STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 00 B. WING	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF BREMEN	316 WOODIES LANE BREMEN, IN 46506

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00397720. Complaint IN00397720 - Substantiated. Federal/State deficiencies are cited at F561. Survey dates: February 8, 9, 10, 13, 14 and 15, 2023 Facility number: 000506 Provider number: 155474 AIM number: 100266530 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 1 Medicaid: 40 Other: 10 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/27/23.	F 0000	This Plan of Correction is the facility's credible allegation of compliance. The facility respectfully requests a desk review and has provided evidence of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Signature Healthcare Bremen respectfully requests a desk review. ="" p=""> ="" p="">	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charlie Syer	Admin	03/21/2023

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.

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	§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview the facility failed to provide accommodations for 1 of 1 resident reviewed for resident rights. (Resident B) Finding includes: A clinical record review was completed on 2/14/2023 at 2:00 P.M. Diagnoses included, but were not limited to: osteoporosis with current pathological fracture, right femur, Attention-deficit hyperactivity disorder, and Ehlers-Danlos syndrome. A Significant Change Minimum Data Set (MDS) Assessment on 1/16/2023 indicated Resident B was cognitively intact. She had verbal behavioral symptoms directed towards others that	F 0561	1. 1. Resident B was discharged prior to annual survey and is still no longer a resident at this facility. 2. A onetime audit of current residents' progress notes from 01/15/ 2023 through 2/15/23 was completed to review for any potential resident right issues by the Regional Nurse and DON. All residents with a BIMS of 9 or above were interviewed regarding any concerns with their rights as a resident of the facility. All residents with a BIMS of less than 9 had their responsible party was	03/22/2023

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	significantly disrupted care or the living environment for 1 to 3 days of the 14-day assessment period. She was occasionally incontinent of bladder and always continent of bowel. She was able to make herself understood and understand others. The assessment indicated it was very important for Resident B to take care of her personal belongings and to have snacks available between meals. A Nurse's Note on 11/2/2022 at 4:48 P.M., by the Director of Nursing, indicated, " ...I also discussed with patient she cannot Uber for Redbull caffeine drink. Pt [patient] corrected me to say it was "doordash." I explained that whether Uber or Doordash, Redbull is proven to not be medically safe and may interfere with her medications. I did explain if she had the money and wanted to doordash a pizza or some other type of food. I have no problem with that at all. Pt was agreeable and says "I understand." I was then called to the therapy department because pt was "angry with staff." I spoke to patient with [physical therapist name] and [restorative staff member name] present. Pt concerns were 1. "Why did they take my pitcher of water away?" I explained that typically a person should have 6 to 8 glasses of water a day and she was drinking 2-3 dining room style pitchers that hold at least 8 glasses of water each. We discussed how to much water is not good for the body. Pt was "okay". 2. Why cant [sic] I have Redbull door dashed. I again explained the amount of caffeine in Redbull has been proven to not be healthy and may interact with her medications. I explained she had c/o [complained of] not being able to sleep at night. She ordered the Redbull at 10pm and guzzled it then had concern she couldn't sleep. Pt chuckled ...4. [Resident B's name] asked if her bf [boyfriend] could come and watch a movie with her and could		contacted to determine if they had any concerns with resident rights. Any issues identified will be immediately addressed and corrected. 3. All staff in all departments have been educated on Resident Rights and Self-Determination by the DON, Unit Manager, MDS Coordinator or SDC. The Social Services Director (SSD), Director of Nursing (DON), Unit Manager, Staff Development Coordinator (SDC), Minimum Data Set (MDS) Coordinator or Administrator will interview 5 residents with a BIMS score of 9 or above weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 2 residents weekly for 2 weeks, then 2 residents monthly for 2 months. The SSD, DON, Unit Manager, SDC, MDS Coordinator or Administrator will interview 5 residents' representative for residents with a BIMS score of 8 or below weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 2 residents weekly for 2 weeks, then 2 residents monthly for 2 months, then 1 resident monthly for 4 months or until 100% compliance achieved. Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly. Any issues identified will be	

