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	03/06/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** A. Based on record review and interview, the facility failed to notify responsible party of changes of condition and physician notifications for 1 of 32 residents reviewed for notification (Resident Q). B. Based on record review and interview, the facility failed to ensure a physician was notified when medications were unavailable to administer as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident L). Findings include:A. On 3/02/26 at 12:47 p.m., during a phone interview Resident Q's daughter indicated she and her sister were durable power of attorney (POA) with healthcare and neither of them had been notified of changes in their mother's condition, medication changes, or of an incident when the resident had fallen in her room. On 3/3/26 at 10:00 a.m., the medical record of Resident Q was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease with late onset (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) 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 care plan, dated 10/11/22, indicated Resident Q had impaired cognition related to diagnosis of dementia as evidenced by short term and long term memory impairments and needs for daily cues and reminders. Interventions included, but were not limited to, discuss concerns about confusion, disease process, and nursing home placement with responsible party. Review of the medical record indicated on 9/25/25 diagnostic testing results were reviewed. The record lacked documentation of notification to the responsible party. A quarterly Minimum Data Set (MDS) assessment, dated 12/29/25, indicated the resident had severe cognitive impairment and required assistance with daily care needs. On 11/29/25, STAT (immediate) labs were ordered related to change in condition and increased complaints of pain. The record indicated the lab was unable to send a technician to the facility to draw blood. The record lacked notification to the physician indicating the labs could not be obtained and/or notification that the resident refused to go to the hospital for labs. In addition, the record lacked documentation of notification of the responsible party. On 1/20/26, the medical record indicated a medication change had been ordered. The record lacked documentation of notification of the responsible party. On 1/22/26, the medical record indicated STAT labs were ordered. The record lacked documentation of notification of the responsible party. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/26, the medical record indicated new orders were obtained. The record lacked documentation of notification of the responsible party. On 2/10/26, the medical record indicated the resident fell in her room next to her bed. The nurse documented the resident was her own person and the resident was notified. The record lacked documentation of notification of the responsible party. On 2/10/26, diagnostic lab testing report was obtained. The record lacked documentation of notification of the responsible party. On 2/11/26, the record indicated orders were obtained for lab diagnostic testing and discontinuation of medication. The record lacked documentation of notification of the responsible party. On 2/17/26, the medical record indicated abnormal lab tests were returned, and the resident was notified of the report. The record lacked documentation of notification of the responsible party. On 3/3/26 at 1:00 p.m., during an interview, the Social Services Director indicated the resident's family had not complained about notifications. On 3/6/26 at 8:50 a.m., during an interview, Registered Nurse (RN) 9 indicated she would notify the responsible party of any changes in a resident's condition including labs and medication changes. She indicated if a resident was cognitively impaired she would not consider them their own person and would notify the responsible party of changes. On 3/6/26 at 9:00 a.m., during an interview RN 8 indicated she would notify the family or responsible party of any changes in condition within the day. She indicated if the resident was cognitively impaired she would notify the responsible party of any changes including labs and medication changes. On 3/6/26 at 10:10 a.m., during an interview, the Director of Nursing (DON) indicated if there was a change in condition and the resident was cognitively impaired the family or responsible party should be notified. On 3/6/26 at 2:00 p.m., the Administrator provided a document titled, Notification of Change if Condition, dated7/7/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Guidelines.2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3. The resident and or representative (if applicable), and medical provider should be notified of a change in condition. B. Resident L's record was reviewed on 3/3/26 at 2:47 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems) and personal history of other venous thrombosis and embolism (indicates a past occurrence of blood clots in veins, excluding, or in addition to, standard deep vein thrombosis (DVT) or pulmonary embolism [blood clot in your lung that creates blockage]). Facility census information indicated that the resident was admitted to the facility on [DATE]. A significant change in status Minimum Data Set (MDS) assessment, dated 2/9/26, indicated the (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was cognitively intact and received anti-coagulant (blood thinner) and antibiotic medications. The resident also received oxygen therapy. A care plan, dated 2/26/26, indicated the resident had impaired gas exchange related to COPD. Interventions included but were not limited to, medications/nebulizers/puffers as