was to notify the physician of a BS over 400. She provided a copy of the physician order, dated 10/30/23, indicating to notify the physician of BS over 400. The DON acknowledged the order had not been brought forward under the physician's orders. The DON acknowledged a BS reading above 400 or a BS reading of HI should be reported to the physician immediately. The article, Diabetes, dated 5/15/24, was retrieved on 9/22/25 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/diabetes/diabetes-testing/monitoring-blood-sugar.html. The guidance included: .The following recommended ranges are for most people with diabetes who aren't pregnant. Your target range may be different based on your age, health status and diabetes management plan.Before meals: 80 to 130 mg/dL.After meals (1-2 hours later): Below 180 mg/dL. On 9/22/25 at 10:00 a.m., the medical record of Resident 6 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included, but was not limited to, cerebral infarction (when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), paraplegia (paralysis that occurs in the lower half of the body), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). Review of the resident's glucose blood sugar (BS) levels indicated on 7/23/25 the BS was 506, on 8/2/25 the BS was 401, on 8/19/25 the BS was 406, 8/24/25 BS was 442, and on 9/14/25 the BS was recorded as HI (an indication the reading was above the maximum readings of the glucometer device). The record indicated the resident's BS varied daily and were most often greater than 200. The physician progress notes on 4/7/25, 5/19/25, 6/4/25, 6/16/25, 7/28/25, and 7/21/25 lacked documentation that the physician reviewed or addressed the elevated BS levels of Resident 6. A physician order, dated 8/24/25, indicated to administer Humalog KwikPen Insulin (insulin lispro) insulin pen administer subcutaneous (under the skin) four times a day; 100 unit/mL (milliliter) per sliding scale. If Blood Sugar was 400 to 449, give 12 Units. If Blood Sugar was 450 to 499, give 14 Units. If Blood Sugar was 500 to 549, give 16 Units. If Blood Sugar was 550 to 599, give 18 Units. If Blood Sugar was greater than 600, call MD. A care plan, dated 8/31/25, indicated Resident 6 had a diagnosis of diabetes and was at risk for unstable blood glucose. Interventions included but were not limited to, notify Medical Doctor with significant changes in signs and symptoms. Observe for/report signs and symptoms of hyperglycemia (elevated blood sugar): increased thirst, headaches, blurred vision, increased urination, fatigue, weight loss, blood sugars greater than 180. A physician order, dated 9/19/25, indicated to administer insulin Aspart U-100 insulin pen administer subcutaneous four times a day; 100 unit/mL (3 mL) per sliding scale. If Blood Sugar was 400 to 449, give 12 Units. If Blood Sugar was 450 to 499, give 14 Units. If Blood Sugar was 500 to 549, give 16 Units. If Blood Sugar was 550 to 599, give 18 Units. If Blood Sugar was greater than 600, call MD. On 9/22/25 at 11:25 a.m., during an interview, the facility Medical Director indicated the staff should notify him of BS levels above 400 and the facility was working to improve communication with the physician and the facility. He indicated he did not recall if he was notified of elevated BS levels of Resident 6 and it may have been that the staff did not document calling him and reporting the elevated levels. On 9/22/25 at 2:00 p.m., during an interview, the Medical Director indicated he reviewed his notes, and he did not receive a call regarding (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's elevated BS levels and he had reviewed the resident's blood sugars on 9/22/25 and would make medication adjustments. On 9/23/25 at 2:15 p.m., during an interview Registered Nurse (RN) 21 indicated, if a BS is over 400 she would notify the physician immediately. She indicated the glucose monitor will reach a level of 600. If the BS is over 600 the glucose monitor will indicate a reading of HI. On 9/22/25 at 3:04 p.m., the DON provided a document, titled, Notification of Change of Condition, dated 9/13/23, and indicated it was the policy currently being used by the facility. The policy indicated, .The facility must inform, consult with the resident's physician.b. A significant change in the resident's physical, mental, or psychosocial status. c. A need to alter treatment significantly. 3.1-5(a)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to monitor for side effects for residents who received antipsychotic medications for 3 of 5 residents reviewed for unnecessary medications (Resident 8, 5, and 99). The deficient practice was corrected on 8/8/25, prior to the start of the survey, and was therefore past noncompliance Findings include: 1. Resident 8's record was reviewed on 9/18/25 at 11:48 a.