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	they cuddle? I asked what cuddle meant. Just wants to sit and watch a movie and hold hands and lean on his shoulder. I encouraged her to have him come visit. We discussed visiting hours as 8am to 9 pm ...." On 11/12/2022 at 1:33 P.M., a Nurse's Note indicated, " ...This writer was notified by cna [certified nursing assistant] and therapist that resident had a male and female in her room visiting for a short time that has since left, and that they smelled a strong odor in the room when the entered. Therapist said that the door had been shut and that she knocked and when she walked into the room, the visitors jumped and appeared startled. They quickly left after that. The man went outside, then came back to residents [sic] room for a few minutes then left again and there were no staff in the room when he came back. This writer then went to residents [sic] room after this was brought to her attention and upon entering the room, noticed a strong odor that this writer had not smelled before. This writer asked resident who had been her visiting her and she said it was her ex [ex-boyfriend] and his girlfriend. This writer asked if they or her had been vaping or smoking anything and she said no. She said that her visitors may have been smoking something on their way here though. She didn't know. This writer talked with [DON name] DON as she stopped in the building briefly and discussed with her the visitors and strange odor in the room. Per [DON name] DON, if the visitors come back, the door has to be kept open until IDT [interdisciplinary team] can further discuss this. Resident was updated on this and said she understands ...." On 1/4/2023 at 1:00 P.M., a Nurse's Note by the Director of Nursing indicated, " ...Resident		corrected and 1:1 re-education completed for stakeholder if indicated. 4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction. QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	ordered Tarot cards and they arrived today. Staff concern over spirituality of cards. Notified Corporate to ask how to handle this as some see Tarot Cards as Wiccan. Instructed to let resident know if anyone is offended, she will need to put them away and or let me keep them in my office until those offended are not present. Writer and BOM [Business Office Manager] went to speak with resident and explained reason Tarot cards may offend some. Spoke of some believe in spirituality of the cards as being satanic in nature. Left room after asking resident twice if she had any questions or felt offended. Explained many times offense was not the plan but to educate on why some might be offended ...." A Care Plan on 1/16/2023, and revised on 1/18/2023, indicated Resident B was at risk for active problems for verbal abuse, social inappropriateness, and resistive/uncooperative with medications and care by yelling and swearing loudly at staff, name calling, uncooperative with medications and care. The goal indicated that Resident B would not harm themselves or others secondary to their behaviors. Resident B's approaches included to intervene as needed to protect the rights and safety of others. On 11/4/2022, a Care Plan indicated Resident B required assistance with activities of daily living. The approaches included supportive devices as ordered: bed side commode, walker, and wheelchair. During an interview on 2/16/2023 at 9:42 A.M., the Director of Nursing indicated that a couple of employees were concerned that Resident B was getting into something that wasn't beneficial for the resident, and wanted to ensure that Resident B understood what tarot cards represent to some			

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	people. She indicated the staff was educated on Resident B having the tarot cards and not being alarmed. She indicated the resident has her right to practice her religious beliefs. The Director of Nursing indicated, Resident B ordered Redbull from Doordash and chugging the beverage one evening. She indicated she provided education as to the effects to the body and heart when consuming this beverage. She indicated Resident B did many purchases from Doordash and Instacart. She also indicated, a pitcher of water was brought to the resident as many times as she wanted. The Director of Nursing indicated the walker was moved, but not across the room or out of the room. The Director of Nursing provided a current policy on 2/16.2023 at 12:54 P.M. titled, "Resident Rights". The policy indicated, " ...All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life ...1. f. Privacy and confidentiality ...h. Voice grievances and have the facility respond to those grievances ...l. Visit and be visited by others from outside the facility ...2. Residents are entitled to exercise his/her rights and privileges as a resent of the facility and as a citizen or resident of the United States, to the fullest extent possible without interference, coercion, discrimination, or reprisal ...3. The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness, and dignity ...." This Federal tag relates to complaint IN00397720. 3.1-3(a)(1) 3.1-3(i) 3.1-3(u)(3)			

