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	02/17/2025

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 IN00450422, IN00452469, IN00451149 & IN00450663. Complaint IN00450422 - No deficiencies related to the allegations are cited. Complaint IN00452469 - No deficiencies related to the allegations are cited. Complaint IN00451149 - No deficiencies related to the allegations are cited. Complaint IN00450663 - No deficiencies related to the allegations are cited. Survey dates: February 11, 12, 13, 14 & 17, 2025 Facility number: 000506 Provider number: 155474 AIM number: 100266530 Census Bed Type: SNF/NF: 61 Total: 61 Census Payor Type: Medicare: 7 Medicaid: 35 Other: 19 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 2/24/2025	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Lewis	Administrator	03/07/2025

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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F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on record review and interview, the facility failed to ensure an advance directive was completed upon admission for 1 of 24 residents reviewed for advance directives (Resident 63). Finding includes: A record review was completed on 2/13/2025 at 10:21 A.M. for Resident 63 and indicated the resident was admitted to the facility on 1/21/2025. An Admission Minimum Data Set (MDS) assessment, dated 1/28/2025 indicated the resident's cognition was significantly impaired. A Physician's Order, dated 1/22/2025 indicated the following: "Do Not Resuscitate (DNR)." The record lacked documentation of a completed DNR form signed by Resident 63 and/or the resident's representative. During an interview on 2/13/2025 at 3:00 P.M., the Administrator indicated the resident should have had a signed DNR form upon admission. On 2/13/2025 at 2:35 P.M., the Administrator provided a policy titled, "Advance Directives," dated 5/13/2024 and indicated it was the policy currently being used by the facility. The policy indicated, "...During the admission process the facility will attempt to determine whether the resident has an advance directive and, if not, determine whether the resident wishes to formulate an advance directive...." 3.1-4(f)(5)	F 0578	F 578 It is the intent of Signature Healthcare to honor every resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #63 Advanced Directive has completed and reflects the resident wishes. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; an audit of all Advanced Directives has been completed and all residents/legal representative have made their declarations and orders in place to honor their choices. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Re-education of the licensed nurses regarding Advanced Directives Policies by the Director of Nursing/Designee. The DON, or designee, will complete an audit of 5 residents for advanced directive completeness and presence. Audit will be conducted weekly X 4, then every other week X 2	03/14/2025

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			months, then monthly X 3 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; The audits will be reported to the Quality Assurance Performance Improvement committee monthly times 6 months the Quality Assurance Performance Improvement committee will determine at that time the need for continued monitoring.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to notify the ombudsman of hospital transfers for 1 of 4 residents reviewed for hospitalizations. (Resident 52) Finding includes: A record review for Resident 52 was completed on 2/13/2025 at 10:13 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, delusional disorder, neuromuscular disfunction of the bladder and obstructive and reflux uropathy. A Quarterly Minimum Data Set (MDS) assessment, dated 1/14/2025, indicated Resident 52 had severe cognitive impairment and had an indwelling urinary catheter. A Nursing Progress Note, dated 9/7/2024 at 2:20 P.M., indicated Resident 52 was transferred to a neuropsychological hospital.	F 0623	F 623- It is the intent of Signature Healthcare of Bremen to notify the ombudsman of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman as prescribed. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 52 discharged was sent to the State Ombudsman. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Of all discharged residents. An audit was completed with no findings. what measures will be put into place and what systemic changes will be made to ensure that the	03/07/2025

