PRINTED: 12/10/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  TO SERVICES  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155474		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIEI JRE HEALTHCARE		316 W	ADDRESS, CITY, STATE, ZIP COD DODIES LANE EN, IN 46506	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	IN00445742.  Complaint IN0044: related to the allegal and F755.  Unrelated deficience Survey dates: October 2024  Facility number: 00 Provider number: 1 AIM number: 1002  Census Bed Type: SNF/NF: 61  Total: 61  Census Payor Type Medicare: 2  Medicaid: 37  Other: 22  Total: 61  These deficiencies accordance with 41	per 30, 31 and November 1,  00506 55474 62530 :	F 0000		
F 0557 SS=D Bldg. 00	Based on observation review, the facility	Right to have Prsnl Property on, interview and record failed to provide a continent stance for toileting that	F 0557	F557 It is the intent of Signatur Healthcare at Bremen to treat everyone with dignity and resp	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE

Linda Lewis Administrator 11/27/2024

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

Event ID: 4R3Q11 Facility ID: If continuation sheet

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155474	B. W	ING		11/01/	2024
				CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
SIGNATI	JRE HEALTHCARI	E OE RREMEN			EN, IN 46506		
SIGNATO	JAL HEALTHUARI	L OI DIVLIVIEN	•	DIVEINE	-iv, iiv 40000		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ntinence episode for 1 of 1			· what corrective action(s) will		
	residents reviewed	for toileting. (Resident C)			accomplished for those reside		
					found to have been affected b	-	
	Finding includes:				deficient practice; Resident C		
	, , , , , , , , , , , , , , , , , , ,	10/20/2024 : 12.22			longer resides at the facility.		
	1	tion, on 10/30/2024 at 12:20			adverse effects were noted pr	or to	
	P.M., Resident C was in a small dining room				discharge.		
	sitting in a reclining chair. The resident asked				· how other residents having t		
	CNA 10, who walked by her, to take her to the				potential to be affected by the		
	bathroom. CNA 10 responded "I'll see what your				same deficient practice will be		
	aides are doing now."				identified and what corrective		
	At 12:21 P.M., the resident started to moan and				action(s) will be taken; An aud		
	stated "Please help!", while trying to reposition				was conducted of the residen		
	_				able to voice toileting needs in	ı ine	
		ning chair. Resident C was er right hand down numerous			facility for toileting needs no		
	I -	er right hand down numerous st of the chair while still			concerns identified.	ıto	
	moaning.	St of the chair willie still			· what measures will be put in		
	moaning.				place and what systemic char will be made to ensure that the	_	
	CNA 10 observed t	to entered the dining room and			deficient practice does not red		
		What's going on?", Resident C			The Director of Nursing (DON		
		go to the bathroom".			designee, will complete and a		
	1 sprica, i neca to g	, to the outhout .			of 5 residents per week to ens		
	CNA 10 indicated	"Well, we are about to eat".			that residents are toileted as	J. G. T. G.	
		ed, "I know but I have asked for			requested. Audit to occur wee	klv	
		bathroom and they say I can't			X 4 weeks, then every other v	-	
		IA 10 left the dining room			X 2 months, then monthly X 3		
		esident C to the bathroom.			months. Re-education of all		
		served trying to position			clinical staff by DON/Designe	е	
		ning chair and moaning.			timely toileting of residents to		
		-			include taking residents to the		
	CNA 10 returned to	o the dining room with Resident			bathroom during meal if reque		
	C's lunch tray and	sat down beside Resident C			· how the corrective action(s)	will	
	and was observed	to start feeding the resident.			be monitored to ensure the		
	The resident was st	till moaning.			deficient practice will not recu	r,	
					i.e., what quality assurance		
	After she had assisted Resident C with her meal,				program will be put into place	; As	
	1	ed Resident C out of the dining			a measure of ongoing complia		
	· ·	y the nurse's desk. Resident C			audit results will be submitted	to	
	was heard saying, '	'Please help me". Another staff			the campus administrator, or		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155474	B. W	'ING		11/01/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L .			OODIES LANE		
SIGNATU	JRE HEALTHCARE	OF BREMEN			N, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	and asked her what she			designee, for review by the Qu	uality	
		indicated she needed to go to			Assurance Performance		
		staff member said she would			Improvement Committee until		
		the resident indicated,"I want			substantial compliance is		
	to go to the ladies room-they just walk past me".				achieved. The QAPI committe		
					has the right to modify or exte	nd	
	_	on, on 10/30/2024 at 12:53			monitoring times according to		
		as in her room in the reclining			outcomes of audits.		
	-	saying she wanted to go home					
		o the bathroom. Resident C					
		vere wet. CNA 10 indicated, with the nurse first".					
	"we have to check"	with the nurse first".					
	During an observati	ion, on 10/30/2024 at 12:57					
	_	as in her reclining chair					
		ad not been assisted to the					
	bathroom.	ad not been assisted to the					
	outin oom.						
	During an observati	ion, on 10/30/2024 at 12:59					
	-	as placed in a hoyer					
		for transfers) lift and					
	transferred to her be	ed. Her brief was checked and					
	noted to be wet witl	n wetness observed extending					
	up towards the back	of the brief.					
	-	y, on 10/30/2024 at 1:10 P.M.,					
		a resident was saying they					
	_	bathroom, she would take					
	-	nterview, LPN 9 interupted and					
		C's family had requested she					
		air until after lunch. LPN 9 was					
		C had been in the dining room					
		quested to go to the bathroom					
		PN 9 just reiterated Resident C					
		chair until after the lunch					
	meal.						
	During an interview	y, on 10/30/2024 at 1:11 P.M.,					
	_	She (Resident C) usually is wet,					
		During the interview with					
	one is incomment.	Daring the interview with					

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	R MEDICARE & MEDIC						ORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155474	l í	JILDING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIEF			316 W	ADDRESS, CITY, STATE, ZIP C DODIES LANE EN, IN 46506	OD		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE HPPROPRIATE	(X5) COMPLETION DATE	
	desk and asked if R She was informed t in bed to check her Administrator aske been offered a bed not know. The nurs informed the reside when she was laid o indicated, "Why w when she was wet." the staff to put the r time. She indicated resident to her roon she had requested to  During an interview C.N.A 11 indicated about keeping the r after lunch.  A Bowel and Bladd 10/23/2024 to 10/2 a total of 5 incontin assessment time fra incontinent of her b  A current Care Plar on 10/24/2024, indi for complications a incontinence. Interv not limited to: obta peri care after incon changes in bladder output, foul smelling	strator approached the nurse's resident C had been toileted. The resident had been laid down for incontinence. The d LPN 9 if the resident had pan. LPN 9 indicated she did to and Administrator were not was not offered a bed pan down in bed. LPN 9 then could we offer the bed pan of the Administrator instructed resident on the bed pan at this they should have taken the not and offered a bed pan when to go to the bathroom  We on 10/30/2024 at 1:12 P.M., a she did not know anything resident up in her chair until the resident C had nent episodes during the time but was not always pladder.  In, dated 10/172024 and revised dicated the resident was at risk associated with urinary ventions included, but were in labs; provide assistance with notinence as needed; report any status to nurse-low urine; ag urine; discolored urine; Pain; Frequency; Urgency; and						

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On 11/1/2024 at 3:40 P.M., the Administrator provided the policy titled,"Resident Rights",

