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	03/12/2024

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 IN00429013. Complaint IN00429013 - No deficiencies related to the allegations are cited. Survey dates: March 6, 7, 8, 11, and 12, 2024 Facility number: 000506 Provider number: 155474 AIM number: 100266530 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 1 Medicaid: 25 Other: 25 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/20/24.	F 0000	Signature Health car of Bremen respectfully asked for paper compliance review.	
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

Linda Lewis | Administrator | 04/10/2024

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

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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 interview and record review, the facility failed to honor resident preferences related to bathing choices, for 1 of 3 residents reviewed for choices. (Resident 48) Finding includes: During an interview, on 3/6/2024 at 2:47 P.M., Resident 48 indicated she received a shower every other week, and did receive bed baths, but would like a shower weekly at a minimum. A record review for Resident 48 was completed on 3/11/2024 at 8:48 A.M. Diagnoses included, but were not limited to: quadriplegia, rheumatoid arthritis, and atrial fibrillation.	F 0561	Signature Healthcare of Bremen respectfully asked for paper review. Residents have the right and Signature Bremen Healthcare promotes resident self-determination through the support of resident choice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #48 no longer resides at facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	04/08/2024

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	A Care Plan, dated 1/18/2024 and updated 2/23/2024, indicated Resident 48 was limited in physical mobility, bedfast all or most of the time related to quadriplegia and muscle spasms, a required extensive assistance to full dependence on staff for mobility, transfers, toileting, and eating. A Social Service Initial History, dated 1/22/2024 at 9:40 A.M., indicated Resident 48 preferred to have a bathing performed in the morning three times a week. An Admission Minimum Data Set (MDS) assessment, dated 1/25/2024, indicated Resident 48 was cognitively intact, and was dependent on bathing. She had impairment of the upper and lower extremities on both sides. A review of the shower/bathing documentation in the electronic medical record, from 2/14/2024-3/12/2024, indicated Resident 48 received a shower on 2/14/2023, and a complete bed bath on 2/28/2024. During an interview, on 3/12/2024 at 12:49 P.M., CNA 2 indicated a shower schedule was followed weekly for every resident. Resident 48 was scheduled for showers on Wednesdays and Saturdays on day shift. CNA 2 indicated Resident 48 would receive her showers unless she was not feeling well or became anxious, and she had only refused a shower a couple of times. Showers/bathing were documented in the electronic health record and on paper. CNA 2 indicated Resident 48 had complained that she does not receive her scheduled showers. A policy was provided on 3/12/2024 at 2:41 P.M.		action(s) will be taken; Interviews of all the residents completed for preferences and plan of care updated. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. Nursing staff in-services 3.13.2024 discussing resident self-determination. Conducted by the Administrator. F561 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 audit for showering weekly times 8 then monthly times 4 will be conducted by DON/designee. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. The committee will determine if auditing to continue to be conducting.	

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	by the Vice President of Clinical Services, titled "Resident Showers". The policy indicated, " ...Resident shower preferences will be documented on admission and updated per resident choice ...CNAs will have access to shower preferences on the resident's profile ...Unit managers will present daily shower assignments to the CAN/Nurse. The CAN will be responsible to ensure that preference is met related to showers ...CNAs will document completion of showers into the medical record. Refusals should be documented in the medical record and reported to the nurse ...Unit mangers to ensure preference is met and add documentation and preference change as needed ...." 3.1-3(u)(3)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii)			

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	and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the			

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	State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility	F 0623	It is the intent of Signature	04/08/2024

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	failed to ensure a complete written notice of transfer or discharge was provided, for 2 of 3 residents reviewed for hospitalization. (Residents 23 and 49) Findings include: 1. The record for Resident 23 was reviewed on 3/8/2024 at 9:03 A.M. Diagnoses included, but were not limited to: malignant neoplasm of the right breast, generalized anxiety disorder, dementia with behavioral disturbance, delusional disorders, schizophrenia (7/18/2023), major depressive disorder, post traumatic stress disorder (PTSD), restless leg syndrome, and insomnia. The record indicated the resident had no family or guardian and was her own responsible person. The Nursing Progress Notes for February 2024 indicated the resident had displayed episodes of daily mood instability, delusional behaviors, at times expressed suicidal ideation and had attempted to exit the building. The resident was discharged to an inpatient psychiatric hospital on 2/28/2024. There was no written notice of discharge or transfer located in the clinical record. During an interview, on 3/12/2024 at 11:36 A.M., LPN 9 indicated she utilized computerized resident information including the medication order list, most recent vital signs, face sheets, and then also completed the required paper forms for transfer, including a bed hold policy and included all the information in a transfer packet that was sent with a resident when they were transferred to the hospital. She indicated the electronic forms she		Healthcare Bremen to provide written notification to the resident and/or responsible party upon transfer and /or discharge. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #23 and #49 provided with transfer/discharge paperwork. 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 was completed of all residents transferred or discharged 2024, deficiencies corrected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. License Nursing staff in-services for written notification of transfer/discharge completed. 3.28.2024. Conducted by the Director of Nursing. 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 audit for transfer/discharge written notification for all transfers/discharges weekly times 8 then monthly times 4 conducted by Social Services/designee. Audits will be reported to the Quality Assurance Performance	

