

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2024
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP COD 3500 MAPLE AVE TERRE HAUTE, IN 47804
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00438294, IN00439201, and IN00439657.</p> <p>Complaint IN00438294 - Federal/State deficiencies related to the allegations are cited at F742.</p> <p>Complaint IN00439201 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00439657 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 26, 29, 30, and 31, 2024</p> <p>Facility number: 000513 Provider number: 155426 AIM number: 100275360</p> <p>Census Bed Type: SNF/NF: 141 Total: 141</p> <p>Census Payor Type: Medicare: 16 Medicaid: 99 Other: 26 Total: 141</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 9, 2024.</p>	F 0000		
F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychosocial Concerns			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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	<p>Based on record review and interview, the facility failed to provide personalized care and interventions for a resident (Resident F) with the diagnoses of schizophrenia (serious mental health condition that affects how people think, feel and behave) and behaviors for 1 of 5 residents reviewed for behavior management which resulted in Resident F having resident to resident altercations with 4 cognitively impaired residents residing on the same locked unit (Residents B, G, H, and J).</p> <p>Findings include:</p> <p>During the survey a document titled, "All About Me," undated, was observed in Resident F's room. The document described the resident's likes and dislikes, such as her favorite hobbies, food, movies, snacks, etc. Her dislikes included when people touched her without letting her know and when people tried to make her eat when she didn't want to eat.</p> <p>The clinical record for Resident F was reviewed on 7/30/24 at 1:43 p.m. Resident F was 43 years old and resided in the facility's secured behavioral unit. Diagnoses included, but were not limited to, schizophrenia, behaviors, cerebral palsy, mild cognitive impairment, developmental disorder of speech and language, blindness in the left eye, and normal vision in the right eye.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/6/24, indicated the resident had a moderate cognitive impairment with no behaviors noted during the 7-day look back assessment period.</p> <p>An Indiana Department of Health (IDOH) facility</p>	F 0742	<p>Requesting a IDR as facility does not feel that criteria is met for psychological harm of chronic or recurrent fear and anxiety. Residents have all resided on locked memory care unit and receive person centered care based on each one's specific needs. No harm was evidenced at time of occurrence or since incidents.</p> <p>Deficiency ID: F742 Treatment/Services Mental/Psychosocial Concerns Date of Compliance: 08/19/24 Plan of Correction 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practices. a. Resident F is currently residing in a behavioral health facility. Upon return will remain one on one until discharge. b. Resident B has received psychosocial follow-up relating to the incident with resident F and care plan has been updated. c. Resident G has received psychosocial follow-up relating to the incident with resident F and care plan has been updated. d. Resident H has received psychosocial follow-up relating to the incident with resident F and care plan has been updated. e. Resident J has received psychosocial follow-up relating to the incident with resident F and</p>	08/19/2024

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	<p>reported incident record (FRI), dated 6/17/24 at 9:01 p.m., submitted by the facility indicated Resident F made physical "contact" with Resident B. Both residents resided on a secure unit. Resident B had diagnoses, including but not limited to, severe dementia, frontotemporal neurocognitive disorder, and Alzheimer's disease. Both residents were assessed and there were no injuries.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported 6/17/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 6/29/24 at 6:10 p.m., submitted by the facility indicated Resident F tossed a two handled cup into the air. The cup landed on Resident G's left shoulder. Resident G tossed the cup back to Resident F and the cup struck Resident F above the eyebrow causing a laceration on Resident F's left temple. Resident G had diagnoses, including but not limited to, vascular dementia, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 6/29/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/6/24 at 6:50 p.m.,</p>		<p>care plan has been updated.</p> <p>2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken:</p> <p>a. Residents with dementia residing on the memory care unit have the potential to be affected by alleged deficient practice.</p> <p>b. The care plans of residents with dementia residing on the memory care unit were updated to include behavioral interventions as needed.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Facility staff will be re-educated on the existing facility's policy of "Abuse, Neglect and Misappropriation of Property, Nursing staff will be educated on behavior management and will be completed by the DON or designee.</p> <p>b. IDT will review behaviors daily, Monday - Friday during clinical meeting for completed documentation of interventions to prevent resident to resident altercations.</p> <p>c. SCC to re-educate facility leadership on implementation and adding interventions to care plans to prevent resident to resident altercations. Leadership staff included in training – CEO, DON, ADONs, Unit Manager, MDS, and</p>	

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	<p>submitted by the facility indicated Resident B was walking into the dining room and Resident F reached out and touched Resident B's legs. Staff tried to intervene and redirect residents from touching each other. Resident B fell to the ground. The residents were immediately separated and redirected by staff. Resident B had diagnoses, including but not limited to, severe dementia, frontotemporal neurocognitive disorder, and Alzheimer's disease. Both residents were assessed and there were no injuries.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/6/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/8/24 at 4:30 p.m., submitted by the facility indicated Resident G was sitting in a chair in the day room. Resident F came over to Resident G and began raising fists up and down hitting Resident G's chair and arms. Resident G had diagnoses, including but not limited to, vascular dementia, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>A behavioral care plan, dated 7/9/24, indicated Resident F was involved in a resident-to-resident altercation with the interventions of head-to-toe assessment, report to regulatory entities, and separate residents immediately with the target goal, dated 8/2/24, of the resident would not have any adverse effects from the incident. The plan lacked documentation of interventions to prevent</p>		<p>SS.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>a. CEO/designee will conduct weekly audits of 5 residents for 4 weeks, 4 residents for 4 weeks, 3 residents for 4 weeks, then 5 residents monthly times 3 months to ensure residents that reside on the memory care unit have completed documentation of interventions to prevent resident to resident altercations.</p> <p>b. Audit results will be submitted to the CEO/designee for review by the Quality Assurance Performance Improvement Committee monthly for 3 months, or until the QAPI committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.</p>	