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155474	B. WING	<del></del>	11/01/2024
			<del></del>		
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
				OODIES LANE	
SIGNATU	JRE HEALTHCARE	OF BREMEN	BREMI	EN, IN 46506	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1710		revised on 9/15/2023, and	1710		DITTE
		was the one currently used			
		policy indicated "3. The			
		very effort to support each			
		ng his/her right to assure that			
		ys treated with respect,			
	kindness, and dignit	ty"			
	3.1-9(a)				
E 0500					
F 0580	483.10(g)(14)(i)-(i				
SS=D	Notify of Changes	(Injury/Decline/Room, etc.)			
Bldg. 00					
		view and interview, the facility	F 0580	F-580 It is the intent of Signat	ure 11/27/2024
	failed to notify the	physician of an elevated heart		Healthcare to provide notificat	ion
	rate and seizure acti	ivity and missed medications		when vital signs are out of nor	mal
	for 2 of 7 residents	reviewed for pharmaceuticals.		range to the responsible party	and
	(Resident N and E)			physician.	
				what corrective action(s) will	be
	Findings include:			accomplished for those reside	
				found to have been affected b	
	1. The record for Ro	esident N was reviewed on		deficient practice; Resident N	<b>'</b>
		5 A.M. Diagnoses included, but		physician notified of increased	, l
		unspecified dementia, anxiety,		pulse rate 11.3.2024 no new	
		nsion, diabetes mellitus, atrial		orders. Resident E physician a	and
		onic venous hypertension.		responsible party notified of	ariu
	normation and eme	onic venous hypertension.		missed medications and seizu	ıre
	Physician Orders fo	or Resident N, dated 1/2/2024,		activity, no new orders. Both	ii e
	-	nticoagulant) 2.5 mg		residents were assessed with	
					110
		et twice a day for atrial gular heart rhythm that begins in		adverse effects noted.	h -
	` `			· how other residents having t	
	the heart's upper cha	amoers or airia).		potential to be affected by the	
	A C P1	19/21/2024 : 1: 4 1		same deficient practice will be	
		n, reviewed 8/21/2024, indicated		identified and what corrective	,
		agnosis of atrial fibrillation.		action(s) will be taken; 7 days	ot
		led but were not limited to:		vital signs were audited to	
	-	ort heart palpitations, irregular		determine that notifications ar	
		cardia (a heart rate that is		assessments were completed	
	faster than a hundre	ed beats per minute), and	1	any out-of-range vital signs no	oted.

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notify physician with any significant changes.

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All residents with a change in

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
		, and the second			<u> </u>	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED	
		155474	B. WING		11/01/2024	
NAME OF 1	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
010114	UDE LIEAL TUOASS	- OF DDEMEN		OODIES LANE		
SIGNAT	URE HEALTHCARE	OF BREMEN	BREME	EN, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				condition were reviewed to ens		
		s Note, dated 10/22/2024 at		that notifications were complet	ed.	
	· ·	ted RN 1 assessed Resident N		7 days of medication		
	for anxiety and four	nd Resident N to have a heart		administration were reviewed t	o	
	rate of 211.			ensure that all medications we	re	
				administered as ordered with		
		s Note, dated 10/22/2024 at		notifications completed, if		
	10:20 A.M., indicat	ted Resident N's heart rate was		indicated. No adverse effects		
	now 176 bpm (beat	s per minute).		noted.		
				· what measures will be put int	0	
	A Nursing Progress Note, dated 10/22/2024 at			place and what systemic chan	ges	
	10:30 A.M., indicated Resident N had a heart rated			will be made to ensure that the	;	
	of 181 bpm.			deficient practice does not reci	ur;	
				The DON, or designee, will		
		s Note, dated 10/22/2024 at		complete an audit of 5 residen	ts	
	11:10 A.M., indicat	ted Resident N had a heart rate		with out-of-range vital signs, as	s	
	of 100 bpm.			available, for notifications. Aud	lit	
				will be conducted weekly X 4,	then	
	There was no docur	mentation the physician was		every other week X 2 months,	then	
	notified of Resident	t N's elevated heart rates.		monthly X 3 months. The DON	l, or	
				designee, will review 5 residen	ıts,	
	_	v, on 10/31/2024 at 2:20 P.M.,		as available, who have had a		
		nange in condition for a		change in condition to ensure	that	
		ut was not limited to: a change		notifications have been comple		
		f range blood sugars or		Audit will be completed weekly		
	deterioration in the	resident's physical		weeks, then every other week		
	assessment.			months, then monthly x3 mont		
				The DON, or designee, will aud	dit 5	
		v, on 10/31/2024 at 2:28 P.M.,		residents for medication		
		a resident had a change in		administration to ensure that a	ny	
	· ·	ng staff would notify the		missed administrations have		
		ctor of Nursing (DON) and the		documentation. Audit will be		
	resident's representa			completed weekly x4 weeks, the		
		for Resident E was completed		every other week x2 months, the		
		07 P.M. Diagnoses included,		monthly x3 months. Director of	f	
		d to: Lennox-Gastaut syndrome		Nursing/Designee provided		
		lepsy), severe intellectual		Re-education of the nurses		
		disorder and schizophreniform		completed for notification of vit	als	
	disorder, Resident I	E was admitted to the facility	1	signs at are out of range. Staff	· [	

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on 8/16/2024.

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able to pass medications

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155474	B. W	ING		11/01	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			OODIES LANE		
SIGNATI	JRE HEALTHCARI	E OF BREMEN			EN, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					educated on if medication		
		r Resident E was completed on			unavailable process and requ		
	10/30/2024 at 2:07 P.M. Diagnoses included, but				notifications by DON/Designe		
		: Lennox-Gastaut syndrome (a			Re-education of licensed nurs		
		elong form of epilepsy that			required notifications for char	_	
	starts in early childhood), severe intellectual				condition by the DON/designe		
	disabilities, autistic disorder, schizophreniform				· how the corrective action(s)	WIII	
	disorder, and epilepsy.				be monitored to ensure the		
	An Admission Minimum Data Set (MDS) assessment, dated 8/23/2024, indicated Resident E				deficient practice will not recu	ιг,	
					i.e., what quality assurance	·	
	had severe cognitive disability and received				program will be put into place		
	medications of an antipsychotic, antianxiety and				a measure of ongoing compli- audit results will be submitted		
	antidepressant.				the campus administrator, or	. 10	
	antidepressant.				designee, for review by the Q	uality	
	Physician Orders in	ncluded, but were not limited to:			Assurance Performance	danty	
		sizure medication) 20 milligrams			Improvement Committee until	I	
	·	8/29/2024, given in the morning			substantial compliance is	'	
	from 8/17/24-8/28/	-			achieved. The QAPI committee	ee .	
	-Fycompa (anti-sei	zure medication) 30 milliters			has the right to modify or exte	end	
		s at bedtime starting on 8/			monitoring times according to		
	817/2024.				outcomes of audits.		
	-Lamotrigine (anti-	epileptic medication) 200					
	milligrams 2 tabs t	wice daily starting 8/17/2024.					
	-Rufinamide (anti-	convulsant medication) 40					
	milligrams per mil	liliter 40 milliliters equals 1600mg					
	twice daily starting	§ 8/17/2024.					
	A review of the Au	gust the Medication					
		cord (MAR) indicated the					
		on had been missed when					
	signed out for Resi	dent E:					
	-Fycompa had miss	sed doses on 8/17/2024,					
	8/18/2024, 8/19/20	24, 8/23/2024, 8/25/2024,					
	8/26/2024, 8/28/20	24 and 8/31/2024.					
	A Nursing Progres	s Note, dated 8/20/2024 at 2:09					
		sident E had three noted					
	seizures and the se	izure activity was quickly					
	reversed using a m	agnet.					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155474	B. W	ING		11/01	/2024
NAME OF	PROVIDER OR SUPPLIEI	· }	•		ADDRESS, CITY, STATE, ZIP COD	-	
					OODIES LANE		
SIGNAT	URE HEALTHCARE	OF BREMEN		BREME	EN, IN 46506		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Muraina Progress	s Note, dated 8/22/2024 at 4:08					
		sident E had seizure activity					
	· ·	a stiffening phase, clonic: a					
		g phase) lasting less than one					
	minute twice during						
		s Note, dated 8/29/2024 at 5:58					
	P.M., indicated Resident E experienced a seizure, which lasted about 10 seconds. The magnet						
		thich reversed the seizure					
	activity immediatel						
	activity ininitediates	<i>y</i> .					
	A review of the Sep	otember MAR indicated the					
	following medication	on had been missed when					
	_	dent E: -Fycompa had missed					
		9/17/2024, 9/27/2024, 9/28/2024,					
	9/29/2024 and 9/30	/2024.					
	Δ Nursing Progress	s Note, dated 9/03/2024 at 8:46					
		If had observed a small seizure					
		me out of within seconds.					
	~ ~	s Note, dated 9/29/2024 at 9:26					
	· ·	pharmacy was contacted					
		E's medication, Fycompa,					
	1	ne pharmacist indicated the					
		rently out of stock. The					
	available 9/30/2024	ed the medication may be					
	available 7/30/2025	1 th 10.00 / 1.171.					
	A review of the Sep	otember MAR indicated the					
	_	on had been missed when					
		dent E:-Fycompa doses were					
		24, 10/13/2024, 10/18/2024,					
	10/19/2024, 10/21/	2024, 10/30/2024 and 10/31/2024.					
	A Niversia - Dur -	Note deted 10/05/2024 -4					
		s Note, dated 10/05/2024 at ed Resident E had multiple					
		s from 9:30 P.M. to 10:00 P.M.,					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155474	A. BUILDING B. WING	00	COMPLETED 11/01/2024	
		100474	_		1 1/0 1/2024	
NAME OF I	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD		
SIGNATI	JRE HEALTHCARE	OF BREMEN		EN, IN 46506		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION one minute and intervals of 2-3	TAG	DEFICIENCIT	DATE	
	minutes between se					
	A Nursing Progress	Note, dated 10/07/2024 at 6:00				
		NA had reported Resident E				
		possible seizure in the shower				
	room with symptoms of staring off and not answering questions.					
	answering questions.					
	A Nursing Progress Note, dated 10/22/2024 at 9:43 P.M., indicated Resident E was watching a movie					
	and had a seizure. The nurse applied the magnet					
	and Resident B responded well.  A Nursing Progress Note, dated 10/29/2024 at					
		Resident E was in the shower				
	·	ated, " his head was lying on				
		urned around and notice [sic]				
	he was having a sei	zure."				
	A Nursing Progress	s Note, dated 10/30/2024 at 3:15				
		sident E had a seizure with				
		lasted 15 seconds with no				
	adverse effects note	ed.				
	During an observat	ion, on 10/31/2024 at 8:33				
	_	vas observed having an active				
	seizure while in the	_				
	A Niversia - Du	Note detect 10/21/2024 -4 2:20				
		s Note, dated 10/31/2024 at 2:28 sident E was out of his				
	Fycompa and had n					
	)					
	A Nursing Progress	Note, dated 10/31/2024 at 2:43				
		sident E had a less than 15				
	second seizure.					
	A Nursing Progress	s Note, dated 11/01/2024 at 7:54				
		sident E had a short seizure				
		ssisting him with morning care.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4R3Q11 Facility ID: 000506