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review the facility failed to ensure care plans were in place for 1 of 22 Residents reviewed for care plans. (Resident 27) Finding includes: A clinical record was reviewed for Resident 27 on 2/14/2023 at 9:43 A.M. Diagnoses included, but not limited to: anxiety disorder, dementia, lack of coordination and difficulty walking. A skin event was initiated on 2/2/2023 for a skin tear to the peri-area. A Physician Order, dated, 2/2/2023, indicated apply antibiotic ointment, skin tear to peri-area until healed, once a day. Resident 27's medical record indicated no skin integrity or an acute care plan for the skin tear was in place. During an interview, on 2/14/2023 at 12:58 P.M., the MDS Nurse indicated that she does not see a care plan for skin integrity or for the skin tear on 2/2/2023 and there should have been one. On 2/16/2023 at 8:03 A.M., the Director of Nursing provided a policy titled, "Comprehensive Care	F 0656	1. Resident 27's skin integrity impairment was healed on 2/14/23, two days prior to the Survey Exit. 2. The DON, Unit Manager, MDS Coordinator, SDC, or Regional Nurse completed a one-time audit of the current resident population with known impaired skin integrity to validate the residents' care plans were developed and up to date with these residents' skin integrity impairments. 3. The Interdisciplinary Team and all Licensed Nurses have been educated by the DON, Unit Manager, SDC, MDS coordinator, or Regional Nurse on the need to develop a care plan for any known skin integrity impairment to ensure staff have a care plan to provide staff guidance on what the problems is, what the goal is, and what the interventions are. Emphasis was given on the development of a person-centered care plan for those residents	03/22/2023

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	Plans", revised on 7/19/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...A person-centered Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The care plan will include how the facility will assist the resident to meet their needs, goals and preferences...." 3.1-35(a)		exhibiting impaired skin integrity issues. The SSD, DON, Unit Manager, SDC, MDS Coordinator or Administrator will be responsible to audit 5 Skin Integrity Care Plans weekly x 2 weeks, then 3 Care Plans weekly x 2 weeks, then 2 Care Plans weekly x 2 weeks, then 2 Care Plans Monthly for 2 months, then 1 care plan monthly for 4 months or until 100% compliance achieved to ensure development of a person-centered care plan for those residents exhibiting skin integrity issues. Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly. Any issues identified will be immediately addressed, with 1:1 re-education provided. 4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to ensure the care plan	F 0657	1. Resident 27's care plan has been reviewed to validate the care	03/22/2023

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	was revised for 1 out of 22 residents reviewed for care plans. (Resident 27) Finding includes: A clinical record was reviewed for Resident 27 on 2/14/2023 at 9:43 A.M. Diagnoses included, but not limited to: anxiety disorder, dementia, lack of coordination and difficulty walking. During an observation, on 2/9/2023 at 2:35 P.M., the resident was awake in bed, her bed was next to the wall and a bed bolster along the side you would exit the bed, a hoyer pad was sitting in a broda chair. A Physician Order, dated 1/25/2023, indicated utilize mechanical lift for transfers every shift, day, evening, night. Resident 27's medical record did not indicate she was using a bed bolster on her bed. During an interview, on 2/14/2023 at 10:23 A.M., the Director of Nursing indicated the bed bolster was used to define the edges of the bed. She did not see any documentation for the bed bolster in the medical record or when it was initiated and there should have been. The bed bolster was put in place as a nursing intervention. On 2/14/2023 at 10:25 A.M., the MDS Nurse indicated she did not see either the bed bolster or mechanical lift on the care plan and they should have been added when initiated. On 2/16/2023 at 8:03 A.M., the Director of Nursing provided a policy titled, "Comprehensive Care Plans", revised 7/19/2018, and indicated the policy was the one currently used by the facility. The		plan reflects the current status of the resident. 2. A one-time audit of the current resident population to ensure residents who use bolsters was completed by the DON, Unit Manager, SDC, MDS Coordinator, or Regional Nurse to validate these residents' care plans were reviewed and revised to reflect the use of any bolsters or positioning devices. 3. The Interdisciplinary Team and all Licensed Nurses have been educated by the DON, Unit Manager, SDC, MDS coordinator, or Regional Nurse on the need to review and revise care plans for use of bolsters to ensure the care plans accurately reflect the use of these items. The SSD, DON, Unit Manager, SDC, MDS Coordinator or Administrator will be responsible to audit 5 care plans of residents who utilize bolsters and / or position devices weekly x 2 weeks, then 3 care plans weekly x 2 weeks, then 2 Care Plans weekly x 2 weeks, then 2 care plans monthly for 2 months, then 1 Care Plan monthly for 4 months or until 100% compliance achieved to ensure care plans have been reviewed and revised with any bolsters or positioning devices that are in use for the residents.	