ordered, and notify doctor of changes as needed. A care plan, dated 2/21/26, indicated the resident had a diagnosis of HTN (hypertension- elevated blood pressure), CAD (coronary artery disease – plaque build up that reduces blood flow) and history of MI (myocardial infarction- heart attack). Interventions included but were not limited to, administer anti-coagulants as ordered. A physician order, dated 2/13/26, indicated to administer azithromycin (antibiotic medication) 250 milligrams (mg), 2 tablets by mouth in the evening for 1 day, then administer 1 tablet by mouth for 4 days for COPD. Review of February 2026 MAR (Medication Administration Record) indicated on 2/13/26 the 500 mg dose of azithromycin was unavailable and not stocked in cart. The record lacked documentation that the nurse administered the antibiotic on 2/13/26. The record lacked documentation that the resident ever received the 500 mg dose of azithromycin as ordered. Resident L's record lacked documentation of the physician being notified of the azithromycin medication being unavailable and therefore was not administered. A physician order, dated 1/30/26, indicated to administer Xarelto (blood thinner medication) 20 mg, one tablet by mouth daily for personal history of other venous thrombosis or embolism. Review of February 2026 MAR indicated on 2/18/26 and 2/27/26 the 20 mg dose of Xarelto was unavailable to administer. The record lacked documentation that the nurse administered the blood thinner on 2/18 or 2/27/26. Resident L's record lacked documentation of the physician being notified of the Xarelto medication being unavailable and therefore was not administered. During an interview on 3/4/26 at 11:02 a.m., the Clinical Consultant indicated azithromycin was available in the EDK (emergency drug kit). She was unaware if the azithromycin was empty on 2/13/26 in the EDK and if that was why the nurse didn't administer the medication. The physician should have been notified that the medications were not available and if he or she would want to substitute the medication for something else or wait for the dose to come in from the pharmacy. During an interview, on 3/4/26 at 11:48 a.m., the Clinical Consultant indicated the nurse should have administered the 500 mg of azithromycin as soon as it came in from the pharmacy. She was unable to provide documentation that the antibiotic was administered as ordered by the physician or that the physician was notified that the medication was never given. On 3/4/26 at 11:49 a.m., the Clinical Consultant provided a document, dated 01/23, titled, Non-Controlled Medication Orders, and indicated it was the current policy being used by the facility. The policy indicated, .4. The prescriber shall be contacted by nursing for direction when delivery of a medication will be delayed or the medication is not available. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Intake 2740716. 410 IAC (Indiana Administrative Code) 16.2-3.1-5(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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure critical abnormal lab results were reported to the physician in a timely manner for 1 of 2 residents reviewed for labs (Resident D) and failed to obtain STAT (immediate) labs for 1 of 2 residents reviewed for labs (Resident Q). Findings include:1. On 3/5/26 at 1:00 p.m., the medical record of Resident D was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and hypertension (high blood pressure). The most recent quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was cognitively impaired and required maximum assistance from the staff for daily care needs. The most recent hospital stay was on 6/28/25. The resident was sent to the emergency department, related to critical lab of low hemoglobin (it indicates how well your blood carries oxygen throughout the body. Low levels usually indicate anemia). The resident returned to the facility after the hemoglobin level had adjusted to non-critical levels. On 7/3/25 blood was drawn for diagnostic labs. At 2:30 p.m., the critical lab values were reported to the facility. The record lacked documentation of notification to the physician of critical abnormal labs. On 3/6/26 at 10:10 a.m., during an interview the Director of Nursing (DON) indicated if there was a change in a resident's condition or abnormal labs it should be reported to the physician. On 3/6/26 at 2:00 p.m., the Administrator provided a document titled, Notification of Change if Condition, dated7/7/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Guidelines.2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3. The resident and or representative (if applicable), and medical provider should be notified of a change in condition. 2. On 3/3/26 at 10:00 a.m., the medical record of Resident Q was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Alzheimer's disease with late onset (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) 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 care plan, dated 10/11/22, indicated Resident Q had impaired cognition related to diagnosis of dementia as evidenced by short term and long term memory impairments and needs for daily cues and reminders. Interventions included, but were not limited to, discuss concerns about confusion, disease process, and nursing home placement with responsible party. A quarterly Minimum Data Set (MDS) assessment, dated 12/29/25, indicated the resident had severe cognitive impairment and required assistance with daily care needs. On 11/29/25, STAT (immediate) labs were ordered related to change in condition and increased complaints of pain. The record indicated the lab was unable to send a technician to the facility to draw blood. The record lacked notification to the physician