If continuation sheet Page 9 of 34

PRINTED: 12/10/2024

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155474	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/01/2024		
NAME OF 1	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD			
SIGNAT	URE HEALTHCARE	OF BREMEN	BREMEN, IN 46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	During an interview LPN 12 indicated s Resident B missing seizure activity.  A policy was provi on 11/1/2024 at 2:0 "Notification of Ch"To ensure approof changes in conditional inform the resident physician; and notification of there is: b. A signification of the alter treatment situation of the resident of notification or more corded in the resident and applicable], and menotified of a change	w, on 10/31/2024 at 2:11 P.M., the had not notified the MD of this doses of Fycompa or ded by the Executive Director, 19 P.M. The policy titled, ange of Condition", indicated, opriate individuals are notified tion1. The facility must the consult with the resident's fy consistent with his or her ent representative[s] when iteant change in the resident's resychosocial status. c. Needs gnificantly2. Documentation of tification attempts should be dent electronic medical record. For representative [if the edical provider should be deni condition. The medical de guidance related to the						
	3.1-5(a)(2)							
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Impleme	nt Comprehensive Care Plan						
J	interview, the facili	on, record review and ty failed to develop a care plan f 8 residents reviewed for ent E)	F 065	6	F-656 It is the intent of Signature Healthcare Bremen to develop Implement Comprehensive Carplan · what corrective action(s) will accomplished for those resides	and re be	11/27/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete

A record review for Resident E was completed on

10/30/2024 at 2:07 P.M. Diagnoses included, but

were not limited to: Lennox-Gastaut syndrome

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If continuation sheet

found to have been affected by the

deficient practice; Resident E care

plan was updated to include

seizures. No adverse effects

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
			ľ í		ſ '
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155474	B. WING		11/01/2024
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
CICNIATI		OF BDEMEN		DODIES LANE	
SIGNATU	JRE HEALTHCARE	OF BREWEN	BKEME	EN, IN 46506	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	(severe form of epil	epsy), severe intellectual		noted.	
	disabilities, autistic	disorder and schizophreniform		· how other residents having t	he
	disorder. Resident I	E was admitted to the facility		potential to be affected by the	
	on 8/16/2024.			same deficient practice will be	
				identified and what corrective	
	A record review for	Resident E was completed on		action(s) will be taken; An aud	lit of
	10/30/2024 at 2:07	P.M. Diagnoses included, but		all residents receiving seizure	
	were not limited to:	Lennox-Gastaut syndrome,		medications completed for car	re
	severe intellectual d	lisabilities, autistic disorder,		plan in place. No concerns no	ted.
	schizophreniform d	isorder, and epilepsy.		· what measures will be put in	to
				place and what systemic chan	iges
	An Admission Minimum Data Set (MDS)			will be made to ensure that the	e
	assessment, dated 8/23/2024, indicated Resident E			deficient practice does not rec	ur;
	had severe cognitive disability and received			MDS nurse education on care	
	medications of an antipsychotic, antianxiety and			plans for seizures completed.	The
	antidepressant. He l	nad an active diagnosis of		MDS coordinator, or designee	, will
	seizure disorder			complete an audit of new orde	ers
				for anti-seizure medications or	n 5
	Current Physician's	Orders for medications to treat		residents, as available, to ens	ure
	seizures included, b	out were not limited to:		care plan is in place. Audit will	lbe
	-Clobazam 20 milli	grams at bedtime starting		completed weekly x4 weeks, t	hen
	8/29/2024, given in	the morning from		every other week x2 months, t	then
	8/17/24-8/28/24.			monthly x3 months.	
	-Fycompa 30millite	ers equals15milligrams at		· how the corrective action(s)	will
	bedtime starting on	8/ 817/2024.		be monitored to ensure the	
	-Lamotrigine 200 m	nilligrams 2 tabs twice daily		deficient practice will not recui	r,
	starting 8/17/2024.			i.e., what quality assurance	
		ligrams per milliliter 40 milliliters		program will be put into place;	•
		ce daily starting 8/17/2024.		a measure of ongoing complia	ince,
	-Clonazepam 1mg t	three times a starting 8/16/2024.		audit results will be submitted	to
				the campus administrator, or	
		Note, dated 8/20/2024 at 2:09		designee, for review by the Qu	uality
		ident E had three noted		Assurance Performance	
	seizures and was qu	nickly reversed with the seizure		Improvement Committee until	
	using magnet.			substantial compliance is	
				achieved. The QAPI committe	е
	A Nursing Progress	Note, dated 8/22/2024 at 4:08		has the right to modify or exte	nd
	P.M., indicated Res	ident E had seizure activity		monitoring times according to	
	tonic-clonic lasting	less than 1 minute twice		outcomes of audits.	

FORM CMS-2567(02-99) Previous Versions Obsolete

during the shift.

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155474	B. WI	NG		11/01/	/2024
				CED DEET A	ADDRESS OF A STATE OF COR	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
CIONIATI		OF DDEMEN			OODIES LANE		
SIGNATO	JRE HEALTHCARE	OF BREWEN		BREINE	EN, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A Nursing Progress	Note, dated 8/29/2024 at 5:58					
	P.M., indicated Resident E experienced a seizure which lasted about 10 seconds. The magnet						
	bracelet was used which reversed seizure						
	immediately.						
	A Nursing Progress Note, dated 9/03/2024 at 8:46						
	P.M., indicated staff observed a small seizure that						
	the resident came or	ut of within seconds.					
		12 doses of clonazepam on					
	10/23/2024 based o	n the narcotic signature sheet.					
		Note, dated 10/05/2024 at					
		ed Resident E had multiple					
	-	s from 9:30 P.M. to 10:00 P.M.,					
		one minute and intervals of 2-3					
	minutes.						
		s Note, dated 10/05/2024 at					
		ed Resident E was seen at the					
		ift being closely monitored.					
		an active tonic seizures.					
		ponsive and oriented to people					
		and was to name nurses and					
	_	out ten minutes Resident E					
		to verbal and tactile stimuli					
	_	nkly in between an episode of					
		E was picked up from the EMS					
	(emergency medica	al services) around 10:20 P.M.					
	A Nijpaina Daaaa	Note dated 10/06/2024 at 5:27					
		Note, dated 10/06/2024 at 5:37 sident E was returned to the					
	facility at 1:34 A.M						
	iacinty at 1:34 A.M	i. 101 SCIZUICS.					
	A Nursing Progress	Note, dated 10/07/2024 at 6:00					
		NA witnessed during a shower					
		naving a seizure with symptoms					
	<u>-</u>	ot answering questions					