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	A Nursing Progress Note, dated 9/23/2024 at 11:42 A.M., indicated Resident 52 returned to the facility. A Nursing Progress Note, dated 9/27/2024 at 9:09 P.M., indicated Resident 52 had removed her urinary catheter. A Nursing Progress Note, dated 10/2/2025 at 11:24 P.M., indicated Resident 52 returned to the facility from the hospital. A report was provided from the hospital that the urinary catheter had been replaced. A review of the provided September and October transfer and discharge list sent to the Ombudsman did not have Resident 52 listed as a transfer from the facility. During an interview, on 2/17/2025 at 11:48 A.M., the Director of Nursing (DON) indicated the Ombudsman should have been notified of the transfers from the facility. A current policy was provided by the executive Director on 2/17/2025 at 1:02 P.M. The policy titled, "Transfer/Discharge Notice", indicated, " ...7. Before a facility transfers or discharges a resident: a ...Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman ...." 3.1-12(a)(6)(A)((iv)		deficient practice does not recur; Social Services Designee was provided education regarding the notification of discharge to the State Ombudsman by the Administrator. The Administrator or designee will complete an audit of monthly report prior to submission and for timely submission to the Ombudsman for the completeness. Audit will be conducted monthly X 6 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; an Audits will be reported to the Quality Assurance Quality Improvement committee monthly times 6 and the committee will determine the need for future monitoring.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility	F 0641	what corrective action(s) will be accomplished for those residents	03/14/2025

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	failed to accurately complete the Minimum Data Set (MDS) assessment for 1 of 4 residents reviewed for accidents. (Resident 54) Finding includes: During an interview on 2/11/2025 at 11:16 A.M., Resident 54 indicated she had fallen about 5 times with no major injuries within the last few months. A record review was completed on 2/14/2025 at 1:15 P.M. for Resident 54. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus, chronic bronchitis and generalized anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 2/10/2025, indicated Resident 54's cognition was intact, she had no behavior issues, no functional impairments, ambulated without assistive device, was independent with toileting and transfers, and had no falls since the previous MDS assessment. The Events section of the clinical record for Resident 54 indicated the resident had two falls in January 2025, on 1/2/2025 and on 1/3/2025. There were no major injuries. During an interview on 2/14/2025 at 2:21 P.M., the MDS Nurse indicated she participated in the follow up Interdisciplinary Team Meetings after falls and used information found in the clinical record under the Events section to determine if there had been falls since the last MDS assessment. She indicated the two falls in January 2025 should have been documented on the Quarterly MDS assessment completed on 2/10/2025.		found to have been affected by the deficient practice; Resident #54 MDS has been resubmitted with correction. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit of the residents with falls compared to MDS has been completed with no new findings. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Re-education of the MDS coordinator was completed by the Regional MDS consultant regarding accuracy of MDS. The MDS Coordinator or designee, will review 5 residents, as available, who have had a MDS assessment completed for accuracy, falls. Audit will be completed weekly x4 weeks, then every other week x2 months, 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; an Audits will be reported to the Quality Assurance Quality Improvement committee monthly times 6 and the committee will determine the need for future monitoring.	

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	0214/25 03:05 PM The ED indicated there was no facility policy for completing MDS assessments as they followed the Resident Assessment Instrument (RAI) Manual.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review, interview and observation, the facility failed to develop and implement a comprehensive person-centered care plan for skin issues and abusive behaviors for 3 of 19 residents whose care plans were reviewed. (Residents 5, 38 and 52) Findings include: 1. During an interview, on 2/11/2025 at 11:53 A.M., Resident 5 indicated she picked at the areas on her face. Two scabbed areas with redness were bserved on the residents' face. The record for Resident 5 was reviewed on 2/14/2025 at 9:44 A.M. Diagnoses included but were not limited to: arthritis, osteoporosis and dysphagia. A Nursing Progress Note, dated 6/24/2024, indicated the following: " 3.2 x 2.0 x 0 circle redness to the left cheek. The resident denies pain to the area, itchy at times". Current Physician Orders included: Triamcinolone acetonide cream 0.025 % apply topical to irritation to left cheek twice a day, ordered on 6/26/2024. A Nursing Progress Note, dated 6/26/2024, indicated "triamcinolone 0.025 twice daily ordered for irritated spot-on left cheek. The resident states	F 0656	F-656 It is the intent of Signature Healthcare to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #5 cancerous area, #38 discolored areas to skin and resident #52 physical altercations have been reviewed and updated. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Resident care plans were reviewed by the Interdisciplinary Team and updated for skin conditions and aggressive behaviors. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Interdisciplinary Team was provided re-education for person-center care plans by the Regional MDS Consultant. MDS	03/14/2025