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	printed were in the resident's clinical electronic chart, and the paper forms, she copied and sent to medical records so they could scan them into the resident's chart. During an interview with Employee 8, on 3/12/2024 at 11:36 A.M., she indicated she thought she had recently scanned the discharge/transfer information for Resident 23 for her 2/28/2024 transfer to the hospital into the chart. On 3/12/2024 at 11:50 A.M., the Director of Nursing (DON) provided a form, titled, "Nursing Home to Hospital Transfer Form," which indicated where the resident was being transferred, the date and time, her primary care physicians, indicated the resident was her own contact person, listed diagnosis codes for key clinical information, listed a set of vitals and pain assessment, listed the resident's usual metal status and functional status and listed "harm to self or others" as risk alerts and the form was signed by the discharging nurse. The form was on an "Interact" company form and did not contain all of the required information regarding appeal rights. The DON indicated there were no other forms because the facility was in a hurry during the discharge and something was wrong with the computers, so they had to complete the discharge forms by hand. 2. During an interview, on 3/6/2024 at 2:06 P.M., Resident 49 indicated he had been transferred to the hospital in the beginning of February due to disorientation, nausea and vomiting, and not eating. A record review for Resident 49 was completed on 3/8/2024 at 8:55 A.M. Diagnoses included, but were not limited to: hemiplegia affecting non-dominant left side, generalized anxiety, malignant neoplasm, and depressive disorder.		Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	An Admission Minimum Data Set (MDS) assessment, dated 2/2/2024, indicated Resident 48 was cognitively intact. He had a Discharge MDS dated 2/13/2024 and an Admission MDS also dated 2/13/2024. A Progress Note, dated 2/8/2024 at 12:00 P.M., indicated the physician's office had been called and the nurse spoke with the on-call physician regarding Resident 48's vomiting and request to transfer to the emergency room. On 2/13/2024 at 4:59 p.m., a Nurse's Note indicated Resident 49 returned from the hospital. A Transfer/Discharge Form could not be located in the electronic medical record. During an interview, on 3/11/2024 at 3:04 P.M., the Regional Social Service Director indicated she was unsure where to find the transfer/discharge forms in the medical record. On 3/11/2024 at 3:09 P.M., the Medical Records Coordinator indicated the transfer/discharge form should be located under the Discharge Summary tab of the electronic medical record. During an interview, on 3/12/2024 at 10:44 P.M., LPN 4 indicated the paperwork required at discharge included the Continuity of Care Record (face sheet, medications, diagnoses, allergies, vital signs, code status, payor status, tuberculosis testing, care plans, and social history), a notice of transfer/discharge, and a bed hold policy. LPN 4 indicated a copy was sent to the hospital, and a copy kept for the facility. During an interview, on 3/12/2024 at 11:02 A.M.,			

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	the Medical Records Coordinator indicated Resident 49 did not have a Transfer/Discharge Form in the Electronic Health Record, or in the overflow records. The Medical Records Coordinator indicated she had not received any transfer paperwork. A policy was provided on 3/11/2024 at 8:50 A.M. by the Executive Director. The policy titled, "Transfer/Discharge Notice", indicated, " ...The appropriate notice will be provided to the resident and/or resident representative, along with other required organization, if it is necessary to transfer or discharge a resident from a facility ...1. In this event, the facility will notify the resident The facility may decide to discharge/transfer a resident only for the reasons permitted under applicable federal and state laws, which may include the following: ...2. In this event, the facility will notify the resident/resident representative in writing of: The reason the facility has initiated the involuntary transfer/discharge to another legally responsible institutional or non-institutional setting ...The effective date of the transfer or discharge ...The location to which the resident is transferred or discharged ...." 3.1-12(a)(4)(D)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-			

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	(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on observation, record review and interview, the facility failed to ensure a written notice of the bed hold policy form was provided, for 3 of 3 residents reviewed for hospitalization. (Residents 23, 48 and 49) Findings include: 1. The record for Resident 23 was reviewed on 3/8/2024 at 9:03 A.M. Diagnoses included, but were not limited to: malignant neoplasm of the right breast, generalized anxiety disorder, dementia with behavioral disturbance, delusional disorders, schizophrenia (7/18/2023), major depressive disorder, post traumatic stress disorder (PTSD), restless leg syndrome, and insomnia. The record indicated the resident had no family or	F 0625	It is the intent of Signature Healthcare Bremen to provide residents upon discharge /Transfers a copy of the bed hold policy. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #23, #49 provided with bed hold paperwork. Resident #48 no longer resides at facility. 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 was completed of all residents transferred or discharged 2024,	04/08/2024

