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	12/10/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to development and implement a baseline care plan for 1 of 3 residents reviewed for admission. (Resident B)Findings include:A clinical record review for Resident B was completed on 12/9/25 at 10:29 a.m. Diagnoses included chronic obstructive respiratory disease (COPD), need for assistance with personal care, diabetes mellitus II, atrial fibrillation, end-stage renal disease requiring dialysis, altered mental status, and history of stroke. The resident admitted to the facility on [DATE] at 3:51 a.m., following an acute care hospital stay. The clinical record lacked a nursing admission assessment and development of a baseline care plan until the afternoon on 3/17/25. During an interview on 12/10/25 at 9:46 a.m., the Director of Nursing (DON) indicated she had not found documentation regarding Resident B's admission in the clinical record. The resident's baseline care plan was not completed in a timely manner. There had been no documented physical assessment, skin assessment, baseline care plan or catheter assessment. The staff should document an admission assessment and baseline care plan in the clinical record.A current facility policy, revised 9/15/23, titled, Baseline Care Plan Policy, provided by the Corporate Nurse Consultant on 12/10/25 at 11:21 a.m., included the following: Policy Statement A Baseline Care plan is developed and implemented to promote continuity of care and communication among facility stakeholders to increase resident safety and safeguard against adverse events that are most likely to occur right after admission. Guidelines: 1. The Baseline Care Plan will be developed and implemented within 48 hours of a resident's admission .This citation is in regard to Intake 2641934.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a newly admitted resident had quality of care when staff failed to complete a nursing admission assessment, wound assessments, and admission orders for two respiratory medications and a urinary catheter for 1 of 3 residents reviewed for admission. (Resident B) Findings include: A clinical record review for Resident B was completed on 12/9/25 at 10:29 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), need for assistance with personal care, diabetes mellitus II, atrial fibrillation, end-stage renal disease requiring dialysis, altered mental status, and history of stroke. The resident admitted to the facility on [DATE] at 3:51 a.m., following an acute care hospital stay. The clinical record lacked a nursing admission assessment including vital signs, skin assessment, and catheter assessment. A review of the resident's progress notes lacked nursing documentation regarding the resident's arrival to the facility. The record lacked a nursing progress note being entered until 3/16/25 at 5:02 p.m. A review of the resident's vital signs record lacked documentation of a blood pressure, heart rate, or oxygen saturation level until 3/17/25, two days following admission. A review of the resident's medication orders lacked the following medications as being ordered on admission: albuterol-ipratropium (a common prescription rescue medication used to treat or prevent wheezing and difficulty breathing caused by lung conditions like asthma and COPD) inhalation aerosol, 1 puff four times a day as needed; and budesonide (a steroid medication to treat asthma and COPD) 0.5 mg (milligram) per 2 ml (milliliter) inhalation suspension, four times a day as needed. These medications were not ordered until 3/17/25 in the afternoon. A review of the resident's electronic treatment administration record lacked orders for catheter care until 3/19/25. A Skin and Wound progress note, dated 3/17/25, indicated the resident was being evaluated as a new admission to the facility for a skin/wound assessment. The reported included, Skin and wound assessment completed. Pt is noted to have multiple pressure injuries and arterial ulcers of 2nd and 4th R [right] foot, 2nd toe L [left] foot, PI [pressure injury] of L buttock, coccyx, and L gluteal fold, L and R heels. A progress note, dated 3/19/25 at 6:46 a.m., indicated the resident was sent to an acute care hospital due to shortness of breath, wheezing, congested lung sounds, and cough with elevated blood pressure and heart rate. He was admitted to the hospital with shortness of breath. During an interview on 12/10/25 at 9:46 a.m., the Director of Nursing (DON) indicated she had not found documentation regarding Resident B's admission in the clinical record. There had been no documented physical assessment, skin assessment, catheter assessment or baseline care plan completed. The staff should document arrival and a nursing admission assessment in the clinical record. A current facility policy, revised 10/31/25, titled, Admissions to the Facility, provided by the Corporate Nurse Consultant on 12/10/25 at 11:21 a.m., included the following: .Procedure: 1. Prior to or at the time of admission, the resident's Physician must provide the facility with information needed for immediate care of he resident, including orders cover, but not limited to, the following: routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan. This citation relates to Intake 2641934. 3.1-37(a)