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	she has had it for years and it's skin cancer she scratches open at times." The residents' record lacked a care plan related to the cancerous areas on her cheek or her behaviors of picking at her face. During an interview, on 2/17/2025 at 1:36 P.M., the Administrator indicated there should have been a care plan for the cancerous areas on her face. 2. During an interview, on 2/12/2025 at 9:09 A.M., Resident 38 was observed with numerous purple areas on both of his arms and hands. The record for Resident 38 was reviewed on 2/13/2025 at 2:00 P.M. Diagnoses included, but were not limited to congestive heart failure, diabetes, renal disease and hypertension. Current Physician Orders included: Aspirin 81 mg (milligrams) every day. An Admission Assessment, dated 2/3/2025 at 4:32 P.M., indicated the resident had Skin Impairments upon admission. The assessment directed staff to complete an event form if there were noted skin impairments. A Nursing Progress Note, dated 2/3/2025, indicated the resident returned to the facility on 2/3/2025 from a hospital stay with numerous bruises on his upper extremities, bilaterally, related to IV's and blood draws. The clinical record lacked a care plan related to the use of aspirin and the purple/discolored areas on the resident's arms that were present upon readmission.		Coordinator or designee will complete an audit of new behaviors including physical aggression and cancerous lesions/skin discolorations on 5 residents, as available, to ensure care plan is in place. Audit will be completed weekly x4 weeks, then every other week x2 months, 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; Audits will be reported to the Quality Assurance Quality Improvement committee monthly times 6 and the committee will determine the need for future monitoring.	

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	During an interview, on 2/14/2025 at 3:55 P.M., the Administrator indicated there was no skin event assessment completed and no progress were completed related to the numerous bruises noted upon admission. 3. During an observation, on 2/12/2025 at 9:25 A.M., Resident 52 was noted to be crying at an activity. A record review for Resident 52 was completed on 2/13/2025 at 10:13 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia with agitation, major depressive disorder, post-traumatic stress disorder and delusional disorder. A Quarterly Minimum Data Set (MDS) assessment, completed on 1/14/2025, indicated Resident 52 had severe cognitive impairment, no mood or behavior issues and was taking an antipsychotic, antianxiety and antidepressant medication. A Physician's Order, dated 11/7/2024, indicated the facility was to monitor the resident's behaviors related to pointing her finger at other residents and taking her clothing off. A Physician's Order, dated 11/24/2024, indicated the facility was to monitor the resident's exit seeking behaviors. A Nursing Progress Note, dated 9/5/2024 at 8:15 P.M., indicated Resident 52 poked Resident 27 in the chest. Resident 27 responded by striking resident 52 in the right eye. A Nursing Progress Note, dated 9/7/2024 at 6:45 A.M., indicated Resident 52 was unkind to Resident 27. While staff walked away with Resident 52 arm in arm, Resident 52 struck			

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	Resident 27 in the face with Resident 27 instantly striking back. A new physician order was received to send Resident 52 to a psychiatric hospital for an evaluation and treatment and one-on-one observations were implemented. A Nursing Progress Note, dated 12/9/2024 at 4:30 P.M., indicated Resident 52 became upset about a Crayon box and made physical contact with the tips of her fingers to Resident 55's face. 15-minute checks were initiated by the facility. A Nursing Progress Note, dated 12/18/2024 at 7:25 P.M., indicated Resident 52 swatted at Resident 27 on the resident's forearms. A Nursing Progress Note, dated 2/1/2025 at 4:00 P.M., indicated Resident 52 was holding Resident 34's wrists. During the separation of Resident 52 and 34, Resident 52 pushed Resident 34's head. 15-minute checks were initiated by the facility. Resident 52 did not have a behavioral care plan in place to address physical altercations with other residents and preventative interventions other than a plan to address her behavior of pointing her finger at other residents. A policy was provided by the Executive Director, on 2/17/2025 at 1:02 P.M. The policy, titled, "Comprehensive Care Plans", indicated, " ...The facility will develop and implement a comprehensive person-centered care pan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychological needs that are identified in the comprehensive assessment ....6. The Comprehensive Care Plan will be person-centered for each resident ...."			