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	guardian and was her own responsible person. The Nursing Progress Notes for February 2024, indicated the resident had displayed episodes of daily mood instability, delusional behaviors, at times expressed suicidal ideations and had attempted to exit the building. The resident was discharged to an inpatient psychiatric hospital on 2/28/2024. There was no written notice of discharge or transfer located in the clinical record. During an interview with LPN 9, on 3/12/2024 at 11:36 A.M. indicated she utilized computerized resident information including the medication order list, most recent vital signs, face sheets and then also completed the required paper forms for transfer, including a bed hold policy and included all the information in a transfer packet that was sent with a resident when they were transferred to the hospital. She indicated the electronic forms she printed were in the resident's clinical electronic chart and the paper forms she copied and sent to medical records so they could scan them into the resident's chart. During an interview with Employee 8, on 3/12/2024 at 11:36 A.M. she indicated she thought she had recently scanned the discharge/transfer information for Resident 23 for her 2/28/2024 transfer to the hospital, into the chart. On 3/12/2024 at 11:50 A.M., the Director of Nursing provided a form, titled, "Nursing Home to Hospital Transfer Form" which indicated where the resident was being transferred, the date and time, her primary care physician's, indicated the resident was her own contact person, listed diagnosis codes for key clinical information, listed		deficiencies corrected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. License Nursing staff in-services for bed hold policy and providing resident with a copy of the bed hold upon transfer/discharge completed. 3.28.2024. Conducted by the Director of Nursing. 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 audit for transfer/discharge for Bed hold for weekly times 8 then monthly times 4 conducted by Social Services/designee. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	a set of vitals and pain assessment, listed the resident's usual metal status and functional status and listed "harm to self or others" as risk alerts and the form was signed by the discharging nurse. In addition, a Bed Hold policy was provided. The Bed Hold Policy was just the facility's policy regarding when a bed hold policy form should be given to a resident and/or their representative but was not the appropriate, individualized form completed for the 2/28/2024 transfer/discharge for Resident 23. During an interview with the Director of Nursing, on 3/12/2024 at 11:50 A.M. she indicated there was no other documentation regarding discharge forms for Resident 23's 2/28/2024 transfer/discharge. She indicated the staff was in a hurry during the discharge and something was wrong with the computers so all the documentation was completed by hand. There was no explanation as to why the correct paper bed hold form was not completed and provided for Resident 23. 2. A record review for Resident 48 was conducted on 3/11/2024 at 8:48 A.M. Diagnoses included, but not were limited to: quadriplegia, rheumatoid arthritis, and history of deep vein thrombosis and pulmonary embolism. An Admission Minimum Data Set (MDS) assessment, dated 1/25/2024, indicated Resident 48 was cognitively intact. A Nurse's Note, dated 1/30/2024 at 6:18 P.M., indicated Resident 48 was at the emergency room related to laboratory work due to significant results of liver function tests. During an interview, on 3/11/2024 at 3:09 P.M., the Medical Coordinator indicated the			

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	155474	A. BUILDING 00 B. WING	03/12/2024

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	Transfer/Discharge Form and Bed hold form would be located under the Discharge Summary tab. During an interview, on 3/12/2024 at 10:44 P.M., LPN 4 indicated the paperwork required at discharge included the Continuity of Care Record (face sheet, medications, diagnoses, allergies, vital signs, code status, payor status, tuberculosis testing, care plans, and social history), a notice of transfer/discharge, and a bed hold policy. LPN 4 indicated a copy was sent to the hospital, and a copy kept for the facility. On 3/12/2024 at 11:02 A.M., the Medical Record Coordinator indicated a bed hold policy record was not available. 3. During an interview on 3/6/2024 at 2:06 P.M., Resident 49 indicated that he had been hospitalized at the beginning of February for disorientation and nausea. A record review was conducted on 3/8/2024 at 8:55 A.M. Diagnoses included, but were not limited to: hemiplegia affecting the non-dominant left side, generalized anxiety, and malignant neoplasm. A Nurse's Note, dated 2/8/2024 at 12:00 P.M., indicated a new order was received to send Resident 49 to the hospital for evaluation and treatment. On 2/13/2024 at 4:59 P.M., a Nurse's Note indicated Resident 49 returned to the facility. During an interview on 3/11/2024 at 3:09 P.M., the Medical Coordinator indicated the Transfer/Discharge Form and Bed hold form			

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	would be located under the Discharge Summary tab. During an interview, on 3/12/2024 at 10:44 P.M., LPN 4 indicated the paperwork required at discharge included the Continuity of Care Record (face sheet, medications, diagnoses, allergies, vital signs, code status, payor status, tuberculosis testing, care plans, and social history), a notice of transfer/discharge, and a bed hold policy. LPN 4 indicated a copy was sent to the hospital, and a copy for the facility. On 3/12/2024 at 11:02 A.M., the Medical Record Coordinator indicated a bed hold policy record was not available. A policy was provided on 3/12/2024 at 12:48 P.M. by the Corporate MDS (Minimum Data Set) Coordinator. The policy tilted, "Facility Bed-hold", indicated " ...The facility will notify the resident and/or resident representative of the facility's bed-hold policy at admission and anytime a resident is transferred to the hospital or goes out on therapeutic leave. The facility will also notify the resident and/or resident representative in writing of the reason for transfer/discharge to another legally responsible institution or non-institutional setting and about the resident's right to appeal the transfer/discharge ...." 3.1-12(a)(27)			
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)			

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	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 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			