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Event ID:

4R3Q11 Facility ID: 000506

If continuation sheet Page 12 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED		
		155474	B. WING		11/01/2024
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
				OODIES LANE	
SIGNATU	JRE HEALTHCARE	OF BREWEN	BKEM	EN, IN 46506	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPR		ATE COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE
	A Nursing Progress	Note, dated 10/22/2024 at 9:43			
		ident E was watching a movie			
		The nurse applied the magnet			
	and Resident E resp	oonded well.			
	Δ Nursing Progress	Note, dated 10/29/2024 at			
		Resident E was in the shower			
	· ·	ated " his head was lying on			
		urned around and notice he			
	was having a seizur	e."			
	AN ' P N 14 14 110/20/2024 4 2 15				
	A Nursing Progress Note, dated 10/30/2024 at 3:15 P.M., indicated a seizure with minimal movement				
	· ·	vith no adverse effects noted.			
	100000 10 00001100				
	During an observati	ion, on 10/31/2024 at 8:33			
	_	itnessed an active seizure			
	while Resident E w	as in the television lounge.			
	A Murcing Progress	Note, dated 10/31/2024 at 2:43			
		ident E had a less than 15			
	second seizure.				
		Note, dated 11/01/2024 at 7:54			
		sident E had a short seizure			
	morning care.	CNA was assisting with			
	morning care.				
	There was no curren	nt care plan for seizures for			
	Resident E.				
	D · · · ·	11/1/2024			
	_	y, on 11/1/2024 at 12:27 P.M., etor indicated Resident E			
		zure medications without a			
	disruption in admin				
	1				
	A policy regarding	care plans was requested but			
	not received prior to	o the survey exit.			
			1		

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED	
		155474	B. WING		11/01/2024
	PROVIDER OR SUPPLIEF		316 W	ADDRESS, CITY, STATE, ZIP COD OODIES LANE EN, IN 46506	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	3.1-35(a)				
F 0677 SS=E Bldg. 00		ed for Dependent Residents	- 0.6		
	review, the facility provided for 8 of 17	on, interview and record failed to ensure showers were 7 residents reviewed for ADL's Living). (Residents H, J, L, C,	F 0677	F-677 It is the intent of Signature Healthcare of Bremen to provious the assistance as needed for a care.	de ADL
	Findings include:  1. The record review for Resident H was completed on 10/31/2024 at 10:34 A.M. Diagnosis included, but were not limited to dementia, anxiety, need for assistance with personal care slower street included.		what corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice; Residents H, J, L, N, M, and Q have all received a shower. Resident C no longer resides at the facility.	Р,	
	assessment, dated 8 resident was dependent Shower documenta 10/1/2024 thru 10/3 had only received a	the potential to be same deficient pridentified and who shower documentation for Resident H, dated  1.0/1/2024 thru 10/31/2024, indicated Resident H  the potential to be same deficient pridentified and who action(s) will be to completed and A		how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken: An audicompleted and All resident has received a shower.	the
	resident needed star mobility, transfers a During an interview the Director of Nur	n, dated 9/13/2024, indicated the ff assistance with bed and toileting.  v, on 11/1/2024 at 8:45 A.M., sing indicated the resident ed two showers a week.		what measures will be purinto place and what systemic changes will be made to ensuthat the deficient practice does recur; Re-education of the star provided by the DON/Designe completion of showers per resident preference, on documentation of showers	re s not ff
		iew, on 10/30/2024 at 11:41 dicated he did not always to times a week.		provided. The DON, or design will complete an audit of 5 residents for completion of	ee,

showers per preference and

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155474	B. W	ING		11/01	11/01/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIEF	8		316 W	OODIES LANE			
SIGNAT	URE HEALTHCARE	OF BREMEN		BREME	EN, IN 46506			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		Resident J was completed on			documentation. Audit will be			
	10/31/2024 at 10:16 A.M. Diagnoses included: Parkinson's disease, dementia, anxiety and neurogenic bladder.				completed weekly x4 weeks, t			
					every other week x2 months, t	nen		
	neurogenic biadder.	•			monthly x3 months.			
	A Ouarterly MDS a	assessment, dated 8/2/2024,			how the corrective action(	s)		
	indicated the resident had impairment to his upper and lower extremity on one side and was dependent on staff for toileting, showering and will be monitored to ensure deficient practice will not i.e., what quality assurant				will be monitored to ensure the			
					deficient practice will not recui			
					· · · · · · · · · · · · · · · · · · ·	,		
			program will be put into place;	As				
					a measure of ongoing complia			
	The shower documentation, dated 10/1/2024 thru 10/31/2024, indicated Resident J had only received				audit results will be submitted	to		
					the campus administrator, or			
	a shower on 10/5/20	024.			designee, for review by the Qu	uality		
					Assurance Performance			
	_	v, on 11/1/2024 at 8:45 A.M.,			Improvement Committee until			
		sing indicated the resident			substantial compliance is			
	should have receive	ed two showers a week.			achieved. The QAPI committe has the right to modify or exte			
	3. The record for Re	esident L was completed on			monitoring times according to			
		6 A.M. Diagnoses included, but			outcomes of audits.			
		Alzheimer's disease,						
	hypertension, depre	ession dementia and need for						
	assistance with pers	sonal care.						
	An Admission Min	imum Data Set (MDS)						
		/4/2024, indicated the resident						
		/maximum assists for						
	showering.							
	The shower docume	entation, dated 9/1/2024 thru						
	10/31/2024, indicat	ed Resident L only received						
	showers on the follo	owing dates:						
	- 9/92024							
	- 9/19/2024							
	- 9/29/2024 10/5/2024							
	1 10/5/2021						1	

- 10/24/2024

During an interview, on 11/1/24 at 8:16 A.M., the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	_ <del></del>		
		155474	B. WING		11/01/2024	
			STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		VOODIES LANE		
SIGNATI	JRE HEALTHCARE	OF RREMEN		MEN, IN 46506		
JIGNATO		- OI BILLIVILIN	DIXL	WEN, IN 40000		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1	g indicated the resident should				
		wo showers a week.4. During				
		10/30/2024 at 2:16 P.M.,				
		served with greasy hair with				
	the comb tracts visi	ble.				
	_	ion, on 10/31/2024 at 8:52				
		vas observed to be in the				
	1	nir combed back with comb				
	tracts visible. Her n	air was dirty and greasy.				
	During an observat	ion, on 11/1/2024 at 11:11				
	A.M., Resident C was observed in the dining					
	room. Her hair was greasy.					
	100m. Her han was	grousy.				
	A record review for	r Resident C was completed on				
		4 A.M. Diagnoses included, but				
		: Hemiplegia affecting the right				
		ebral infarction, schizophrenia,				
		d major depressive disorder.				
	A Quarterly Minim	um Data Set (MDS)				
	assessment, dated 1	0/8/2024, indicated Resident C				
	required substantial	l/maximal assistance with				
	showering and had	impairment of an upper and				
	lower extremity.					
		4/15/2024 and revised on				
		ted Resident C required				
		with activities of daily living				
		ed mobility, eating and toileting				
		plegia and multiple sclerosis				
	diagnosis.					
	Rathing documents	ation indicated Resident C only				
		n the following days:				
	10/3/2024 shower	ii the following days.				
	10/5/2024 shower 10/5/2024 complete	e hed hath				
	10/7/2024 complete 10/7/2024 shower	oca vani				
	10///2024 shower 10/11/2024 shower					
	10/11/2027 SHOWEL		1	i .		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4R3Q11 Facility ID: 000506