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F 0677 SS=D Bldg. 00	3.1-35(a) 483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to ensure residents received scheduled showers for 2 of 4 residents reviewed for activity of daily living (ADL) care. (Residents 57 & 48) Findings include: 1.During an observation, on 2/11/2025 at 12:05 P.M, Resident 57 was observed in the dining room and had greasy and disheveled hair. During an observation, on 2/12/2025 at 10:39 A.M., Resident 57 was observed in the dining room and had greasy and disheveled hair. During an observation, on 2/14/2025 at 11:58 A.M., Resident 57 was observed in his room with his hair disheveled, greasy and with white specks in his hair. Resident 52 indicated he had not refused his showers and received a shower the other night. A record review for Resident 57 was completed on 2/13/2025 at 9:23 A.M. Diagnoses included, but were not limited to: dementia and diabetes mellitus type 2. An Admission Minimum Data Set (MDS) assessment, dated 12/16/2024, indicated Resident 57 had moderate cognitive impairment and required supervision for bathing. A Physician's Order, dated 12/20/2024, indicated Resident 57 was to have showers on Tuesdays	F 0677	F-677 It is the intent of Signature Healthcare to provide ADL care for dependent residents. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #57 received and shower and nail care and resident # 48 shower preference has been updated. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Dependent residents were audits for shower preferences and received nail care and a shower per resident preference. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were re-educated on process ADL care for dependent residents to including resident preference, showers, and nail care by the Director of Nursing/Designee. The DON, or designee, will complete an audit of 5 residents for completion of showers per preference and documentation and nail care. Audit will be completed weekly x4	03/14/2025

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	and Fridays on second shift and refused showers were to be documented in the nurse's notes. The Medication Administration Record, for December 2024, January 2025 and February 2025, indicated no refusals for showers were documented. The Point of Care documentation for showers received from December 2024 through February 2025 indicated Resident 57 was only provided showers on the following dates: - 12/9/2024 - 12/24/2024 - 1/1/2025 - 1/22/2025 - 1/15/2025. There was no documentation indicating why the resident had not received showers on 12/12/2024, 12/17/2024, 12/20/2024, 12/27/2024, 1/3/2025, 1/7/2025, 1/10/2025 or 1/17/2025. A Care Plan, initiated on 11/19/2024 and updated on 2/12/2024, indicated Resident 57 had a self-care deficiency related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of ADL care. The goal was for Resident 57 to not experience any adverse outcomes related to requiring assistance with ADL care. Interventions included, but were not limited to: provide frequent encouragement, along with prompting and assistance as needed, encourage resident to participate if they are able and provide the amount of assistance resident needs for completion of ADL cares. During an interview, on 2/14/2025 at 11:46 A.M., QMA 3 indicated handwritten shower sheets were		weeks, then every other week x2 months, 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; an Audits will be reported to the Quality Assurance Quality Improvement committee monthly times 6 and the committee will determine the need for future monitoring.	

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	not used for documentation and all shower documentation was completed in the Point of Care module in the electronic medical record. During an interview on 2/14/2025 at 1:45 P.M., RN 5 indicated resident 57 sometimes refused showers and the CNA should have informed the nurse if a shower was refused. She indicated the refusal would be documented in the Medication Administration Record. During an interview, on 2/14/2025 at 3:29 P.M., Resident 57 indicted he was independent and requested when he wanted a shower.2. During an observation, on 2/11/2025 at 10:56 A.M., Resident 48 was observed with long fingernails. The record for Resident 48 was reviewed on 2/14/2025 at 3:25 P.M. Diagnoses included but were not limited to hypertension, hip fracture, aphasia, hemiplegia and anxiety. A Quarterly MDS (Minimum Data Set) assessment, dated 11/19/2024, indicated the resident required partial to moderate assist for transfers and substantial to maximum assist for showers. A Care Plan, initiated on 4/22/2024, indicated Resident 48 required assistance with ADL's (activities of daily living) including late loss ADLs of bed mobility, transfers, eating, toileting related to hemiplegia. Interventions included but were not limited to: Observe for decline in ADL function. Provide verbal, tactile cues to assist with ADL completion as needed. Stand pivot transfers with mod assist. Supportive devices as ordered (walker, splint, brace, wheelchair). A Physician's Order, dated 11/9/2024, indicated			

