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 _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF TERRE HAUTE	3500 MAPLE AVE TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00455678, IN00456099, IN00456232, IN00457701, and IN00457983.

Complaint IN00455678 - No deficiencies related to the allegations are cited.

Complaint IN00456099 - No deficiencies related to the allegations are cited.

Complaint IN00456232 - No deficiencies related to the allegations are cited.

Complaint IN00457701 - No deficiencies related to the allegations are cited.

Complaint IN00457983 - No deficiencies related to the allegations are cited.

Survey dates: April 23, 24, and 25, 2025

Facility number: 000513
Provider number: 155426
AIM number: 100275360

Census Bed Type:
SNF/NF: 157
Total: 157

Census Payor Type:
Medicare: 12
Medicaid: 134
Other: 11
Total: 157

Signature Healthcare of Terre Haute was found to be in compliance with 42 CFR Part 483, Subpart

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 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.

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 _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF TERRE HAUTE	**3500 MAPLE AVE TERRE HAUTE, IN 47804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00IN00455678, IN00456099, IN00456232, IN00457701, and IN00457983. Quality review completed on May 1, 2025.	F 000		