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155474	B. WI	ING		11/01	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			OODIES LANE		
SIGNATU	JRE HEALTHCARI	E OF BREMEN			EN, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	10/14/2024 shower						
	10/21/2024 shower						
		5. The record for Resident N					
		0/30/2024 at 11:45 A.M.					
	-	d, but were not limited to:					
	_	tia, anxiety, depression,					
		etes mellitus, atrial fibrillation					
	and chronic venous hypertension.						
	A current Care Plan, reviewed on 8/21/24,						
	indicated Resident N had a history of refusal of						
	care such as refusing showers multiple times in a						
	row. Interventions included but were not limited						
	to: explain care pro	ocess prior to delivery of care					
	as needed, approac	h resident in a calm and					
	unhurried manner t	to deliver provide services and					
	provide education a	as needed on the benefits and					
	risks of receiving r	ecommended care.					
	The medical record	l for Resident N lacked					
	documentation for	showers or shower refusal for					
	the dates of 10/3/20	024 through 10/30/2024.					
	During an interviev	w, on 10/30/24 at 12:30 P.M.,					
	Resident N indicate	ed she did not get help with					
	showers but indicate	ted she normally cleaned					
	herself up in the ba	-					
	During an interview	w, on 10/30/2024 at 12:18 P.M.,					
	_	ne residents received a shower					
	twice a week.						
	During an interview	w, on 10/31/2024 at 2:20 P.M.,					
	the Administrator i	ndicated there were no printed					
		all showers were documented					
	in the electronic me	edical record (EMR).					
	During an interview	w, on 10/31/2024 at 10:45 A.M.,					
	_	residents received showers					
		they asked. If a resident					

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Event ID:

4R3Q11

Facility ID: 000506

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155474		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIEI URE HEALTHCARI			316 WO	DDRESS, CITY, STATE, ZIP COD ODIES LANE N, IN 46506		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL	PR	ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE COMPOTO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION the aide notified the DON and ival in the EMR.	1	TAG	DEFICIENCE		DATE
	the Administrator i	w, on 11/1/2024 at 11:30 A.M., ndicated she was unaware of ner bath" in the EMR.					
	the Corporate Nurs	w, on 11/1/2024 at 11:30 A.M., e indicated she was unaware of ner bath" in the EMR.					
	6. During an interview, on 10/30/2024 at 10:25 A.M., Resident P's representative indicated Resident P had not received a shower since his admission to the facility.						
	10/30/2024 at 10:3 disheveled hair and	ion and interview, on 5 A.M., Resident P had I beard scruff ¼ inch long. Id he liked a clean-shaven face ache.					
	was seated on his b	ion, on 10/31/2024, Resident P eed, with the same clothes as and the resident's face still had					
	on 10/30/2024 at 12 included but were ralcohol use, urinary	I for Resident P was reviewed 2:20 P.M. The diagnoses not limited to: encephalopathy, y tract infection, acute renal on, acute vision loss bilateral nellitus.					
	assessment, dated 1	imum Date Set (MDS) 10/10/2024, indicated the artial assistance with hing.					
	A current Care Plan	n, initiated on 10/3/2024,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155474	B. WING		11/01/2024	
	PROVIDER OR SUPPLIES		316 WC	ADDRESS, CITY, STATE, ZIP COD DODIES LANE	•	
SIGNATU	JRE HEALTHCARE	- OF BREMEN	BREME	EN, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	RIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		P had a self-care deficit related al functioning and medical				
		entions included but were not				
		frequent encouragement, along				
	_	l assistance as needed and to				
		of assistance resident needs				
	1 ~	Activity of Daily Living (ADL)				
	cares.	icavity of Bany Erving (FibE)				
	The medical record	for Resident P indicated the				
	resident refused a s	hower on 10/12/2024. The				
	record lacked documentation of any other refusal of showers and lacked documentation Resident P					
	received any showe	ers from 10/5/2024 through				
	10/30/2024.					
	7 The medical reco	ord for Resident M was				
		2024 at 2:19 P.M. The				
		but not limited to: Alzheimer's				
	_	ey failure, ventral hernia,				
		on, frequent falls, depression,				
		ning of the urinary tract,				
	post-traumatic stres	-				
	1 ~	function of the bladder,				
	1	and obstructive uropathy.				
	A D' 1 A DC	. 1 . 10/07/0004				
		assessment, dated 9/27/2024,				
		M had memory problems and				
		tively impaired. The MDS ent required partial assistance				
	with showering and					
	with showering and	i baumig.				
	A current Care Plan	n, reviewed on 10/14/2024,				
		M had a self-care deficit				
	related to impaired	physical functioning and				
	_	as evidenced by the need for				
	staff assistance for	adequate completion of ADL				
	cares. Intervention	s included but were not limited				
	to: provide frequen	t encouragement, along with				
	prompting and accid	stance as needed and provide			1	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155474	B. WING		11/01/2024	
NAME OF I	PROVIDER OR SUPPLIER	· ?		ADDRESS, CITY, STATE, ZIP COD		
SIGNATI	JRE HEALTHCARE	F OF BREMEN		OODIES LANE EN, IN 46506		
	•			LIN, IIN 40300		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		tance resident needs for				
	completion of ADL cares.					
	The shower docum	entation for Resident M				
		lly received two showers, one				
		10/24/2024 from October 2 - 30,				
	2024.					
	& During on observe	vation and interview, on				
	_	0 A.M., Resident Q had very				
		resident was unsure when he				
	last showered.					
	During an observation, on 10/31/2024 at 3:00 P.M.,					
	Resident Q still had					
		v, on 10/30/2024 at 12:18 P.M.,				
	twice a week.	esidents received a shower				
	twice a week.					
	During an interviev	v, on 10/31/2024 at 10:45 A.M.,				
		e residents received showers				
		they asked. If a resident				
	documented the ref	he aide notified the DON and				
	documented the let	usai iii tiie Eiviix.				
		for Resident Q was reviewed				
		0:13 A.M. Diagnoses included				
		d to: encephalopathy, alcohol				
		mentia, inguinal hernia, g, depression and anxiety.				
	difficulty in walkin	g, acpression and anxiety.				
	The Admission MI	OS assessment, dated				
	·	ted the resident was severely				
		ed. The MDS assessment				
		Q required substantial				
	assistance with sho	wering and bathing.				
	A current Care Plan	n, dated 10/3/2024, indicated				
		elf-care deficit related to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155474	A. BUILDING B. WING	00	COMPLETED 11/01/2024	
		100717	<u> </u>		11/01/2024	
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD  OODIES LANE		
SIGNATU	JRE HEALTHCARE	OF BREMEN		EN, IN 46506		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION unctioning and medical	TAG	DEFICIENCE	DATE	
		nced by the need for staff				
	assistance for adequate completion of ADL cares.					
	_	led but were not limited to:				
		couragement, along with				
		stance as needed, encourage				
		ate if they are able and provide				
		tance resident needs for				
	completion of ADL	cales.				
	There was only one shower documented, on					
	October 6 for Resident Q from 10/3/2024 through					
	10/30/2024 and no refusals of showers were					
	documented.					
	During an interview the Executive Direct documented in the of There were no paper documentation. She frequency was their was a minimum of indicated the reside preference should be daily living (ADL)  A policy was provided A.M., by the Executivative of Daily Direct healthcare encourage the reside while attempting to maintain as much in their ADL such as the those residents who own activities of daily activities of daily	to, on 11/1/2024 at12:35 P.M., stor indicated the showers were electronic health record chart. For shower sheets utilized for endicated residents' repreference and the standard two showers per week. She ints' frequency of showers he recorded in the activities of care plan.  In the ded, on 11/1/2024 at 10:29 tive Director. The policy, titled, in Living [ADL's]", indicated, in staff will assist, support and lent to maintain adequate ADL allow the resident to ne able to independence as possible with the following: Bathing For the are unable to perform their in assistance for completion of				
	This citation relates	to Complaint IN00445742.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155474		r í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/01/2024	
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 316 WOODIES LANE BREMEN, IN 46506			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX  (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	3.1-38(a)(2)(A)  483.25  Quality of Care  Based on record review and interview, the facility			E COA la in the intent	f Cinn abusa	
	failed to ensure phy were administered medications were r Findings include:	visician ordered medications for 2 of 10 residents whose eviewed. (Residents J & L)	F 0684	F 684 It is the intent of Healthcare of Bremer Quality Care to all res what corrective a be accomplished for the residents found to have affected by the deficients.	n to provide idents. ction(s) will hose ve been	11/27/2024
	1. The record for Resident J was completed on 10/31/2024 at 10:16 A.M. Diagnoses included: Parkinson's disease, dementia, neurogenic bladder and diabetes and pain in joints.			practice; Resident J a physician and respon- notified of missed med adverse effects noted	sible party dications. No	
	Hydrocodone (narc (milligrams) 1 table	Orders for Resident J included: otic pain medication) 5/325 mg et every 6 hours for pain at I., noon and 6:00 P.M.		how other resider the potential to be affe same deficient practic identified and what co action(s) will be taken	ected by the se will be prrective	
	the Hydrocodone, on the had not received	c Controlled Drug Record for dated October 2024, indicated I the 4 scheduled doses on midnight dose on 10/26/2024.		residents taking narco medications have bee compliance with admi No adverse effects no	otic en audit for nistration.	
	the Administrator i			what measures w into place and what sy changes will be made that the deficient prac	ystemic to ensure tice does not	
	10/31/2024 at 11:2 were not limited to hypertension, depre cluster headaches.	esident L was completed on 6 A.M. Diagnoses included, but Alzheimer's disease, ession, dementia and chronic  tt Physician Orders' included:		recur; All licensed nur qualified medication a re-educated on admir documentation of nare EMAR and narcotic re DON, or designee will audit of 5 residents to	ides nistration and cotics in ecord. The I complete an	
		pain medication) 50 mg 1		narcotic records matc		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155474	B. WI	NG	<del></del>	11/01/	
			<u> </u>	_			
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					OODIES LANE		
SIGNATU	JRE HEALTHCARE	OF BREMEN		BREME	EN, IN 46506		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	capsule three times	a day for pain.			administration. Audit will be		
					completed weekly x4 weeks, t	hen	
	The Controlled Dru	g Record for Resident L's			every other week x2 months, t	then	
	Lyrica (pregabalin) 50 mg three times daily indicated the following missed doses:				monthly x3 months.		
	- 1 dose on 10/14/2	024, 10/16/2024, 10/17/2024 and			how the corrective action(	(s)	
	10/2024.				will be monitored to ensure the	е	
					deficient practice will not recui	۲,	
	During an interview, on 11/1/2024 at 8:47 A.M., the Administrator indicated the residents should have received the medications.  On 10/31/2024 at 2:33 P.M., the Administrator provided the policy titled, "Controlled				i.e., what quality assurance		
					program will be put into place;	As	
					a measure of ongoing complia	ince,	
					audit results will be submitted	to	
					the campus administrator, or		
					designee, for review by the Qu	uality	
	Medication", dated	5/30/2024, and indicated the			Assurance Performance		
	policy was the one	currently used by the facility.			Improvement Committee until		
	The policy indicate	d"4. When a controlled			substantial compliance is		
	medication is admir	nistered, the licensed nurse			achieved. The QAPI committe	e	
	administering the m	nedication immediately enters			has the right to modify or exte	nd	
	the following inform	mation on the accountability			monitoring times according to		
	record when remov	ing dose from controlled			outcomes of audits.		
	storagea. Date and	I time of administration. b.					
	Amount administer	ed. c. Signature of the nurse					
	administering the d	ose. 5. Administer the					
	controlled medicati	on and document dose					
	administration on tl	ne MAR"					
		15 P.M., the Administrator					
		not provide a policy for					
	following physiciar	orders.					
	This citation relates	s to Complaint IN00445742.					
		-					
	3.1-37						
F 0755	483.45(a)(b)(1)-(3	3)					
SS=D	Pharmacy	,					
Bldg. 00		/Pharmacist/Records					
		on, interview and record	F 07	755	F-755 It is the intent of Signati	ure	11/27/2024
		failed to ensure routine			Healthcare of Bremen to ensu		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155474 B. WING 11/01/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 316 WOODIES LANE SIGNATURE HEALTHCARE OF BREMEN BREMEN, IN 46506 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medications were available and dispensed routine medications are available according to physician's orders for 3 out of 8 and dispensed per physician residents reviewed for medication administration. orders. (Residents M, L and C) what corrective action(s) will be accomplished for those Findings include: residents found to have been affected by the deficient 1. The medical record for Resident M was practice; Resident C no longer reviewed on 10/30/2024 at 2:19 P.M. The resides at the facility. Resident L diagnoses included but were not limited to: and M physician and responsible Alzheimer's disease, acute kidney failure, ventral party notified of missed hernia, urinary tract infection, frequent falls, medications. No adverse effects depression, other artificial opening of the urinary noted. tract, post-traumatic stress disorder, sepsis, neuromuscular dysfunction of the bladder, how other residents having neurogenic bladder and obstructive uropathy. the potential to be affected by the same deficient practice will be Physician Orders for Resident M included identified and what corrective Mupirocin ointment 2% 1 application topically action(s) will be taken: An audit of twice a day, dated 8/31/2024 until 10/30/2024, and medication administration record Clonazepam 0.25 mg 1 tablet by mouth twice a for unavailable medications was day, dated 10/3/2024. completed on all residents. Residents assessed and MD The October MAR indicated Resident M did not notified, if warranted. receive Mupirocin as ordered on the following dates: what measures will be put 10/18/2024 Evening dose due to medication into place and what systemic unavailable. changes will be made to ensure 10/19/2024 Morning and evening doses due to that the deficient practice does not medication unavailable, recur; All licensed nurses and 10/21/2024 Evening dose due to medication qualified medication aides unavailable, re-educated on medications being 10/22/2024 Morning dose due to medication administered as ordered and unavailable. process if medications are 10/23/2024 Evening dose due to medication unavailable. The DON, or unavailable, designee, will complete an audit of 10/25/2024 Morning dose due to medication 5 residents for missed unavailable administration/medications 10/29/2024 Morning dose due to medication unavailable. Audit will be