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	155474	A. BUILDING 00 B. WING	02/17/2025

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	the resident preferred to receive showers on Wednesdays and Saturdays Day shift. The order instructed the facility to document in the progress notes if the resident refused showers. In addition the order indicated the nurse was to complete a skin assessment on Saturdays. The shower documentation, dated 1/18 to 2/14/2025, indicated the resident had not received any showers from 1/18 to 1/29/2025 (11 days) and no showers from 2/2 to 2/12/2025 (11 days). There was no documentation of any shower refusals in the Nursing Progress Notes from 1/8/2025-2/14/2025 for Resident 48. During an interview, on 2/13/2025 at 1:18 P.M., CNA 8 indicated the showers were only documented on the computer. On 2/17/2025 at 1:23 P.M., the Director of Nursing provided the policy titled, "Activities of Daily Living (ADLs)", dated 1/31/2025, and indicated the policy was the one currently used by the facility. The policy indicated... "1. For those residents who are unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of care...." 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure a resident who returned from a hospital stay was assessed for new and or existing skin issues for 1 of 2 residents reviewed for skin issues. (Resident 38)	F 0684	F-684 It is the intent of Signature Healthcare the fundamental principles of quality of care that applies to all care of the residents. what corrective action(s) will be accomplished for those residents	03/21/2025

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	Finding includes: During an interview, on 2/12/2025 at 9:09 A.M., Resident 38 was observed with numerous purple areas to both arms and hands. The record for Resident 38 was reviewed on 2/13/2025 at 2:00 P.M. Diagnoses included, but were not limited to congestive heart failure, diabetes, renal disease and hypertension. Current Physician Orders included: - Aspirin 81 mg (milligrams) every day. - Weekly Skin Assessment . A Nursing Progress Note, dated 2/3/2025, indicated the resident returned to the facility and numerous bruises on his upper extremities bilaterally were observed, related to IV's and blood draws. An Admission Assessment, dated 2/3/2025, indicated the resident had a Skin Impairment upon admission and staff were directed to complete a Skin Event assessment. The clinical record lacked a skin event and documentation/assessment of the numerous bruised areas to the residents' bilateral arms and hands. A Weekly Skin Assessment completed, on 2/8/2025, documented the resident as having existing impaired skin. There was no indication of where the skin impairment was located and/or a description of the skin issue. During an interview, on 2/14/25 at 2:09 P.M., the Director of Nursing indicated skin assessments should be done weekly. She indicated the wound		found to have been affected by the deficient practice; Complete head to toe assessment of resident was conducted for resident #38 with events opened as warranted. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Resident have the potential to be affected, head to toe skin assessments completed recorded in their EMR per policy for all residents. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nursing personnel received re-education of the admission process including skin assessment and documentation per policy. The DON, or designee, will complete an audit of 5 residents as available for admission skin assessment for completeness. Audit will be conducted weekly X 4, then every other week X 2 months, then monthly X 3 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; an Audits will be reported to the Quality Assurance Quality Improvement committee	