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	policy indicated "...13. Care plans are ongoing and revised as information about the resident and the resident's condition change...." 3.1-35(d)(2)(B)		Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly. Any issues identified will be immediately addressed, with 1:1 re-education provided. 4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction. QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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SIGNATURE HEALTHCARE OF BREMEN	316 WOODIES LANE BREMEN, IN 46506

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	and the residents' choices. Based on record review and interview, the facility failed to notify the physician for blood sugars indicated in an order for less than 100 milligrams per deciliter for 1 of 3 residents reviewd for insulin administration. (Resident 157) Finding includes: During an initial interview on 2/10/2023 at 11:22 A.M., Resident 157 indicated he received insulin injections. A clinical record review was completed on 2/13/2023 at 9:14 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, generalized anxiety, and hypertension. An Admission Minimum Data Set (MDS) Assessment on 1/20/2023 indicated Resident 157 received insulin injections for 7 days of the 7 days look back period. Physician Orders indicated Resident 157 received: 1. Lantus U-100 Insulin (insulin glargine) solution 100 units/milliliter with 45 units injected subcutaneously daily. 2. Lispro 300 units/3 milliliter with 12 units injected subcutaneously before meals. 3. Humalog 300 units/3 milliliter sliding scale to be injected subcutaneously as blood sugar follows: 150-200 give 2 units 201-250, give 4 units 251-300, give 6 units 301-400, give 8 units >400 and call (physician's name) to be given before meals and at bedtime. 4. Blood sugars check before meal and at bedtime. Contact (physician's name) for blood sugars less than 100 and greater than 400. Blood sugar reviews indicated the following	F 0684	1. Resident 157 was evaluated by their primary care physician and the physician reviewed the diabetic care and wrote and order for new parameters for notification. Resi has remained stable with no adverse outcome r/t his diabetes. 2. A onetime audit of residents with blood glucose monitoring has been completed by the DON, Unit Manager, or Regional Nurse to review physician ordered parameters and for compliance with physician notification related to blood sugar results outside of the ordered parameters. Any findings have been reported to the physician and resident representative. 3. All Licensed Nurses were re-educated by the DON, Unit Manager, SDC, or Regional Nurse on notifying the primary care physician for blood glucose results that are outside of the physician's ordered parameters. The DON, Unit Manager, SDC, MDS Coordinator, or Regional Nurse will be responsible to audit diabetic residents for blood glucose results, whether or not the results were outside the ordered parameters, and if the physician was notified for results outside of the parameters. This will be	03/22/2023