unavailable.

completed weekly x4 weeks, then

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155474	B. WI	NG		11/01/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 316 WOODIES LANE BREMEN, IN 46506				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOUIDEDIG DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
TAG	The October MAR receive Clonazepandates:  10/19/2024 Morning medication not avaidates:  10/21/2024 Morning medication not avaidates:  10/22/2024 Morning medication not avaidable,  10/23/2024 Both do not avaidable,  10/24/2024 Morning medication not avaidable,  10/25/2024 Morning medication not avaidated in indicated in not avaidated in not avaidated in indicated indicated in indicated indicated in indicated in indicated in indicated in indicated in i	indicated Resident M did not a sordered on the following g dose missed due to lable, g dose missed due to lable, g dose missed due to lable, sees missed due to lable, go dose missed due to lable, g dose missed due to lable.  7, on 11/1/2024 at 12:45 P.M., he medication should always with the MAR prior to lesident L was completed on 6 A.M. Diagnoses included, but Alzheimer's disease, ssion, dementia and chronic the Physician Orders included: nedication) 50 mg 1 capsule		TAG	every other week x2 months, to monthly x3 months.  how the corrective action(will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; a measure of ongoing complia audit results will be submitted the campus administrator, or designee, for review by the Qu Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or externonitoring times according to outcomes of audits.	As ance, to uality	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155474	B. W	ING		11/01	/2024
NAME OF T	DROWNER OF CURPY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	(		316 WC	OODIES LANE		
SIGNATURE HEALTHCARE OF BREMEN				BREME	EN, IN 46506		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	LAN OF CORRECTION	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		received on 10/8/2024. d on 10/14/2024, 10/16/2024,					
	10/17/2024 and 10/						
		received on 10/23/2024.					
		ministration Record (MAR),					
		ru 10/31/2024, indicated the					
	-	edication was not available on					
		10/5/2025 for the 7:00 A.M. to					
		d the 11:15 A.M. to 3:00 P.M.					
	shift. On 10/7/2024 for the 7:00 A.M. to 11:00 A.M. shift.						
	Jillit.						
	During an interview	v, on 11/1/2024 at 8:47 A.M.,					
	the Administrator in	ndicated the resident should					
		nedication and should not have					
	received the extra d	loses.					
	3 The record review	w for Resident C was					
		0/2024 at 2:27 P.M. Diagnoses					
	_	not limited to: dementia, acute					
		low back pain, and chronic					
	kidney disease.						
	Physician Orders fo	or Resident C included the					
		n (anti hypertensive					
	_	1 tablet every 12 hours at 8:00					
	A.M. and 8:00 P.M	•					
	The Medication Ad	ministration Record (MAR) for					
		ated the Valsartan medication					
		ed on the following dates:					
		e of the medication was					
	documented as not	available.					
	- 10/20/2024 1 does of the medication was						
	documented as not						
		es of the medication was					
	documented as not	available.					
	During an interview	v, on 11/1/2024 at 8:47 A.M.,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPLETED	
		155474	B. WING 11/01/2024				
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN		STREET ADDRESS, CITY, STATE, ZIP COD 316 WOODIES LANE BREMEN, IN 46506					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRE	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		Tz	TAG DEFICIENCY)			DATE
		ndicated the medications that					
		nould have been pulled from					
		cy dispensing machine) or the					
		ave been called for a STAT					
	(immediate) deliver	ry.					
	During an interview	v, on 11/1/2024 at 1:58 P.M., the					
	~	rated the facility has no policy					
		ng unavailable. The					
		eated that the nurse should call					
	pharmacy and then	notify the attending physician					
	when a medication	is unavailable					
		:33 P.M., the Administrator					
	provided the policy						
		5/30/2024, and indicated the					
		currently used by the facility. d"4. When a controlled					
		nistered, the licensed nurse					
		nedication immediately enters					
	_	nation on the accountability					
	_	ing dose from controlled					
		I time of administration. b.					
	Amount administer	ed. c. Signature of the nurse					
	_	ose. 5. Administer the					
		on and document dose					
	administration on th	ne MAR"					
	This citation relates	to Complaint IN00445742.					
	3.1-25(a)						
	3.1-25(e)(2)						
	3.1-25(e)(3)						
				ļ			
F 0757	483.45(d)(1)-(6)						
SS=D		Free from Unnecessary					
Bldg. 00	Drugs						
		on, record review and	F 0757		F-757 It is the intent of Signatu		11/27/2024
		ty failed to ensure an			Healthcare of Bremen to have	drug	
	annanxiety drug wa	as not adiministered for an			regimen free of unnecessary		Ì