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	nurse and the ADON (Assistant Director of Nursing) completed skin rounds every week. During an interview, on 2/14/2025 at 4:02 P.M., the Administrator indicated no skin event form was completed when Resident 38 returned from the hospital. During an observation and interview, on 2/17/2025 at 9:15 A.M., the resident indicated he was to receive his showers on Tuesdays and Fridays. He indicated a nurse did not complete any skin assessments on his shower days. Resident 38 was observed with numerous dark, purple areas to the his left arm and hand. Resident 38 indicated the areas on his left hand was where he had gotten the skin taken off by a wheelchair. There were other areas to the left upper arm and right arm that he indicated he received while in the hospital. On 2/17/2025 at 1:23 P.M., the Director of Nursing provided the policy titled, "Skin Integrity", dated 1/31/2025, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Upon admission, the licensed nurse shall complete the initial skin check... 3. Recommend ongoing observation of skin integrity by licensed nursing staff. 4. The licensed nurse shall initiate applicable Skin Integrity documentation if a new area of impairment is identified...." No further wound/skin assessments for Resident 38 were provided prior to the survey exit on 2/17/2025. 3.1-37		monthly times 6 and the committee will determine the need for future monitoring.	
F 0740 SS=D	483.40 Behavioral Health Services			

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Bldg. 00	Based on observation, record review and interview, the facility failed to implement effective behavior monitoring to prevent resident to resident altercations from recurring. . (Resident 52) Findings include: 1. During an observation, on 2/12/2025 at 9:25 A.M., Resident 52 was crying at an activity. A record review for Resident 52 was completed on 2/13/2025 at 10:13 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, dementia with agitation, major depressive disorder, post-traumatic stress disorder and delusional disorder. A Quarterly Minimum Data Set (MDS) assessment, on 1/14/2025, indicated Resident 52 had severe cognitive impairment, no mood or behavior issues and was taking an antipsychotic, antianxiety and antidepressant medication. A Physician's Order, dated 11/7/2024, indicated behavior monitoring for pointing fingers at other residents and taking her clothing off. A Psychiatry Initial Consult note, dated 11/8/2024, indicated Resident 52 was observed pacing, restless, crying, confused and mildly agitated. Resident 52 was difficult for staff to redirect and was unable to sit still during the visit. Staff had attempted to redirect, but redirection was not accepted. A Physician's Order, dated 11/24/2024, indicated an order for behavior monitoring for exit seeking behavior.	F 0740	F-740 It is the intent of Signature Healthcare to provide behavior monitoring for residents. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #52 careplan was reviewed and update to include behavior monitoring by the interdisciplinary team. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Resident careplans were reviewed for behavior monitoring and updated by the interdisciplinary team. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Interdisciplinary Team was provided re-education for behavior management careplans by the Regional MDS Consultant. The Social Services Designee, or designee, will complete an audit of new behaviors on 5 residents, as available, to ensure care plan is in place. Audit will be completed weekly x4 weeks, then every other week x2 months, then monthly x3 months. how the corrective action(s) will be monitored to ensure the deficient	03/14/2025

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	A Nursing Progress Note, dated 9/5/2024 at 8:15 P.M., indicated Resident 52 poked Resident 27 in the chest. Resident 27 responded by striking resident 52 in the right eye. A Nursing Progress Note, dated 9/7/2024 at 6:45 A.M., indicated Resident 52 was unkind to Resident 27. While staff walked away with Resident 52 arm in arm, Resident 52 stuck Resident 27 in the face with Resident 27 instantly striking back. A new physician order was received to send Resident 52 to a psychiatric hospital for evaluation and treatment and one-on-one observations were placed. A Nursing Progress Note, dated 12/9/2024 at 4:30 P.M., indicated Resident 52 became upset about a Crayon box and made physical contact with the tips of her fingers to Resident 55's face. 15-minute checks were initiated by the facility. A Nursing Progress Note, dated 12/18/2024 at 7:25 P.M., indicated Resident 52 swatted at Resident 27 on the forearms. A Nursing Progress Note, dated 2/1/2025 at 4:00 P.M., indicated Resident 52 was holding Resident 34's wrists. During the separation of Resident 52 and 34, Resident 52 pushed Resident 34's head. 15-minute checks were initiated. Resident 52 did not have a behavioral care plan in place with preventative interventions to address physical altercations. During an interview, on 2/17/2025 at 10:52 A.M., the Executive Director indicated behaviors were discussed every morning and monthly with the Nurse Practitioner, Social Service Director, Director of Nursing and Pharmacy Consultant.		practice will not recur, i.e., what quality assurance program will be put into place; an Audits will be reported to the Quality Assurance Quality Improvement committee monthly times 6 and the committee will determine the need for future monitoring	