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	results: 01/15/2023 4:41 P.M. Blood Sugar: 97 mg/dL 01/23/2023 7:36 A.M. Blood Sugar: 99 mg/dL 01/29/2023 5:16 A.M. Blood Sugar: Low 01/28/2023 5:21 A.M. Blood Sugar: 97 mg/dL 01/31/2023 9:40 A.M. Blood Sugar: 99 mg/dL 02/01/2023 7:31 A.M. Blood Sugar: 83 mg/dL 02/05/2023 5:40 A.M. Blood Sugar: 90 mg/dL 02/05/2023 8:23 A.M. Blood Sugar: 90 mg/dL 02/06/2023 7:02 A.M. Blood Sugar: 81 mg/dL 02/10/2023 4:51 A.M. Blood Sugar: 95 mg/dL 02/10/2023 8:24 A.M. Blood Sugar: 95 mg/dL 02/12/2023 6:29 A.M. Blood Sugar: 99 mg/dL The Medication Administration Record on 1/29/2023 indicated Resident 157 received Lantus 45 units and Lispro 12 units in the morning. Humalog was no administered. There was no PRN Glucagon administered, and a as need blood sugar was not obtained. A Care Plan initiated on 1/22/2020, and revised on 7/21/2020, indicated Resident 157 had a diagnosis of diabetes and at risk for unstable blood glucose levels. The goal was to have a fasting blood glucose level below 140 milligrams per deciliter. The interventions included to observe and report signs and symptoms of hypoglycemia. There were no Nurse's Notes that indicated the physician had been notified of the blood sugars below 100 milligrams per deciliter. During an interview on 2/16/2023 at 8:57 A.M., LPN 1 indicated an indication of low on the glucometer indicated the blood sugar is below a certain number. She indicated the nurse should retest, notify the physician, and proceed with the procedure for hypoglycemia. She indicated documentation should be in the nurse's notes or		completed on 10 Residents weekly for 2 weeks, then for 5 residents weekly for 2 weeks, then 3 residents weekly for 2 weeks, then 2 residents monthly for 2 months, then 1 resident monthly for 4 months or until 100% compliance achieved. Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholder. Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly. Any issues identified will be immediately addressed, with 1:1 re-education provided. 4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	medication administration record for notification of the physician. On 2/16/2023 at 9:10 A.M., LPN 2 indicated she indicated Resident 157 had blood sugars below 100 a couple of times. On 2/16/2023 at 9:13 A.M., the Administrator indicated that a result of "low" would be free typed into the medication administration record. The manual for the Rosie RealTime Blood Glucose Monitoring System Version 1.0 2018/07 indicated on page 36, indicated, ..."Lo" appears when your blood glucose test result is below the lower measurement limit, which is less than 20 milligrams per deciliter. On 2/16/2023 at 12:54 P.M., the Director of Nursing provided the policy titled, "Notification of Change of Condition Policy". The policy indicated, " ...To ensure appropriate individuals are notified of changes of conditions ...1.. The facility must inform thee resident, consult with the resident's physician and notify consistent with his or her authority, the resident representative(s) when there is: ...c. need to alter treatment significantly ...2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record ...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide skin integrity assessments while an AFO (ankle foot orthotic) was in place to prevent the development of pressure ulcers for 1 of 2 residents reviewed for skin conditions. (Residents 33) Finding includes: On 2/10/2023 at 9:25 A.M., Resident 33 was observed sitting in his wheelchair in his room with an orthopedic sandal on his left foot. He indicated at this time during an interview, he has two sores on his heel and ankle. He indicated the staff took away his AFO when they determined the AFO was causing skin damage. A clinical record review was completed on 2/14/2023 at 10:27 A.M. Diagnoses included, but were not limited to: Parkinson's disease, chronic obstructive pulmonary disease (COPD), and emphysema. An Annual Minimum Data Set (MDS) Assessment on 12/6/2022 indicated Resident 33 had an unstageable deep tissue injury. He required extensive assistance with two or more staff members for dressing.	F 0686	1. Resident #33 is being evaluated weekly by the wound care nurse. Resident's wound has continued to be stable or improve. On 3/1/23 the primary care physician changed the treatment order. Resi has had no reported pain or discomfort from the wounds. 2. Potentially all residents with a splint or brace could be affected. A one-time skin assessment was completed for the current resident population that has a splint or brace in use to identify any impaired skin integrity related to the use of these. All residents with a splint or brace have been evaluated by nursing and occupational therapy for accurate fit. 3. All Licensed Nurses have been educated on residents receiving the care consistent with professional standards to prevent avoidable skin integrity issues, observing for proper fit of splints or	03/22/2023