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure a comprehensive, person-centered care plan for activities was developed, for 1 of 3 residents reviewed for activities. (Resident 42) Finding includes: During the initial tour of the facility, on 3/6/2024 between 9:45 A.M. - 11:00 A.M., Resident 42 was observed seated in a high back wheelchair in the unit lounge. He was seated behind three large broda-type recliner chairs. The television in the room was turned on, but the volume was not very loud. Resident 42 was noted to be fiddling with the looped strap of the mechanical lift pad that was underneath him. Resident 42 was observed on 3/7/2024 from approximately 8:30 AM. - 11:14 A.M. He was in his wheelchair and was either located in the hallway across from the nurse's station or in the day lounge behind the large broda-type recliner chairs. The resident was noted to alternate between wakefulness and sleeping. Other than the television on a low volume in the day lounge, there was no activity provided to Resident 42. Resident 42 was observed on 3/8/2024 8:30 A.M., seated in his wheelchair awake across from the nurse's station. At 9:47 A.M., he was taken to his room to get him "ready for the day." A visitor was noted at his bedside. By 10:47 A.M., the visitor had left and the resident was placed in his wheelchair across from the nurse's station. On 3/8/2024 at 1:48 P.M., Resident 42 was	F 0656	It is the intent of Signature Healthcare Bremen to develop a comprehensive person-centered plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #42 no longer resides at facility. 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 was completed of all residents for completion of activities, deficiencies corrected, and plan of care updated. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. Activities staff and interdisciplinary team in-services for comprehensive plan of care completed. 3.29.2024. Conducted by the Administrator. 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 audit for completion of activities assessments with comprehensive plan of care completed by MDS/designee weekly times 8	04/08/2024

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	observed seated in his wheelchair in the day lounge, attempting to scoot his wheelchair. He was holding onto the top of the mechanical lift pad strap. The television was playing with a low volume in the lounge, but Resident 42 did not appear to be watching the television. On 3/11/2024 at 8:47 A.M., Resident 42 was observed seated in his wheelchair in the hallway, across from the nurse's station. He remained in the same position, alternating between sleep and wakefulness until 11:12 A.M., when he was taken to his room for personal care. The clinical record for Resident 42 was reviewed on 3/8/2024 at 10:37 AM. Diagnoses included, but were not limited to: traumatic subdural hemorrhage, hemiplegia and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, dated 12/19/2023, indicated the resident was severely cognitively impaired and dependent on staff for all daily care needs. The preferences section indicated it was very important for the resident to keep up with the news, be around groups of people, have pet visits, do things outside and listen to music. There was no Admission Life Enrichment assessment completed for Resident 42. The current Activity Care Plan, initiated on 12/18/2023, indicated the resident was not at ease joining groups of other residents. The goal was for the resident to express satisfaction with activity involvement and the only intervention was to: "Approach: Interview family or significant other if resident is not interviewable."		then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	There was no personalized care plan, based on the resident's comprehensive assessment or preferences. In addition, the resident was observed to spend large portions of his day time hours without any activity intervention. During an interview with the Activity Director (AD), on 3/11/2024 at 10:00 a.m., he indicated he had started about 4 months ago and was trying to catch up the assessments, but had to "kind of start over." During an interview with the AD, on 3/12/24 at 1:15 P.M., he agreed the care plan was not individualized and he indicated he was newer to the building and was in the process of updating and revising all of the activity assessments and care plans. The facility policy and procedure, titled "Comprehensive Care Plans" provided as current by the Administrator on 3/12/2024 at 8:45 A.M. included the following: "The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments...3. The Comprehensive Care Plan is based on a thorough assessment that includes, but is not limited to, the Resident Assessment Instrument and Minimum Data Set Assessments...." 3.1-35(a)			
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			

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	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, record review, and interview, the facility failed to ensure care plan meetings were conducted timely, for 1 of 4 residents reviewed for care plan meetings. (Resident 35) Finding includes: During an interview on 3/6/2024 at 10:53 A.M., Resident 35's spouse indicated she had not been invited to a care plan meeting in a long time. She could not recall the last time but, did know that	F 0657	It is the intent of Signature Healthcare to ensure timely care plan meetings occur. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #35 care conference completed. 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	04/08/2024

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	one was not held this year. A record review was completed on 3/8/2024 at 2:00 P.M. The resident's diagnoses included, but were not limited to: aphasia following cerebral infarction, peripheral vascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and left foot drop. The last documented care plan meeting in the electronic medical record indicated it was completed on 8/9/2023. A Care Plan for Activities of Daily Living Functional/rehabilitation status, dated 10/26/2023, included an intervention to invite the Resident and his family to care plan meetings. During an interview on 3/11/2024 at 10:39 A.M., the Social Service Director indicated the facility policy for care plan meetings was to follow the Minimum Data Set (MDS) schedule, so he should have had care plan meetings on or around 12/1/2023 and 2/28/2024. On 3/12/2024 at 8:45 A.M., the Administrator provided a policy titled, "Comprehensive Care Plan," revised 2/9/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...2. The facility will encourage the resident and/or the resident's representative, as applicable, to participate in the development of and the reviewing and revising of the Comprehensive Care Plan as willing. 4. Each resident's Comprehensive Care plan is designed to: c. Revised as necessary with changes...." 3.1-35(2)(B)		conducted for care conference and deficiencies corrected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of Interdisciplinary team regarding care conference meetings, holding and time of, completed 3.29.2024. Conducted by the Administrator. 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 audit completion of care conference meetings completed Social Services/ designee weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure ADL (activities of daily living assistance was provided, related to grooming and personal hygiene, for 2 out of 3 dependent residents reviewed for Activities of Daily Living. (Residents 22 & 35) Findings include: 1. During an observation on 3/6/2024 at 11:40 A.M., Resident 22 was in her bed. She had long jagged fingernails on both hands with a brown substance under them, and long facial hair under her chin. During observations on 3/7/2024 at 8:45 A.M., on 3/8/2024 at 9:31 A.M., and on 3/11/2024 at 8:49 A.M., Resident 22 was seated in the dining room eating her breakfast. Her fingernails were still long and jagged with a brown substance under them, and she still had long facial hair under her chin. A record review for Resident 22 was completed on 3/8/2024 at 1:30 P.M. The resident's diagnoses included, but were not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 12/9/2023, indicated she was severely cognitively impaired and was dependent	F 0677	It is the intent of Signature Healthcare Bremen to ensure bathing, dressing, grooming for all residents is met per their preference. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents #22 and # 35 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 completed with inspection of nails and facial hair. Deficiencies corrected and resident's preferences added to plan of care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of nursing staff for ADL care including nail care and shaving, completed 3.13.2024. Conducted by the Administrator. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	04/08/2024