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, bipolar disorder (mental health condition causing extreme shifts in mood, energy, and activity levels, characterized by periods of mania and depression) unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 8/20/25, indicated the resident had a moderate cognitive impairment and received an antipsychotic (treats psychosis) medication during the look-back period. An admission observation, dated 2/22/25, indicated the resident had not received an antipsychotic medication, and an Abnormal Involuntary Movement Scale (AIMS) was not completed. A physician's order, dated 2/22/25 and discontinued on 4/9/25, indicated to administer Rexulti (antipsychotic) 2 milligrams (mg) by mouth daily. A care plan, initiated on 2/26/25, indicated the resident was at risk for side effects related to psychotropic medications used to treat bipolar disorder. Interventions included, but were not limited to, observe for any drug related signs or symptoms such as abnormal involuntary movements. A physician's order, dated 4/9/25 and discontinued on 4/23/25, indicated to administer Rexulti 2 mg by mouth daily. A physician's order, dated 4/23/25 and discontinued on 6/18/25, indicated to administer Rexulti 2 mg by mouth daily for bipolar disorder. A physician's order, dated 6/24/25, indicated to administer Rexulti 2 mg by mouth daily for bipolar disorder. An AIMS, dated 8/8/25, indicated the resident did not have abnormal movements. The resident's record lacked documentation an AIMS was completed prior to 8/8/25. During an interview, on 9/19/25 at 10:32 a.m., the Regional Clinical Consultant indicated AIMS should have been completed for residents on antipsychotic medications at admission, with changes/new orders, and every six months. Resident 8's was missed at admission when the admitting nurse did not know Rexulti was an antipsychotic medication. When they completed an audit on antipsychotic medications in August 2025, they realized the AIMS had not been completed and it was rectified at that time. 2. On 9/19/25 at 10:16a.m., the medical record of Resident 5 was reviewed. The resident was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE]. admission diagnosis included but not limited to, depression (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), 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), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A physician order, dated 12/13/24 and 4/17/25, indicated to administer amitriptyline 100 mg (milligram) tablet orally for depression once a day. A care plan, dated 10/28/25, indicated psychotropic drug use. Interventions included, but were not limited to, observe for any drug related signs and symptoms such as hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL decline, decrease in appetite, and abnormal involuntary movements. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 8/8/25. The record lacked documentation of AIMS assessment prior to 8/8/25. During an interview, on 9/19/25 at 10:32 a.m., the Regional Clinical Consultant indicated AIMS should have been completed for residents on antipsychotic medications at admission, with changes/new orders, and every six months. When they completed an audit on antipsychotic medications in August 2025, they realized the AIMS had not been completed and it was rectified at that time. 3. On 9/18/25 at 1:47 p.m., the medical record of Resident 99 was reviewed. The record indicated the resident had been admitted and discharged five times since first admission on [DATE]. The record indicated the most recent admission was on 7/6/25. admission diagnosis included, but was not limited to, depression (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), and 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 physician order, dated 7/24/25, indicated to administer quetiapine 150 milligrams (mg) orally once a day for dementia. A care plan, dated 7/24/25, indicated psychotropic drug use. Interventions included, but not limited to, observe for any drug related signs and symptoms such as hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL decline, decrease in appetite, and abnormal involuntary movements. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 2/12/25. The record lacked documentation of AIMS assessment after most recent admission. During an interview, on 9/19/25 at 10:32 a.m., the Regional Clinical Consultant indicated AIMS should have been completed for residents on antipsychotic medications at admission, with changes/new orders, and every six months. When they completed an audit on antipsychotic medications in August 2025, they realized the AIMS had not been completed and it was rectified at that time. On 9/19/25 at 3:20 p.m., the Director of Nursing (DON) provided a document titled, Monitoring for Tardive Dyskinesia, dated 10/24/24, and indicated it was the policy currently being used by the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. The policy indicated, .The facility will maintain an ongoing process to monitor residents receiving psychotropic medications for adverse consequences.Residents will be monitored on an ongoing basis, at regular intervals and with any change in condition or medication. The deficient practice was corrected by 8/8/25 after the facility implemented a systemic plan that included the following actions: auditing resident records for antipsychotic medications, educating staff, and continued monitoring of resident antipsychotic medications. 