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	A Braden Scale was completed on 11/17/2022. The score indicated Resident 33 was at mild risk for skin breakdown. A Nurse's Note on 1/9/2023 indicated the left heel area was healed. On 1/16/2023 at 6:11 A.M., a Nurse's Note indicated a bruise to the left outer ankle measuring 1 centimeter by 0.8 centimeters and the left inner heel measuring 1 centimeter by 1.5 centimeters due to the resident's AFO. An Interdisciplinary (IDT) Note on 1/16/2023 at 12:12 P.M., indicated Resident 33 continued with the left ankle and heel bruises and to refer the resident to occupational therapy for evaluation of the AFO for proper fit. A Nurse's Note on 1/23/2023 at 11:30 P.M., indicated the bruise to the left heel had turned into a blister measuring 1.3 centimeters by 1.8 centimeters. On 1/24/2023 at 9:34 A.M., a Nurse's Note indicated a new physician order was received for skin prep the left heel four times daily. On 1/25/2023 at 3:07 P.M., Wound Management entries indicated Resident 33 had a 1.5 centimeter by 1.4-centimeter blister to the inner left foot, and a 0.8 centimeter by 1.3-centimeter blister to the left ankle with bloody exudate. An IDT Note on 1/27/2023 10:24 A.M., indicated the team met to review Resident 33's two pressure areas to the left ankle and heel. The measurements of the left ankle were 0.8 centimeters by 1.3 centimeters with bright red bloody exudate and the left heel was 1.5 centimeters by 1.4		devices, and monitoring skin integrity when residents are wearing a splint or brace. The DON, Unit Manager, SDC, MDS Coordinator, Wound Care Nurse, or Regional Nurse will be responsible to audit 3 residents' skin who utilizes splints or braces daily 5 times a week for 2 weeks, then 3 residents three times a week for 2 weeks, then 3 residents once a week for 2 weeks, then 3 residents monthly for 2 months, then 1 resident monthly for 4 months or until 100% compliance achieved . Results of the audits will be forwarded to the QAPI Committee monthly for review for any needed recommendations. Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholder. 4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	centimeters. Resident 33 had a Physician's Order for a head-to-toe skin check weekly. A Care Plan on 2/12/2021 and revised on 1/16/2023 indicated Resident 33 was at risk for a pressure injury due to incontinence, weakness, pain, and other diagnoses. The goal was for the skin to be intact, free of redness, blisters, discoloration, or open areas over bony prominences. During an interview on 2/16/2023 at 9:22 A.M., LPN 1 indicated weekly skin assessments were completed. She also indicated the nurses check the resident's skin on shower days and when applying and removing the AFO. She indicated the staff did not check the left foot area every shift for skin breakdown. The Director of Nursing provided a policy on 2/16/2023 at 12:54 P.M. titled, "Skin Integrity Policy". The policy indicated, " ...The facility will ensure that based on the comprehensive assessment of a resident: 1. A resident receives care, consistent with professional standards of practice, to prevent avoidable skin integrity issues and does not development unavoidable skin integrity issues unless the individual's clinical condition demonstrates that they were unavoidable ...." 3.1-40(a)		The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review, observation, and interview, the facility failed to provide the prescribed supplementation for a resident with significant weight loss and document consumption of prescribed supplementation for 1 of 4 residents reviewed for nutrition. (Resident 1) Finding includes: A clinical record review was completed on 2/13/2023 at 11:22 A.M. Diagnoses included, but were not limited to: Spastic quadriplegic cerebral palsy, bipolar disorder, and chronic obstructive pulmonary disease. An Admission Minimum Data Set (MDS) Assessment on 12/20/2022 indicated Resident 1 had moderate cognitive impairment. He required extensive assistance with one staff member for eating. He had no weight loss and had an unstageable pressure ulcer present on admission.	F 0692	1. Resident 1 has been re-assessed by the Registered Dietitian for weight loss prevention interventions. The physician and resident representative have been notified. Resident #1's supplements have been added to the medication administration record to ensure accurate documentation of consumption. 2. A one-time audit of current residents was completed to review weight status and Registered Dietitian (RD) recommendations for the past 30 days to validate recommended and approved supplements were initiated and consumption amounts were recorded. 3. The nursing staff have been	03/22/2023

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	A Dietician note on 10/13/2022 indicated Resident 1's current body weight was 91.5 pounds. He had a body mass index of 16.28. He was prescribed Boost High Protein shakes daily, and a new order for health shakes three times daily with meals was obtained. The Dietician Note then indicated, " ...Will recommend to discontinue health shake TID [three times daily] with meals to promote PO [by mouth] intake of meals vs [versus] supplement ...." A new Physician Order was received on 10/13/2022 for, " ...Health shakes with all meals ...." There was no documentation of consumption amount of the health shake. The Boost High Protein shakes were discontinued on 10/27/2022. On 1/3/2023 Resident 1's weight was 83.5 pounds. A Nurse's Note on 1/12/2023 at 5:13 P.M., indicated a weight review was completed and Resident 1 had maintained a weight of 83.5 pounds for two weeks and had a 6.2 percent weight loss in two weeks. The nurse spoke with the dietician and a new order was received for no hard fruit. An Interdisciplinary Team (IDT) Note on 1/16/2023 at 12:04 A.M., indicated the team reviewed the dietician's recommendation from 10/5/2022. " ...Resident currently on regular dysphasia advanced, no hard fruit health shakes for all meals. IDT continues to meet residents care needs ...." On 1/17/2023 at 11:39 A.M., a Dietician's Note indicated Resident 1 presented with significant weight loss and a body mass index of 14.79,		provided re-education on providing nutritional supplements as ordered, and documenting consumption of the supplements in the medical record. The DON, Unit Manager, SDC, MDS Coordinator, RD, or Regional Nurse will be responsible to validate supplements are available and consumptions of supplements are recorded. This audit will be completed for 5 residents weekly for 2 weeks, then for 3 residents 3 times a week for 2 weeks, then for 2 resident weekly for 2 weeks, then for 2 residents monthly for 2 months, then 1 resident monthly for 4 months or until 100% compliance achieved. Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly. Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholder. 4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction. QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make	