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	for personal hygiene, shower/bathing needs, toileting hygiene needs and upper and lower body dressing needs. A Care Plan, initiated on 12/22/2022 and reviewed as current, indicated the resident required assistance with Activities of Daily Living including personal care. An intervention included assisting the resident with trimming and filing her nails as needed. During an interview\, on 3/8/2024 at 1:50 P.M., CNA 2 indicated when she completed A.M. care, she assisted them with washing their face, hands, underarms and peri-area as needed. She then assisted them with dressing, transferred them and took them to breakfast. When she gave a shower, she assisted the resident to the shower bed or chair, covered them and took them to the shower room. She then washed and rinsed their hair, then assisted them with washing as needed. Next she assisted them to dry off, applied lotion, then documented in electronic charting and filled out the paper shower sheet with any skin issues and gave the form to the nurse. During an interview on 3/8/2024 at 2:00 P.M., CNA 3 indicated that when she completed A.M. care, she had the resident assist with washing their face and underarms, applied lotion, assisted them to get dressed, brushed their hair and rinsed off their dentures. When she gave a shower, she collected the supplies she needed, undressed the resident and made sure the water temperature was good. She then washed them, starting from the top, down their body, dried them off, and applied lotion and assisted them to get dressed. She marked any skin issue on the paper shower sheet and documented the shower or care in the electronic charting system.		quality assurance program will be put into place; An audit of 5 resident randomly for nail care and facial hair conducted by DON/designee weekly times 8 then monthly times 8. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	During an interview, on 3/12/2024 at 12:46 P.M., LPN 4 indicated she would expect the CNA's daily care to include: washing, dressing, hygiene, grooming, transferring and transportation to breakfast. When providing shower assistance, she would expect them to wash the resident with soap and water, provide peri-care, apply deodorant, dress the resident, and do a skin check and notify the nurse of any areas, and if a treatment was needed, to let the nurse know so she could complete the treatment. 2. During an interview and observation on 3/6/2024 at 10:59 A.M., Resident 35 indicated he rarely received nail care. He indicated his nail care was to be done by a nurse. The resident's right hand fingernails were long and jagged, with a brown substance under them, and his left hand was fisted. He opened up his left hand using his right hand, and the left hand nails were extremely long, the palm was red with an indent from his nails in the palm of his hand. During an observation and interview on 3/7/2024 at 10:56 A.M., Resident 35 indicated a nurse came in last night, trimmed his nails, did not file his nails, and used the washcloth and her fingernail to try to clean under his nails. The nails were uneven and still had a brown substance under them. The palm of the left hand was no longer red, nor was there an imprint of nails in the skin. A record review was completed on 3/8/2024 at 2:00 P.M. The resident's diagnoses included, but were not limited to: aphasia following cerebral infarction, peripheral vascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and left foot drop.			

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A Quarterly Minimum Data Set (MDS) assessment, dated 2/28/2024, indicated Resident 35 was alert and oriented, was dependent for shower/bathing needs, toileting and hygiene needs, and lower body dressing needs and required substantial/maximal assist for personal hygiene needs..

During an interview on 3/8/2024 at 1:50 P.M., CNA 2 indicated, when she does A.M. care, she assisted the resident with washing their face, hands, underarms and peri-area as needed, then dressed, transferred and took them to breakfast. When she gave a shower, she assisted the resident to the shower bed or chair, covered them and took them to the shower room. She then washed and rinsed their hair then assisted with washing as needed, dried them off, applied lotion, then documented in the electronic charting system and filled out the shower sheet with any skin issues and gave it to the nurse.

During an interview on 3/8/2024 at 2:00 P.M., CNA 3 indicated, when she completed A.M. care, she had the resident assist with washing their face and underarm, applied lotion, dressed them, brushed their hair and rinsed off dentures. When she gave a shower, she collected the supplies she needed, undressed them and made sure the water temperature was good. She then washed them starting from the top down, dried them off, and applied lotion and dressed them. She marked any skin issue on the shower sheet and documented in the electronic charting system.

During an interview, on 3/12/2024 at 12:46 P.M., LPN 4 indicated that she would expect the CNA's daily care to include: washing, dressing, hygiene, grooming, transferring and transporting them to