3.1-3(w)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pharmacy review of resident medications were completed quarterly and failed to ensure the physician was notified of recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident 5). Findings include:On 9/19/25 at 10:16 a.m., the medical record of Resident 5 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included, but not limited to, depression (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), 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), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). On 5/12/25 a pharmacy recommendation suggested the following labs for medication monitoring: Magnesium level. The medical record lacked documentation of a magnesium level lab being completed or notification to the Physician. On 9/19/25 at 9:45 a.m., during an interview, the Director of Nursing (DON) indicated the lab recommendation for magnesium level had not been completed. Physician orders, dated 12/13/24 and 4/17/25, indicated to administer amitriptyline tablet; 100 mg (milligrams) orally for depression. On 5/15/25 a recommendation was entered by the mental health provider indicating, to consider a trial GDR (gradual dose reduction) of amitriptyline to 75 mg every evening. The medical record lacked documentation of physician notification. On 9/23/25 at 1:47 p.m., the DON provided a document titled, Medication Monitoring, Medication Regimen and Reporting, dated 01/24, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures.2. The consultant Pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medication each resident receives are clinically indicated.8.Recommendations should be acted upon within 30 calendar days or per facility protocols. 3.1-25(h)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 3 of 6 residents (Resident 26, 3, and 152) observed during the medication pass. There were 27 opportunities for error observed with 3 medication errors, resulting in a medication error rate of 11.1 percent. Findings include:1. On 9/18/25 at 9:24 a.m., Registered Nurse (RN) 7 prepared and administered medication to Resident 26. The medication included propranolol (treats high blood pressure) 10 milligrams (mg) 1 tablet by mouth. Resident 26's record was reviewed on 9/22/25 at 10:04 a.m. Diagnoses on the resident's profile included, but were not limited to, essential, primary hypertension (high blood pressure). A physician's order, dated 8/28/25 and discontinued on 9/15/25, indicated propranolol 20 mg, give 1 tablet by mouth twice daily for coronary artery disease. A physician's order, dated 9/15/25, indicated propranolol 10 mg, give 2 tablets by mouth twice daily coronary artery disease. On 9/19/25 at 10:25 a.m., the Regional Clinical Consultant provided a document titled, Medication Administration General Guidelines, dated January 2025, and indicated it was the policy currently being used by the facility. The policy indicated, .Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber.If necessary, the nurse contacts the prescriber for clarification. 2. On 9/19/25 at 11:13 a.m., Registered Nurse (RN) 15 checked Resident 3's accu check, and it was 254 milligrams (mg)/deciliter (dL). RN 15 administered insulin lispro (rapid acting insulin) 6 units (u) via insulin pen subcutaneously (SQ). The insulin pen was not primed prior to the administration. Staff obtained and served Resident 3's lunch tray on 9/19/25 at 11:53 a.m., 40 minutes after the rapid acting insulin was administered. Resident 3's record was reviewed on 9/22/25 at 10:21 a.m. Diagnoses on the resident's profile included, but were not limited to, type two diabetes mellitus without complications. A physician's order, dated 8/11/25, indicated insulin lispro before meals and at bedtime per sliding scale (scaled dosing based on the accu check results). The sliding scale indicated if the resident's accu check was between 250 mg/dL and 299 mg/dL, administer 6 u of insulin lispro. 