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	indicating Resident 1 was underweight. The Dietician Note indicated Resident 1 had a 6.2 percent weight loss in 30 days, 8.7 percent weight loss in 90 days. The Dietician recommend fortified pudding at all meals to promote weight stability with no further recommendation. On 1/20/2023 at 8:17 P.M., a Nurse's Note indicated Resident 1 had maintained a weight of 83.5 pounds for two weeks, and a 7.1 percent weight loss in three weeks. An IDT Note on 1/28/2023 at 9:50 P.M., indicated the IDT met to review Resident's 1 weight and nutritional status. The note indicated Resident 1 had lost more than 5 percent in 84 days and gained three pounds this week. On 2/2/2023 at 1:06 P.M., an IDT Note indicated the IDT met to review resident's weight and nutritional status. Resident 1 had lost more than 7.6 percent in 13 days. The note indicated the plan of care was reviewed and the interventions in place were appropriate. On 2/9/2023 at 7:04 P.M., an IDT Note indicated Resident 1 had lost 3.4 percent in one week or three pounds and 9.5 percent in 30 days. The note indicated the plan of care was reviewed and interventions in place were appropriate. A weight was obtained on 2/13/2023 and was 82.5 pounds. A Dietician note on 2/14/2023 at 2:05 P.M., indicated Resident 1 presents with a significant weight loss of 10.3 percent in 104 days. Resident 1's intake was low to fair, and food preferences were reviewed. The dietician indicated that the weight goal at this time was weight stability as medically feasible. The dietician recommended to		recommendations to revise the plan of correction as indicated. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	discontinue the health shakes and begin MedPass 60 milliliters three times daily. A Care Plan on 12/14/2022 and revised on 1/19/2023, indicated Resident 1 was at nutritional risk, body mass index was underweight, a need for therapeutic supplements, and significant weight loss. The goal was for Resident 1 to receive adequate nutrition to meet estimated nutritional needs as evidenced by weight showing signs of stability. A review of the Medication Administration Record indicated there was not any documentation of acceptance and percentage of consumption for the supplemental interventions. On 2/15/2023 at 12:15 P.M., Resident 1's lunch tray was observed. The house supplement was not provided on the lunch tray. On 2/16/2023 at 7:59 A.M., Resident 1's breakfast t ray was observed. The liquids on the tray included orange juice, milk, and hot chocolate. There was no house supplement on the breakfast tray. During an interview on 2/16//2023 at 9:29 A.M., LPN 1 indicated that the nursing staff provide the house supplement, and the type of supplement can change based on supply availability. She indicated if the supplement was to be administered by the nursing staff a percentage of consumption would be documented, but not if it was part of a dietary order. She indicated all supplements should be have documentation of consumption. On 2/16/2023 at 9:37 A.M., the Administrator indicated during an interview that with a dietary order the percentage of consumption will not be			

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	documented, but included in the fluid volume consumed. He indicated if a nurse was providing the supplementation a percentage of consumption would be documented. A policy was provided on 2/16/2023 at 12:54 P.M. by the Director of Nursing titled, "Weighing and Measuring Height". The policy indicated, " ...3. Significant weight changes are considered significant changes in condition and require facility staff assessment/intervention ...." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to properly store the resident's C-PAP (continuous positive airway pressure) mask for 1 of 2 residents reviewed for respiratory devices. (Resident 33) Finding includes: During an observation on 2/9/2023 at 10:14 A.M. and 2:25 P.M., Resident 33's C-PAP mask was lying across his made bed. On 2/10/2023, the C-PAP mask was placed in the upper nightstand drawer without any protection.	F 0695	1. Resident #33 was assessed by the DON on 2/16/23 for signs and symptoms of infection. There were none noted and no noted adverse outcomes. Resident #33 has a bag to store the CPAP. 2. One time audit completed by DON for CPAP or BIPAP. 3. The Licensed Nurses and Certified Nurse Aides have been	03/22/2023

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	155474	A. BUILDING 00 B. WING	02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF BREMEN	316 WOODIES LANE BREMEN, IN 46506

