| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155474 | A. BUILDING **01**<br>B. WING _____ | R<br>**04/11/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SIGNATURE HEALTHCARE OF BREMEN** | **316 WOODIES LANE**<br>**BREMEN, IN 46506** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/13/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).<br><br>Survey Date: 04/11/2023<br><br>Facility Number: 000506<br>Provider Number: 155474<br>AIM Number: 100266530<br><br>At this Life Safety Code PSR, Signature Healthcare of Bremen was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and resident rooms 301-309. Battery powered smoke alarms were located in resident rooms 101-124, and in resident rooms 201-216. The facility has 82 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 52.<br><br>All areas where the residents have customary access were sprinklered, all areas providing facility services were sprinklered<br><br>Quality Review completed on 04/11/23 | {K 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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