3. On 9/19/25 at 11:30 a.m., RN 15 checked Resident 152's accu check, and it was 196. RN 15 administered insulin lispro 8 u via insulin pen SQ. The insulin pen was not primed prior to the administration. Staff obtained and served Resident 152's lunch tray on 9/19/25 at 11:52 a.m., 22 minutes after the rapid acting insulin was administered. Resident 152's record was reviewed on 9/22/25 at 10:25 a.m. Diagnoses on the resident's profile included, but were not limited to, type two diabetes mellitus without complications. A physician's order, dated 9/10/25, indicated insulin lispro, administer 7 u SQ before meals for diabetes mellitus. A physician's order, dated 9/10/25, indicated insulin lispro before meals and at bedtime per sliding scale. The sliding scale indicated if the resident's accu check was between 150 mg/dL and 199 mg/dL, administer 1 u of insulin lispro. During an interview, on 9/19/25 at 11:37 a.m., RN 15 indicated she did not think she had to prime insulin pens before administration of insulin. During an interview, on 9/19/25 at 3:25 p.m., the Regional Clinical Consultant indicated meals should have been served within 15 minutes of the administration of rapid acting insulin. The insulin lispro pen was required to be primed before each insulin administration. On 9/19/25 at 3:25 p.m., the Regional Clinical Consultant provided a document titled, Instructions For Use Insulin Lispro Kwikpen, last revised July 2023, and indicated it was the policy currently being used by the facility. The policy indicated, .Preparing your Pen.Priming your Pen: Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and ?0' is seen in the Dose Window.You should see insulin in the tip of the Needle. On 9/23/25 at 2:45 p.m., the Regional Clinical Consultant provided a document titled, Insulin Lispro: Package Insert/Prescribing (continued on next page)

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	155426	A. Building B. Wing	09/23/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Info, last revised on 12/15/24. The policy indicated, .Insulin Lispro starts acting fast. Inject Insulin Lispro 15 minutes before or right after you eat a meal. 3.1-48(c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during direct patient care services for 3 of 3 random resident observations. (Residents 1,102, and 8). B. Based on observation, record review, and interview, the facility failed to ensure a urinary catheter (a flexible tube inserted into the bladder to drain urine) tubing was kept off the floor for 1 of 2 reviewed for catheter use (Resident 14). Findings include:A1. On 9/23/25 at 11:57 a.m., observed Registered Nurse (RN) 10 washing her hands. The RN turned off the faucet with her bare hand and then dried her hands on a paper towel. The nurse then donned (put on) gloves and picked up the glucometer device from the resident's dresser. On 9/23/25 at 11:59 a.m., observed RN 10 lay glucometer device (a small, portable device that measures the amount of glucose (sugar) in your blood) on the bed of Resident 1. After completing the procedure, she laid the glucometer on the resident's dresser. On 9/23/25 at 11:59 a.m., RN 10 changed her gloves, picked up the glucometer, and placed it on the bed of Resident 102. The RN obtained the blood glucose reading and returned the glucose monitor to the medication cart. On 9/23/25 at 12:05 p.m., during an interview RN 10 indicated she did not ever place a barrier between the resident's bed, table or dresser and she indicated she cleaned the glucometer with an alcohol wipe after she was finished with both glucose tests. She opened the medication cart drawer and indicated she had bleach wipes to use sometimes, but she usually used the alcohol wipes to clean the glucometer device. RN 10 acknowledged she did not sanitize the glucometer between residents, and she placed the glucometer on the residents' beds without a barrier. On 9/23/25 at 12:10 p.m., during an interview the DON indicated she had an issue with RN 10 prior to this, and she had been educated before regarding glucometers and infection control. She indicated there were no residents currently on the South hall with infectious disease. She acknowledged the staff were to disinfect glucometers between residents with approved bleach wipes only and the staff should follow all infection control practices. On 9/23/25 at 12:15 p.m., the medical record of Resident 1 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but not limited to, osteomyelitis (an infection in the bone), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A physician order, dated 7/1/25, indicated administer insulin lispro solution; 100 unit/mL (milliliter) per sliding scale, before meals. A2. On 9/23/25 at 12:30 p.m., the medical record of Resident 102 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but not limited to, congestive heart failure(CHF) (a condition that develops when your heart doesn't pump enough blood for your body's needs), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). A physician order, dated 8/21/25, indicated to administer Lispro insulin pen; 100 unit/mL; amt: per sliding scale before meals and at bedtime. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A3. On 9/19/25 at 11:08 a.m., Registered Nurse (RN) 15 was observed completing Resident 3's accu check (blood sugar level). RN 15 applied gloves and placed the glucometer (checks blood sugar) and supplies on a barrier on the resident's bedside table. RN 15 used both gloved hands and cleaned the resident's fingertip. RN 15 then obtained a glucometer strip from the communal container of strips and placed it in the glucometer. RN 15 did not change gloves or perform hand hygiene after touching the resident, before touching a communal item. After obtaining the resident's accu check, RN 15 placed the glucometer strips back into the medication cart without cleaning it. During an interview, on 9/23/25 at 1:48 p.m., the Regional Nurse Consultant indicated staff should not have touched the glucometer strip container with the same gloves they touched the resident with. On 9/23/25 at 1:47 p.m., the Regional Nurse Consultant provided an undated document titled, Cleaning and Disinfecting Procedures for the Meter, and indicated it was the policy currently being used by the facility. The policy indicated, .The.Meter should be cleaned and disinfected between each patient.The following products have been approved for cleaning and disinfecting the.Meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach.Medline Micro-Kill Disinfecting, Deodorizing, Cleaning Wipes with Alcohol.Clorox Healthcare Bleach Germicidal and Disinfectant Wipes.Medline Micro-Kill Bleach Germicidal Wipes. On 9/23/25 at 2:07 p.m., the Regional Nurse Consultant provided a document titled, Glucometer Cleaning and Disinfecting, last revised on 1/24/24, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose Statement: To minimize the risk of transmitting blood-borne pathogens, cleaning and disinfection procedure should be performed.Guidelines: 1. Licensed staff will follow the manufacturer guidelines and recommendations for the cleaning and disinfection of the glucose monitor. On 9/23/25 at 3:00 p.m., the Regional Nurse Consultant provided a document titled, Finger Stick Blood Glucose Monitoring Competency, dated 7/19/25, and indicated it was the policy currently being used by the facility. The policy indicated, .Performs hand hygiene and dons gloves.Selects appropriate finger and cleans with alcohol swab; allows to air dry. Uses lancet to puncture side of fingertip.Ensures adequate blood sample is applied to strip for accurate reading. Applies gauze to site with gentle pressure to stop bleeding. Reads and records results.Disposes of used supplies and sharps in proper containers. Clean/disinfect glucometer per guidelines. Performs hand hygiene and removes gloves. B. On 9/17/25 at 10:30 a.m., Resident 14 was resting in bed and her Foley catheter (indwelling catheter, inserted into the bladder to drain urine) tubing was in contact with the floor mat that was located on the floor next to her bed. On 9/17/25 at 11:39 a.m., Resident 14 was asleep in bed, and her catheter tubing was in contact with the floor. On 9/17/25 at 1:33 p.m., Resident 14 was resting in bed, and her catheter tubing was in contact with her floor mat next to her bed. On 9/18/25 at 8:35 a.m., Resident 14 was asleep in bed, and her catheter tubing was in contact with her floor mat next to her bed. On 9/18/25 at 1:13 p.m., Resident 14 was asleep in bed, and her catheter tubing was contact with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor underneath her bed. Resident 14's record was reviewed on 9/18/25 at 8:28 a.m. The profile indicated the resident's diagnoses included, but were not limited to, neuromuscular dysfunction of bladder (occurs when damage to the brain, spinal cord, or nerves disrupts the signals between bladder and the brain, leading to problems with bladder control) and urinary retention (difficulty urinating and completely emptying the bladder). A quarterly Minimum Data Set (MDS) assessment, dated 8/22/25, indicated the resident had severe cognitive impairment and had an indwelling catheter. A physician's order, dated 8/7/25, indicated to anchor a Foley catheter size 16 Fr (French) (diameter of catheter tubing) 10cc (cubic centimeter) balloon to straight drainage. A physician's order, dated 6/22/25, indicated change catheter if leaking, blockage, or dislodgement occurs as needed. A physician's order, dated 6126/25, indicated Foley catheter care every shift. A physician's order, dated 6/12/25, indicated urinary output every shift. During an interview, on 9/18/25 at 2:33 p.m., Qualified Medication Aide (QMA) 8 indicated the catheter tubing should not touch the floor, floor mat, and/or any other surface. During an interview, on 9/18/25 at 2:39 p.m., Regional Clinical Consultant indicated catheter tubing should not touch the floor. On 12/15/23 at 10:50 a.m., the DON provided a document, with a date of 1/31/25, titled, Foley Catheter Use, and indicated it was the current policy being used by the facility. The policy indicated, .To ensure that the use of indwelling urinary Foley catheters is medically justified, managed safely, and aligned with CMS requirements to minimize complications, maintain resident dignity, prevent infections 3.1-18(b)(1) 3.1-18(l)