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (	(X3) DATE SURVEY	
	COMPLETED	
	11/01/2024	
CTREET ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD  316 WOODIES LANE		
SIGNATURE HEALTHCARE OF BREMEN BREMEN, IN 46506		
SIGNATURE HEALTHCARE OF BREWIEN		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
excessive duration for 1 of 8 residents reviewed medications.		
for pharmaceutical services (Resident M). • what corrective action(s) will be		
accomplished for those residents		
Finding includes: found to have been affected by the		
deficient practice; Resident M		
The medical record for Resident M was reviewed medications reviewed by psych		
on 10/30/2024 at 2:19 P.M. The diagnoses provider and medication		
included but were not limited to: Alzheimer's adjustments were made.		
disease, acute kidney failure, ventral hernia,  Responsible party notified. No		
urinary tract infection, frequent falls, depression,  adverse effects noted.		
other artificial opening of the urinary tract,  how other residents having the		
post-traumatic stress disorder, sepsis,  potential to be affected by the		
neuromuscular dysfunction of the bladder, same deficient practice will be		
neurogenic bladder and obstructive uropathy.  identified and what corrective		
action(s) will be taken; The psych		
Physician's Orders for Resident M included provider reviewed all residents		
Ativan (an antianxiety medication) 2 mg 1 tablet receiving psychoactive		
by mouth twice a day as needed, initiated on medications and made adjustment		
7/29/2024, and Clonazepam (an antianxiety or provided a note. GDR requested		
medication) 0.25 mg 1 tablet by mouth twice a day, as needed. No adverse effects		
initiated on 10/3/2024. The PRN Clonazepam did noted.		
not have a stop date for the medication use.  • what measures will be put into		
A current Care Plan, reviewed 10/14/2024, place and what systemic changes will be made to ensure that the		
indicated Resident M was at risk for drug related side effect due to psychotropic medication.  deficient practice does not recur; All license nurses educated		
anti-anxiety medication - observe for sedation, drowsiness, ataxia(drunk walk), dizziness, nausea,  of medications when entering an order and obtaining orders for stop		
vomiting, confusion, headache, blurred vision and dates on new PRN psychoactive		
skin rash; psychotropic drug committee to attempt medications. Education to the IDT		
dose reduction per physician's orders and consult  on reviewing new psychoactive		
with psychiatry/psychologist as needed.  with psychiatry psychologist as needed.  medication orders during morning		
clinical meeting. The DON, or		
The October Medication Administration Record designee, will audit 5 new		
(MAR) indicated Resident M received psychoactive medications, as		
Clonazepam as ordered from 10/3/2024 through available, to ensure appropriate		
10/31/2024. The October MAR indicated Resident stop dates are in place. Audit will		
M also received as needed Ativan on the be completed weekly x4 weeks,		
following dates: 10/9/2024, 10/11/2024 through then every other week x2 months,		

4R3Q11

BITTERS TO	R MEDICARE & MEDIC	AID SERVICES			ONIB NO. 0936-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	f .	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155474	A. BUILDING B. WING	00	COMPLETED 11/01/2024	
		155474	<u> </u>		11/01/2024	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF BREMEN			316 W	ADDRESS, CITY, STATE, ZIP COD DODIES LANE EN, IN 46506		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE				1		
(X4) ID PREFIX			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
IAU	10/15/2024, 10/21/2 10/27/2024 through During an interview the Administrator in both Ativan and Claresident's behaviors On 11/1/2024 at 1:0 provided a policy ti Medications Policy indicated the policy by the facility. Thepsychotropic drug toanti-anxietyl drugs are limited to their rationale in the	2024 through 10/25/2024 and a 10/31/2024.  If a 10/31/2024 at 2:20 P.M., andicated Resident M was on conazepam due to all of the standard of the standard properties of the standard pr	TAG	then monthly x3 months.  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; As a measure of ongoing compliance audit results will be submitted to the campus administrator, or designee, for review by the Qual Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits.	s e, ity	
F 0760 SS=D Bldg. 00	Based on record review for 10/30/2024 at 2:07 were not limited to essure 1 or medication use was medication errors recoverdosing/underdomedications. (Residual for 10/30/2024 at 2:07 were not limited to severe intellectual of		F 0760	F 760 It is the intent of Signature Healthcare Bremen to ensure resident are free of medication errors.  what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E assessed, and physician was notified of missed medications. Nadverse reactions noted.  how other residents having the potential to be affected by the	s he	

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An Admission Minimum Data Set (MDS)