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	breakfast. When they provided a shower, she would expect them to wash the resident with soap and water, provide any needed peri-care, apply deodorant and dress the resident. She would also expect them to complete a skin check, notify the nurse of any areas, and if a treatment was needed, let the nurse know so she could do the treatment. On 3/11/2024 at 1:23 P.M. , the Vice President of Operations provided a policy titled, "Activities of Daily Living", dated 9/15/23, and indicated the policy was the one currently used by the facility. The policy indicated "....ADL assistance will be provided on a level appropriate to the resident's level of functioning and learning and/or the responsible party's level of support and contribution to resident care. 2. Direct healthcare staff will assist, support and encourage the resident to maintain adequate ADL while attempting to allow the resident to be able to maintain as much independence as possible with their ADL such as following: Bathing, Grooming, Eating, Toileting, Bed Mobility, Transfers....." On 3/11/2024 at 3:56 P.M. the Vice President of Operations provided a policy titled, "Nail Grooming", dated 7/24/18, and indicated the policy was the one currently used by the facility. The policy indicated "...Regular finger care will promote cleanliness and prevent infection. The nursing staff will provide observation and care of nails for all residents daily and as necessary. 6. Trim the nails using the clippers and file to round the tips of the nails. 7. Clean around and under the nails using a moistened cotton swab....." 3.1-38(3)(D) 3.1-38(3)(E)			

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F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to provide a person-centered activity program for 1 of 3 residents reviewed for activities. (Resident 42) Finding includes: During the initial tour of the facility, on 3/6/2024 between 9:45 A.M. - 11:00 A.M., Resident 42 was observed seated in a high back wheelchair in the unit lounge. He was seated behind three large broda- type recliner chairs. The television in the room was turned on, but the volume was not very loud. Resident 42 was noted to be fiddling with the looped strap of the mechanical lift pad that was underneath him. Resident 42 was observed on 3/7/2024 from approximately 8:30 AM. - 11:14 A.M. He was in his wheelchair and was either located in the hallway across from the nurse's station or in the day lounge behind the large broda-type recliner chairs. The resident was noted to alternate between wakefulness and sleeping. Other than the television on a low volume in the day lounge, there was no activity provided to Resident 42.	F 0679	It is the intent of Signature Healthcare Bremen to conduct activities to meet the needs and interest for each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #42 no longer resides at the facility. 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 activities assessment completed, and resident's preferences added to plan of care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of Activity Department providing person-centered activities,	04/08/2024

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	Resident 42 was observed on 3/8/2024 8:30 A.M., seated in his wheelchair awake across from the nurse's station. At 9:47 A.M., he was taken to his room to get him "ready for the day." A visitor was noted at his bedside. By 10:47 A.M., the visitor had left and the resident was placed in his wheelchair across from the nurse's station. On 3/8/2024 at 1:48 P.M., Resident 42 was observed seated in his wheelchair in the day lounge, attempting to scoot his wheelchair. He was holding onto the top of the mechanical lift pad strap. The television was playing with a low volume in the lounge, but Resident 42 did not appear to be watching the television. On 3/11/2024 at 8:47 A.M., Resident 42 was observed seated in his wheelchair in the hallway, across from the nurse's station. He remained in the same position, alternating between sleep and wakefulness until 11:12 A.M., when he was taken to his room for personal care. The clinical record for Resident 42 was reviewed on 3/8/2024 at 10:37 AM. Diagnoses included, but were not limited to: traumatic subdural hemorrhage, hemiplegia and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, dated 12/19/2023, indicated the resident was severely cognitively impaired and dependent on staff for all daily care needs. The preferences section indicated it was very important for the resident to keep up with the news, be around groups of people, have pet visits, do things outside and listen to music. There was no Admission Life Enrichment		completed 3.29.2024. Conducted by the Administrator. 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 audit of 5 random residents for activities preferences being met conducted by Activities Director/designee weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	assessment completed for Resident 42. The current Activity Care Plan, initiated on 12/18/2023, indicated the resident was not at ease joining groups of other residents. The goal was for the resident to express satisfaction with activity involvement and the only intervention was to: "Approach: Interview family or significant other if resident is not interviewable." There was no personalized care plan, based on the resident's comprehensive assessment or preferences. In addition, the resident was observed to spend large portions of his day time hours without any activity intervention. During an interview with the Activity Director (AD) on 3/11/2024 at 10:00 A.M., he indicated he had just started about 4 months ago and was trying to catch up the assessments, so had to "kind of start over." During an interview with the AD, on 3/12/24 at 1:15 P.M., he indicated per the facility policy, the resident did not qualify for 1:1 individualized activity visits due to his frequent family visits. The AD further indicated the resident was occasionally brought to a facility activity by his family members. The AD indicated the resident's family had attempted to bring him to Bingo, but he became fidgety and began taking apart the table decorations. The AD indicated he was in the process of building the program to include individualized interventions for cognitively impaired residents, and was attempting to acquire supplies for those types of activities. The AD agreed the care plan was not individualized and he indicated he was newer to the building and was in the process of updating and revising all of the activity assessments and care plans.			

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	3.1-33(a)			
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, and the residents' choices. Based on observation, interview, and record review, the facility failed provide transportation to essential medical appointments as scheduled for 1 of 2 residents reviewed for range of motion and failed to identify and monitor a bruising for 1 of 3 residents reviewed for non-pressure related skin conditions. (Residents 35 & 22) Findings include: 1. On 3/6/2024 at 10:00 A.M., a family member who was standing in hallway, was overheard complaining that her husband had missed appointments in the past, and she was worried there was no transportation set up for the next week for his scheduled appointments. During an interview and observation on 3/6/2024 at 11:15 A.M., Resident 35's spouse indicated he had missed an appointment in January 2024. The appointments, scheduled every 12 weeks, were for Botox injections to his left leg, which was helping him. During an interview, on 3/11/2024 at 9:21 A.M.,	F 0684	It is the intent of Signature Healthcare Bremen provide treatment and care to facility residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #22 and # 35 skin assessments completed, and audit of missed appointments completed, and appointments scheduled as needed. 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 transportation completed appointments up to date. Skin assessments completed for all residents. What measures will be put into place and what systemic changes will be made to ensure that the	04/08/2024