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	She indicated a psychologist came to the facility monthly, collaborated with staff to determine the root cause of the behavior and placed interventions, which were care planned. She indicated interventions should be placed in the care plan to detour further altercations/behaviors. A policy for behavior management was requested on 2/17/2025 at 11:28 A.M. A policy was not provided. The Director of Nursing indicated on 2/17/2025 at 1:02 P.M., a policy was not available. 3.1-27(a)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to ensure food was stored, prepared and served under sanitary conditions in 1 of 1 kitchens and 2 of 2 resident nutrition pantries. This deficient practice had the potential to affect 59 of 61 residents who received meals out of the kitchen. (main kitchen, north unit nutrition pantry & south unit nutrition pantry). Findings include: 1. During the initial tour of the kitchen, on 2/11/2025 at 10: 26 A.M., with the Dietary Manager the following was observed: In the walk in freezer: - there was an opened bag of chicken pieces not sealed. - the floor had pieces of food and other debris. 2. In the walk in cooler: - there was an opened container of Med Plus (supplement) with an expiration date of 1/8/2025. - there was 2 opened containers of Thickened	F 0812	F- 812 It is the intent of Signature Healthcare to store, prepare, distribute and serve food in accordance to professional standards. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were cited. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. All residents were assessed with no adverse effects noted. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	03/14/2025

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	liquid with no date when they had been opened. - there was an opened bag of hash browns with a use by date of 2/6/2025. - and a metal container of shredded pork with a use by date of 2/8/2025. 3. In the dry storage area: - there was an opened bag of graham crackers crumbs that were not sealed tightly. During an interview, on 2/11/2025 at 10:49 A.M., the Dietary Manager indicated the expired foods should have been removed, the opened foods should have been sealed tightly and the liquids should have had a date when opened. 4. During a follow-up tour of the kitchen on 2/14/2025 at 9:53 A.M., with the Corporate Dietician, the following was observed: - 3 skillets stored as clean and available for use with missing Teflon off the cooking surface along with rust-colored areas. - 2 small steam table pans stored as clean with dried food substances. - and opened unsealed box of cream wheat. - 2 serving scoops with dried food substances on them. - multiple soup bowls, stored as clean, had dried specs of food. - water pitchers with brown stained areas. - 3 large metal steam table pans stored as cleaned with visible water in them. - the plate covers, soup bowls and coffee cups being utilized to serve meals had a large buildup of lime causing the items to have a white substance on them. During an interview, on 2/14/2025 at 10:20 A.M., the Corporate Dietician indicated the skillets should not be used, the scoops and other cooking		Re-education of the dining staff food storage, dating date open and use by date including snacks, removal of expired food, process for removing equipment that is chipped or affected by lime build up, ware washing standards, Cleaning and temperature monitoring of refrigerators. Housekeeping educated on cleaning of the Microwaves in pantries. Staff re-educated on storage of their food. The Dietary Manager or designee, will complete an audit 3 times weekly for food storage, dating date open and use by date including snacks, and removal of expired food. Audit will be conducted weekly X 4, then every other week X 2 months, then monthly X 3 months. The Dietary Manager or designee will complete an audit for discolored of lime-stained wares and/or pots or pans chipped. Audit will be conducted weekly X 4, then every other week X 2 months, then monthly X 3 months. The Housekeeping Manager or designee will complete an audit for microwaves not in the kitchen for cleanliness. Audit will be conducted weekly X 4, then every other week X 2 months, then monthly X 3 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; an Audits will be	