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	During an interview, Resident 33 indicated the mask and tubing for the C-PAP does not get cleaned regularly. On 2/13/2023 the C-PAP mask was observed lying across the C-PAP machine on the nightstand. A clinical record review was completed on 2/14/2023 at 10:27 A.M. Diagnoses included, but were not limited to: Parkinson's disease, chronic obstructive pulmonary disease (COPD), and emphysema. An Annual Minimum Data Set (MDS) Assessment on 12/6/2022 indicated Resident 33 had a non-invasive mechanical ventilator. A Care Plan developed on 2/12/2021, and revised on 12/20/2022, indicated Resident 33 had a diagnosis of COPD, emphysema, and obstructive sleep apnea with a potential for complications. The care plan, nor physician's orders indicated proper storage of the C-PAP mask. During an interview on 2/16/2023 at 9:14 A.M., LPN 1 indicated the C-PAP m ask should be stored in a bag. On 2/16/2023 at 12:54 P.M., the Director of Nursing provided the policy titled, "CPAP/BIPAP Therapy-Clinical Practice Guidelines". The policy indicated, " ...22. When pap circuit is not in use place in treatment bag ...." 3.1-47(a)(6)		educated on the proper storing of CPAP or BIPAP mask when not in use. The DON, Unit Manager, SDC, MDS Coordinator, Administrator, or Regional Nurse will audit all residents utilizing a CPAP or BIPAP for proper mask storage when not in use daily Monday through Friday for 2 weeks, then three times a week for 2 weeks, then weekly for 2 weeks, then monthly for 6 months **/b> .** **Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly.** **Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholder.** **4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction. QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **The Administrator is**	

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			responsible for the oversight of this plan to ensure ongoing compliance.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure food and beverages were dated/labeled and store pots, mixing bowls, and colanders in a sanitary manner. Findings include: During a brief tour of the kitchen on 2/9/2023 between 9:35 and 9:55 A.M., observed in the walk-in refrigerator 4 dessert cups with fresh fruit uncovered, sausage gravy, brown gravy,	F 0812	1. The dessert cups, sausage gravy, brown gravy, scrambled eggs, cinnamon rolls, and applesauce that the surveyor observed in containers was immediately discarded. The chocolate milk, lactose free milk, butter, and parmesan cheese that surveyor observed were discarded immediately. The pots, bowls, and colander were immediately	03/22/2023

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	scrambled eggs, cinnamon rolls, applesauce in containers with no date/label, 2 open gallons of chocolate milk and quart of lactose free milk undated, one pound of butter half gone wrap in plastic and dry parmesan cheese open in plastic bag undated. During an interview, on 2/9/2023 at 9:53 A.M., the Dietary Manager indicated that anything that is opened needs to be labeled with the date open and the date it expires. During another tour of the kitchen on 9/16/2023 at 8:55 A.M., observed pots, mixing bowls and colanders on a bottom open shelf approximately 8 inches from the floor not inverted, with visible crumbs, grit and dust when hand swept across the shelf. During an interview, on 2/16/2023 at 8:57 A.M., the District Dietary Manager indicated the bowls and pots do not need to be inverted since they are dry and put away, they could get dust and debris on them but the staff would inspect and wash them before use. On 2/9/2023 at 12:12 P.M., the Administrator provided a policy titled, "Food Storage: Cold Foods", revised 4/2018, "...Procedures: 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination...." On 2/16/2023 at 8:58 A.M., the District Dietary Manager provided a policy titled, "Equipment", revised 9/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedures: 3. All food contact equipment will be clean and free of debris...."		washed and stored inverted to prevent dust and debris to contaminate the cookware. 2. A onetime inspection of the stored dishware and cookware was completed to validate items were stored appropriately. A one-time audit of food and beverages being stored in the kitchen was completed for accurate dating/labeling of items. 3. The dietary staff have been re-educated on labeling and dating food items when opened and with expiration date, covering food items while being stored in refrigerator, and proper storage of dishware-cookware in the inverted position. The Dietary Manager, Dietary Cook, or District Manager will be responsible to conduct inspection rounds for proper storage of dishware / cookware and to ensure Food is Stored, Prepared, and Served in accordance with professional standards for food service safety daily for 2 weeks, then weekly for 2 weeks, then monthly for 6 months **/b>. Results of the audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly.** **Any issues identified will be**	

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	3.1-21(i)(3)		**immediately corrected, 1:1 re-education completed for stakeholder.** **4. A QAPI meeting was held on 3/15/23 with Medical Director, Administrator, DON, Unit Manager, Plant OPS, Activity Director to review Plan of Correction QAPI meetings will be held monthly. Based on evaluation of audits, the QAPI Committee will determine if the facility is in substantial compliance or if ongoing auditing will continue. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.**	