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	Resident 35 indicated he had missed his appointment in January and as a result,, had increased pain in his leg and felt his progress in moving his knee had slowed. He indicated in the past, the Botox injections had made a difference in the looseness of his knee. A record review for Resident 35 was completed on 3/8/2024 at 2:00 P.M. Resident 35's diagnoses included, but were not limited to: aphasia following cerebral infarction, peripheral vascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and left foot drop. A Quarterly Minimum Data Set (MDS) assessment, dated 2/28/2024, indicated Resident 35 was alert and oriented. He was dependent for shower/bathing needs, toileting and hygiene needs, and lower body dressing needs, and he required substantial/maximal assist for personal hygiene needs.. During an interview on 3/11/2024 at 10:02 A.M., Physical Therapist (PT) 6 indicated Resident 35 had a knee contracture and planter flexion and inversion contracture of the ankle. She had been treating him in therapy from 1/4/2024 till the end of February. She indicated Resident 35 had Botox injections given in the knee, and it helped loosen up his knee and he was able to complete bed disc ring transfers. Resident 35 had informed her the injections had helped him a lot, allowing him to stand straight and have less pain when he was in bed. She indicated she had to discontinue therapy last month because Resident 35's progress had plateaued. During an interview on 3/11/2024 at 10:57 A.M., CNA 3 indicated she was the scheduler from July		deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of nursing staff and transportation scheduler completed 3.13.2024. Conducted by the Administrator. 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; A random audit of 5 residents for skin assessments and transportation needs weekly times 8 then monthly times 4 by DON/designee. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	2024 until 2 weeks ago. The facility system was to have the nurses leave a note when there was an appointment and she then called and scheduled the appointment with the transportation company. CNA 3 indicated there were many residents who missed appointments in January when the van had broken down. The facility had rented another van, but the van driver had resigned. She had to reschedule appointments, but she thought Resident 35's original appointment had been scheduled for January 10th. 2. During an observation on 3/6/2024 at 11:40 A.M., resident 22 had a nickel size dark purple area on her hand between her thumb and index finger. During an observation on 3/7/2024 at 8:54 A.M., the bruise on her right hand remained the same size and was dark purple. During an observation on 3/8/2024 at 10:00 A.M., the bruise was bigger in size, and the purple discoloration had spread out. A record review for Resident 22 was completed on 3/8/2024 at 1:30 P.M. Her diagnosis included, but were not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 12/9/2023, indicated Resident 22 was cognitively impaired and was dependent for personal hygiene needs, shower/bathing needs, toileting and hygiene needs and upper and lower body dressing needs. A Skin Integrity Care Plan, dated 2/14/2023,			

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	included an intervention to notify nurses immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration noted during bathing or daily care. During an interview on 3/8/2024 at 1:34 P.M., RN 5 indicated when a resident had a new skin condition, staff assessed the area, cleaned the skin, called the doctor to get orders immediately, put a nursing order in the treatment record to check the impaired skin every shift and notified the resident's family. Weekly Skin Assessments were completed routinely in the electronic medical record and coincided with the residents' shower day. An Event Note was completed for any area found and observations were completed weekly for the skin assessments. During an interview on 3/8/2024 at 1:50 P.M., CNA 2 indicated after she completed showers, she was to fill out a shower sheet and note any skin issues and give the completed form to the nurse. During an interview on 3/8/2024 at 2:00 P.M., CNA 3 indicated after she completed a shower, she marked any skin issue on the shower sheet. During an interview on 3/11/2024, LPN 4 indicated Resident 22 had not had any recent lab draws from her hands. During an interview on 3/12/2024 at 12:46 P.M., LPN 4 indicated she would expect the CNAs completing resident showers to do a skin check and notify the nurse of any areas. A Treatment Administration Record (TAR), dated 3/1/2024 to 3/12/2024, indicated a weekly skin assessment was completed on Monday evening, 3/4/2024, with a value of "0" indicating no new			

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	skin impairment was noted, and on Monday evening 3/11/2024, with a value "0" indicating no new skin impairment was noted. A shower sheet for Resident 22, dated 3/11/2024, indicated her skin was clear and no new areas. A shower sheet for Resident 22, dated 3/12/2024, indicated her skin was clear. No documentation was found in Events, Observations or Progress Notes indicating the bruise on Resident 22's hand was observed or monitored. On 3/11/2024 at 3:56 P.M., the Vice President of Operations provided a policy titled, "Skin Integrity", revised 9/15/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...4. The licensed nurse shall initiate applicable Skin Integrity documentation if a new area of impairment is identified. 6. In addition, to ongoing observations of skin integrity impairments mentioned above, nursing stakeholders shall observe the skin for areas of impairment during bathing, dressing, and peri care. Nursing stakeholders will notify the nurse if a new area is identified....." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is			