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	utensils should have been clean, and the steam table pans should not have been put away wet. In addition, she indicated the cream of wheat should have been sealed appropriately. She indicated the plate covers, soup bowls and the coffee cups should not have the white color on them. She indicated the facility was not able to get the white lime buildup off due to the hard water. 4. During an observation, on 2/17/2025 at 1:02 P.M., with the Director of Nursing of the south hall nutrition pantry the following was observed: - a microwave with a yellow substance on the glass turn table. - a microwaveable frozen food with a staff's name on it. - a broken seal along the bottom of the refrigerator door. - a dirty shelf with a brown substance in the refrigerator. - no thermometer was located in the refrigerator. During an interview, on 2/17/2025 at 1:05 P.M., the Director of Nursing indicated the microwave should have been cleaned; there should have been a thermometer in the refrigerator; the seal to the refrigerator should have been fixed and there should be no staff items in the resident's refrigerators. 5. During an observation, on 2/17/2025 at 1:07 P.M., with the Director of Nursing on the north hall nutrition pantry the following was observed: - in the refrigerator was a dirty shelf with a dried food substance. - the refrigerator had a dark substance stuck to the bottom of the drawer. - there was a cup of pudding with a date of 11/4 and a discard date of 11/11/24.		reported to the Quality Assurance Quality Improvement committee monthly times 6 and the committee will determine the need for future monitoring.	

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	During an interview, on 2/17/2025 at 1:10 P.M., the Director of Nursing indicated the refrigerator should have been cleaned and the pudding cup should not have been in the refrigerator. On 2/14/2025 at 11:23 A.M., the Administrator provided the policy titled, "Receiving", dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... Safe food handling for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items... 5. All food items will be appropriately labeled and dated either through manufacture packaging or staff notation...." On 2/14/2025 at 11:23 A.M., the Administrator provided the policy titled, "Ware washing", dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "... All dishware, service ware, and utensils will be cleaned and sanitized after each use... 4. All dishware will be air dried and properly stored...." On 2/17/2025 at 1:37 P.M., the Administrator provided the policy titled, "Snacks", dated 10/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ... 7. All snacks will be properly stored for the time and temperature control, as appropriate...." 3.1-21(i)(3)			
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to follow infection control procedures during a medication pass for 2 of 4 residents observed. (Resident 8 & 20)	F 0880	F-880 It is the intent of Signature Healthcare to maintain an infection prevention and control program. what corrective action(s) will be	03/14/2025

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	Finding includes: During an observation of a medication pass, on 2/12/2025 at 8:01 A.M., LPN 6 prepared Resident 8's medications. LPN 6, with her bare hands, broke 2 potassium chloride tablets in half. She indicated this was the only way she could break the tablets in half and she had sanitized her hands prior to starting the preparation of medication. During an observation, on 2/12/2025 at 8:08 A.M, LPN 6 was at the medication cart and coughed into her bare hand. During an observation, on 2/12/2025 at 8:10 A.M., LPN 6 prepared Resident 20's insulin injection. LPN 6 did not sanitize her hands prior to the preparation of the insulin. LPN 6 administered Resident 20's insulin injection without gloved hands. LPN 6 indicated she should have sanitized her hands between the resident's medication administration. During an interview, on 2/17/2025 at 11:52 A.M., the Director of Nursing (DON) indicated LPN 6 should have worn gloves to break medication tablets and when administering an injection. A policy was provided by the Executive Director, on 2/12/2025 at 12:01 P.M. The policy titled, "Medication Administration", indicated " ...Medication Preparation ...4 ...If breaking tablets is necessary to administer the proper dose, hands will be washed with soap and water and gloves applied prior to handling tablets ...Medication Administration ...11. Hands are washed with soap and water and gloves applied before administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications		accomplished for those residents found to have been affected by the deficient practice; Resident #8 and resident #20 were assessed and findings reported to the physician. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; all residents were assessed with no adverse effects noted. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nurses and qualified medication aides re-educated for infection practices with medication pass including cough hygiene, use of gloves and hand sanitation. Re-education included medication pass observation by Director of Nursing/Designee. The DON, or designee, will audit 5 nurses/qualified medication aides for medication administration to ensure infection control techniques are adherence. Audit will be completed weekly x4 weeks, then every other week x2 months, 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; an Audits will be reported to the Quality Assurance Quality Improvement committee monthly times 6 and the	

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	...." 3.1-18(a)		committee will determine the need for future monitoring.	