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same deficient practice will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIF		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155474	B. WI	NG		11/01	/2024
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ODIES LANE		
SIGNIATI	IRE HEVI THUVE	OF BREMEN		1	:N, IN 46506		
SIGNATURE HEALTHCARE OF BREMEN				DUCINE			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		/23/2024, indicated Resident E			identified and what corrective		
		e disabilities and received			action(s) will be taken; Reside	nts	
		ntipsychotic, antianxiety and			receiving anti convulsive		
	antidepressant.				medications were audited for a	any	
					missed medications, if noted		
	1 -	for medications included, but			physician and responsible par	-	
	were not limited to:				notified. No adverse effects we	ere	
	· ·	izure medication) 20 milligrams			noted.		
		8/29/2024, given in the morning					
	from 8/17/24-8/28/2				what measures will be put	t	
		zure medication) 30milliters			into place and what systemic		
		s at bedtime starting on 8/			changes will be made to ensu		
	817/2024.				that the deficient practice does	s not	
		epileptic medication) 200			recur; Re-education of the		
	_	wice daily starting 8/17/2024.			licensed nurses and qualified		
		convulsant medication) 40			medication aides for process of		
		iliter 40 milliliters equals 1600mg			medication not available, proc		
	twice daily starting			for EDK, and physician notification			
		for anti-seizure medication)			completed by the DON. Audits		
	1mg three times a s	tarting 8/16/2024.			be completed by DON/Design	ee	
					for medication administration		
	_	ust 2024 narcotic signature			compliance on 5 residents		
		ident E missed Fycompa doses			receiving anticonvulsant		
		8/23, 8/25, 8/26, 8/28, and 8/31.			medications, as available, to		
		dent received Clobazam twice			ensure administration complia		
		ordered daily dose, on 8/23			Audit will be completed weekly		
		he narcotic signature sheet.			weeks, then every other week		
		eived 4 doses, instead of the			months, then monthly x3 mont	ıns.	
		of clonazepam on 8/17/2024,					
	1 -	3/2024, only 2 doses on			h 4h	'-\	
	o/2//2024, and only	y 2 doses on 8/30/2024.			how the corrective action(	,	
	Davious of the Court	ombor 2024 norgatic signature			will be monitored to ensure the	_	
	•	ember 2024 narcotic signature			deficient practice will not recur	,	
		indicated Resident E missed			i.e., what quality assurance	۸۵	
		ing dates: 9/7/2024, 9/17/2024,			program will be put into place;		
		24, 9/29/2024, and 9/30/2024. In			a measure of ongoing complia		
	·	E received two doses instead			audit results will be submitted	lO	
		following dates: 9/2/2024,			the campus administrator, or		
		, 9/9/2024, 9/11/2024, 9/12/2024,			designee, for review by the Qu	uality	
	9/13/2024, 9/16/202	24, 9/18/2024, 9/19/2024,	1		Assurance Performance		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		155474	B. WI	NG		11/01/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					OODIES LANE		
SIGNATU	JRE HEALTHCARE	OF RKEMEN		RKFMF	N, IN 46506		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`		]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· /	24, 9/27/2024, 9/29/2024, and the narcotic signature sheet.			Improvement Committee until		
		ent E missed the daily dose of			substantial compliance is achieved. The QAPI committe	. <u> </u>	
		er. On 9/6/2024, Resident E			has the right to modify or exte		
	_	es of the clonazepam instead			monitoring times according to		
	of the ordered three	doses.			outcomes of audits.		
		ber 2024 narcotic signature					
		, Resident E missed doses on					
	_	: 10/4/2024, 10/13/2024, 2024, 10/21/2024, 10/30/2024, and					
		ition, Resident E received twice					
		f Clobazam on the following					
		0/6/2024, 10/7/2024, 10/14/2024,					
	10/16/2024, 10/17/2	2024, 10/19/2024, 10/20/2024,					
	10/22/2024, 10/24/2	2024, 10/25/2024, 10/28/2024					
		30/2024 based on the narcotic					
	_	e resident also missed the					
		ltogether on 10/18/2024 and					
		loses instead of the ordered					
	three doses of clona	zepam on 10/23/2024.					
	A Nursing Progress	Note, dated 10/28/2024 at 7:26					
		pharmacy was contacted					
		E's Clobazam medication and					
	the pharmacy indica	ated the medication was to be					
	delivered tto the fac	cility later in the afternoon.					
	A 31 ' 5	N . 1 . 110/21/2024 . 2 22					
		Note, dated 10/31/2024 at 2:28					
		physician was notified that of his Fycompa medication.					
		eated the medication would be					
	delivered to the facility soon but the medicaiton had not yet arrived. The physician was updated						
	regarding the missed dose of Fycompa.						
		Note, dated 10/31/2024 at 2:43					
		ident E had a less than 15					
	second seizure.						
	l		1				Ī

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155474		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  11/01/2024				
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN		STREET ADDRESS, CITY, STATE, ZIP COD 316 WOODIES LANE BREMEN, IN 46506				
(X4) ID PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG	A Nursing Progress A.M., indicated Resthis morning while morning care.  During an interview the facility pharmace Fycompa 340 millil ordered last on 10/1 10/14/24, ordered 9 and ordered 8/19/24 medication was ord  During an interview RN 13 indicated she the past two days to the pharmacy had st LPN 12 looked in the Fycmpa and the medicated the medicated the medicated the ordered she indicated she resident E missing She indicated the ordered she indicated sh	Note, dated 11/01/2024 at 7:54 sident E had a short seizure a CNA was assisting him with 7, on 10/31/2024 at 9:12 A.M., by indicated Resident E's iters (11-day supply) was 1/24 and delivered on /27/24 and received 9/30/24, 1. The Clobazam 20mg ered on 9/11/24 and 10/28/24. 1. The Clobazam 20mg ered on 9/11/24 and 10/28/24. 1. The Clobazam 20mg ered on 9/11/24 and 10/28/24. 1. The Clobazam 20mg ered on 9/11/24 and 10/28/24. 1. The Clobazam 20mg ered on 9/11/24 and 10/28/24. 1. The Clobazam 20mg ered on 10/31/2024 at 1:52 P.M., the had called the pharmacy for 10 inquire about the Fycompa still not sent the medication. The medication cart for the dication was still not available. 1. The had not notified the MD of 10 multiple doses of Fycompa. The had not notified the MD of 11 multiple doses of Fycompa. The had not sill being administered twice 12 steel regarding medicaion at 9:17 A.M. and a policy was	TAG	DEFICIENCY	DATE	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention					
-	review, the facility	on, interview and record failed to ensure urinary was positioned and	F 0880	F-880 It is the intent of Signatu Healthcare of Bremen to ensu infection control measure are		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155474		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/01/2024			
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN			STREET ADDRESS, CITY, STATE, ZIP COD 316 WOODIES LANE BREMEN, IN 46506				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
I I I I I I I I I I I I I I I I I I I	maintained in a sanite residents reviewed for the following an observation of the following an interview collection bag was low the following an interview control of the following an observation of the following an observation of the following an interview control of the following an observation of the following an interview control of the following an interview control of the following and interview control of the following and interview control of the following and the following and control of the foll	for catheter use. (Resident J)  on, on 10/30/2024 at 11:41 atheter tubing and urine ying on the floor under his  on, on 10/30/2024 at 11:43 A.M., the tubing and the drainage bag e floor.  on, on 10/31/2024 at 10:20 urine collection bag was lying  on, on 11/1/2024 at 9:10 A.M., the dining room with the urine on the floor.  on 10/30/2024 at 11:43 A.M., the tubing and the drainage bag e floor.  1:59 A.M., Resident J was ing room with the urinary drainage bag dragging on the  on, on 10/30/2024 at 3:42 P.M., collection bag and tubing		maintained. what corrective action(s) be accomplished for those residents found to have been affected by the deficient pract Resident J has been assessed and physician and responsible party notified. No adverse effected.  how other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents with foley catheters been audited to ensure cathe bags and tubing have appropinfection control measures. No adverse effects noted.  what measures will be pure into place and what systemic changes will be made to ensure that the deficient practice does recur; Clinical staff educated DON on proper placement of catheter bag and tubing to eninfection control measures are maintained. The DON, or designee, will complete an automatical to touching the floor. Automil be completed weekly x4 weeks, then every other week months, then monthly x3 months.	will  tice; ed e ects  ng / the e ter riate o  ut  ure es not by the essure e udit of ind bag dit k x2		

how the corrective action(s)

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155474		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (	X3) DATE SURVEY  COMPLETED  11/01/2024	
	PROVIDER OR SUPPLIE		316 WC	ADDRESS, CITY, STATE, ZIP COD DODIES LANE EN, IN 46506	
(X4) ID PREFIX TAG	REGULATORY OF REGULATORY OF A Quarterly Minimassessment, dated a had an indwelling of incontinent of his land an indwelling of incontinent of his land an indwelling of incontinent of his land an indwelling of the straight drainage and A Physician's Order indicated the catheter a Tube Tie adhesive to be replaced if not a current Care Planter revision date of 10th had a UTI (urinary included: administer for side effects of the fluids.  A current Care Planter of the straight of the potential coordinate of the provided, but were abdominal pain, obecharacteristics of the provide catheter can be provided to the straight of the use on 10/31/2024 but the straight of the straight of the use on 10/31/2024 but the straight of the straight of the use on 10/31/2024 but the straight of the straight of the use on 10/31/2024 but the straight of the straight of the use on 10/31/2024 but the straight of the straight of the use on 10/31/2024 but the straight of the straight of the use on 10/31/2024 but the straight of the use on 10/31/2024 but the straight of the straight	r, initiated on 8/21/2024, apra-pubic Catheter size 14 coentimeters) balloon to ad privacy bag at all times.  r, initiated on 8/29/2024, ter bag was to be secured with the holder every shift, and was not there.  n, initiated on 9/24/2024, with a 1/10/2024, indicated Resident Juliated tract infection). Interventions ter antibiotic as ordered, observe the antibiotic and encourage  n, initiated on 7/1/2024 and 1/2024, indicated Resident Juliated on 7/1/2024 and 1/2024, indicated Resident Juliated on 1/2024, indicated Resid	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)  will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; a measure of ongoing compliar audit results will be submitted to the campus administrator, or designee, for review by the Quantum Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extent monitoring times according to outcomes of audits.	As nce, o ality
	3.1-18(a)				

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