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	<p>further events.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/9/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>A behavioral care plan, dated 7/11/23 and revised on 7/17/24, indicated the resident was at risk and active behavior problems, such as: smacking self, accusatory actions, attention seeking, physical aggression such as biting/grabbing at others, disrobing in public spaces, urinating on the floor, sitting/lying on the floor, refusal of care, such as medications, showers and meals, and yelling out. Interventions on the care plan, included but were not limited to, assist resident away from other residents, observe for triggers of inappropriate behaviors and alter environment as needed, and observe for unmet needs such as toileting, rest, food, fluids, companionship, etc. The long-term care plan goal, target dated 8/7/24, indicated the resident's behaviors will not result in disruption of others environment.</p> <p>An IDOH FRI report, dated 7/18/24 at 3:15 p.m., submitted by the facility indicated Resident F pushed her hand against Resident J's shoulder causing Resident J to fall to the floor on her left side. Resident J's diagnoses, included but were not limited to, dementia, cognitive communication deficit, hearing loss, and seizures. Both residents were assessed and had no injury.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/18/29/24. The facility's investigation of the</p>			

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	<p>event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/20/24 at 7:23 p.m., submitted by the facility indicated Resident F tossed a dinner tray at Resident G. Resident G was assessed with a 1.5 centimeter (cm) by 1.5 cm pink area above the right eyebrow. Resident G had diagnoses, including but not limited to, vascular dementia, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side, and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>A behavioral care plan, dated 7/20/24, indicated Resident F was involved in a resident-to-resident altercation with the interventions of notify family, notify physician, and separate residents immediately with the target goal, dated 8/2/24, of the resident would not have any adverse effects from the incident. The care plan lacked documentation of interventions implemented to prevent further events after the incident reported on 7/20/24.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/20/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>An IDOH FRI report, dated 7/26/24 at 11:57 p.m., submitted by the facility indicated Resident F went to Resident H's room, as Resident H was asleep in bed. Resident F began to hit Resident H with an open hand waking Resident H. Staff removed Resident F from Resident H's room and</p>			

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	<p>another staff stayed in the room with Resident H. Resident H had diagnoses, including but not limited to, vascular dementia, Parkinson's disease, cognitive communication deficit, and depression. Both residents were assessed and had no injuries.</p> <p>Resident F's electronic record lacked additional documentation of interventions implemented to prevent further events after the incident reported on 7/26/24. The facility's investigation of the event lacked documentation of interventions implemented to prevent further events.</p> <p>Resident F's electronic medical record lacked documentation to implement person-centered, individualized care to prevent Resident F from physically making "contact" with or throwing items at other residents.</p> <p>On 7/29/24 at 11:18 a.m., Qualified Medication Aide (QMA) indicated staff tried to redirect Resident F if she went into another resident's room or got too close to another resident.</p> <p>On 7/30/24 at 8:57 a.m., the Director of Nursing (DON) indicated Resident F had multiple behaviors and the staff's immediate intervention for Resident F was to get the residents separated, check them out from head to toe, and notify the physician, Administrator (ADM), and family of the incident. They tell the family there was an altercation with another resident and the facility was investigating. Resident F was 43 years old and was inappropriate for the facility. She was diagnosed with dementia (a group of thinking and social symptoms that interfered with daily functioning), but the DON did not believe Resident F had dementia, but the resident did have an intellectual cognitive disability deficit. Staff tried to keep her away from the other</p>			

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	<p>residents with diversional activities, but she was harming the older female residents on the unit.</p> <p>On 7/31/24 at 9:34 a.m., ADM provided documentation of Resident F's 30-day Notice of Transfer or Discharge, dated 7/30/24, and indicated she had mailed the 30-day Notice of Transfer or Discharge to the resident's mother. The notice indicated the reason for the transfer or discharge was due to the safety of the individuals in the facility were endangered. The ADM indicated she and the Social Services Director (SSD) had a care plan meeting with Resident F's mother a couple of weeks ago and told her that Resident F was not appropriate for the facility, due to her interactions with the other residents and she was younger and stronger than the other residents.</p> <p>The ADM, on 7/26/24 at 10:45 a.m., provided and identified a document as a current facility policy titled, "Abuse, Neglect, and Misappropriation of Property," dated 5/27/16 and revised on 9/15/23. The policy indicated, "...It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident in the facility...."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2024  
FORM APPROVED  
OMB NO. 0938-039

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	This citation relates to Complaint IN00438294.  3.1-43(a)(1)				