indicating the labs could not be obtained and/or notification that the resident refused to go to the hospital for labs. In addition, the record lacked documentation of notification of the responsible party. On 1/22/26, the medical record indicated STAT labs were ordered. The record lacked documentation of notification of the physician that the labs were not obtained. On 3/6/26 at 8:50 a.m., during an interview, Registered Nurse (RN) 9 indicated she would notify the responsible party of any changes in a resident's condition including labs and medication changes. She indicated if a resident was cognitively impaired she would not consider them their own person and would notify the responsible party of changes. On 3/6/26 at 9:00 a.m., during an interview RN 8 indicated she would notify the family or responsible party of any changes in condition within the day. She indicated if the resident was cognitively impaired she would notify the responsible party of any changes including labs and medication changes. On 3/6/26 at 10:10 a.m., during an interview, the (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) indicated the Nurse Practitioner (NP) was notified of Resident Q's refusal to go to the hospital to have labs drawn. She indicated if the facility had an order to draw labs the facility nurse would draw them. The DON acknowledged the facility had obtained an order to draw blood for diagnostic testing. The order did not specify the lab technician was the assigned person to obtain lab specimen. Documentation of the NP's notification was not provided. On 3/6/26 at 2:00 p.m., the Administrator provided a document titled, Notification of Change if Condition, dated7/7/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Guidelines.2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3. The resident and or representative (if applicable), and medical provider should be notified of a change in condition. This citation relates to Intake 2691760. 410 Indiana Administrative Code (IAC) 16.2-3.1-49(f)(2).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview, observation, and record review, the facility failed to ensure a resident's preference for his meals was met for 1 of 32 residents reviewed for food and food preferences (Resident J). Findings include:During the initial pool interview, on 3/2/26 at 3:30 p.m., Resident J indicated he had requested more food with his meals, but they had not been giving him bigger portions. He had requested this quite a while back, but they still just gave him the regular small amounts. He got hungry in between his meals. During the lunch meal observation, on 3/5/26 at 12:06 p.m., Resident J's lunch tray was observed. Double portions were not observed, in the resident's meal tray, when compared to a regular portion meal tray. Observation of the resident's meal ticket lacked documentation that double portions were to be served. At the same time, the Dietary Manager observed the order as written in the resident's diet orders. She indicated she needed to check the resident's diet orders as they presented in the kitchen. Resident J's record was reviewed on 3/5/26 at 1:50 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a progressive, long-term lung disease that makes it hard to breathe by limiting airflow) and unspecified dementia (a diagnosis for significant memory, thinking, and functional decline where doctors cannot yet determine the specific cause or there is not enough information to classify it). A quarterly Minimum Data Set (MDS) assessment, dated 1/23/26, indicated the resident had moderate cognitive deficit and required set-up assistance with eating. A care plan, dated 7/9/24, indicated the resident was at risk of malnutrition. Interventions included, but were not limited to, meals as ordered by the physician. A physician's order, dated 1/26/26, indicated to provide the resident a regular diet with double portions, per the resident's request. During an interview, on 3/5/26 at 1:31 p.m., the Dietary Manager indicated the resident's meal ticket indicated 4 HLF which meant 4 halves. She indicated that meant the resident received double portions. Regular portion lunch tickets all indicated 2 HLF which meant two halves. At the same time, she provided a copy of the resident's new meal ticket, which she had updated after the conversation on 3/5/26 at 12:06 p.m. The updated meal ticket now indicated Double Portion, at the bottom of the ticket. She indicated the meal that was provided at today's lunch meal was a resident choice meal. The tickets for the resident choice meals did not include any special deviation in portion sizes. All were served as regular portions. During an interview, on 3/6/26 at 9:33 a.m., [NAME] 10 indicated she did not know what the 2 HLF and 4 HLF meant on the lunch tickets. If a resident was to get double portions, it would be written on the meal ticket. During an interview, on 3/6/26 at 9:40 a.m., [NAME] 11 indicated she did not know what 2 HLF and 4 HLF stood for on lunch tickets. During an interview, on 3/6/26 at 10:56 a.m., the Registered Dietician indicated there was an issue with the meal tickets not being clear when indicating the portion sizes and when a special resident choice meal was prepared. The resident's meal ticket did not indicate double portions. On 3/6/26 at 11:00 a.m., the Administrator provided a document, with a revised date of 1/31/25, titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .All residents will be treated in a manner and in an environment that promotes.enhancement of quality of life.the stakeholders will respect the resident's individuality and value their input.through self-determination. This citation relates to intake 2713018. 410 Indiana Administrative Code (IAC) 16.2-3.1-20(a)