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	unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure a splint and brace were applied as ordered, for 1 of 2 residents reviewed for limited range of motion. (Resident 35) Finding includes: During an interview and observation on 3/6/2024 at 11:15 A.M., Resident 35 and his spouse indicated he did not wear a splint on his left hand and ankle. He indicated when he was in therapy, they used to put splints on, but no one put them on him currently. During an interview and observation on 3/7/2024 at 10:52 A.M., Resident 35's left ankle was contracted inward, resting against the footboard of the bed. He and his wife indicated staff used to put on a brace (to his left ankle) but had stopped when his therapy had ended. Staff were also not applying any splints to his hand. During an interview and observation on 3/11/2024 at 9:30 A.M., Resident 35 was not wearing any splint or brace. He indicated he had not worn a	F 0688	It is the intent of Signature Healthcare Bremen to provide care and services to prevent decrease in care and services. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #35 has been reassessed and placed on a restorative plan. 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 was conducted of resident for baseline contractures. Plan put into place and added to plan of care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of nursing staff, restorative, and therapy for use	04/08/2024

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	hand splint or ankle brace during the past weekend. A record review was completed on 3/8/2024 at 2:00 P.M. for Resident 35. His diagnoses included, but were not limited to: aphasia following cerebral infarction, peripheral vascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and left foot drop. A Quarterly Minimum Data Set (MDS) assessment, dated 2/28/2024, indicated he was alert and oriented and was dependent for shower/bathing needs, toileting and hygiene needs, and lower body dressing needs. In addition, he required substantial/maximal assist for personal hygiene needs.. An Activities of Daily Living Care Plan, initiated on 8/21/2022 and reviewed as current, included an intervention for supportable devices as ordered: boot, AFO (ankle foot orthosis) as tolerated. A Physician's Order, dated 1/10/2024, indicated the resident was to wear the left ankle brace with a sock for 4-6 hours during the day. There was no order for a hand splint. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January, February and March of 2024 did not have any documentation of the left ankle brace being administered. There was nothing noted for a hand splint. During an interview, on 3/11/2024 at 10:02 A.M., Physical Therapist (PT) 6 indicated she wrote an order in February for an ankle brace and to complete skin checks, in the electronic charting		and application of splints and for assessments of contractures, completed 3.13.2024. Conducted by the Administrator. 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 audit of 5 random residents for splint wear as schedule being met by Director of Rehabilitation Services/designee weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	system. During an interview, on 3/11/2024 at 10:22 A.M., Occupational Therapist (OT) 7 indicated Resident 35 had an order to wear a soft hand splint to his left hand, putting it on in the morning and taking it off in the afternoon. During an interview, on 3/11/2024 at 10:33 A.M., LPN 4 indicated she believed Resident 35 had an order for a hand splint, but he was currently out of the building so she had not applied the splint. During an interview, on 3/11/2024 at 12:40 P.M., CNA 2 indicated she did not apply Resident 35's hand splint or leg brace. She did not know if they (the splint or leg brace) were discontinued, but she had previously been trained on how to put the splint/braces on and how to remove them. On 3/11/2024 at 3:15 P.M., the Vice President of Operations indicated they did not have a policy on splints/braces but provided a policy on Physician orders. 3.1-42(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must			

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	155474	A. BUILDING 00 B. WING	03/12/2024

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	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to obtain a Physician's Order for the use of a Foley (indwelling urinary catheter) catheter, for 1 of 2 residents reviewed for urinary catheters. (Resident 26) Finding includes: During an interview on 3/7/2024 at 10:45 A.M., Resident 26 indicated she had a Foley catheter when admitted to the facility. A record review was completed on 3/11/2024 at 10:16 A.M. Resident 26 was admitted to the facility on 1/16/2024. Diagnoses included, but were not limited to: multiple sclerosis, overactive	F 0690	Our intent is to provide care and services as prescribed by physician and in accordance to the standard of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #26 no longer has a catheter. 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 resident record who have catheters for order for the use of a	04/08/2024

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	bladder, and constipation. A Hospital Progress Note, dated 3/12/2024, indicated Resident 26 possibly had a neurogenic bladder. An Admission Observation, dated 1/16/2024 at 10:29 P.M., indicated Resident 26 was incontinent of urine with the inability to recognize to void, and had an indwelling urinary catheter in place. An Admission Minimum Data Set (MDS) assessment, dated 1/23/2024, indicated Resident 26 was incontinent of bladder. A Nurse's Note, dated 2/5/2024 at 1:44 P.M., indicated the physician was notified of Resident 26's request to have her Foley catheter removed prior to discharging to home. A new order was obtained to discontinue the Foley catheter. An Interdisciplinary Note, dated 2/6/2024 at 9:32 A.M., indicated the Foley catheter was removed on 2/5/2024 with no issues urinating. A Nurse's Note, dated 2/9/2024 at 11:55 A.M., indicated Resident 26 was continent of urine except for when coughing. A Physician's Order, dated 1/20/2024, indicated to record output from the Foley catheter every shift. There was no order for the Foley catheter which included the type of catheter, care required, or when to change. During an interview, on 3/12/2024 at 10:49 A.M., LPN 4 indicated a Foley catheter would be recommended for urinary retention or a pressure ulcer, and a Physician's Order was needed for a Foley catheter to be placed.		catheter completed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of License Nursing staff completed for the need for a physician's order for a catheter. completed 3.13.2024. Conducted by the Administrator. 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 audit of residents with foley catheter for physician order for foley conducted by DON/designee weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	A policy was provided, on 3/12/2024 at 12:48 P.M., by the Corporate MDS (Minimum Data Set) Coordinator. The policy tilted, "Physicians Orders indicated " ...It is the standard of this facility that physician orders are followed, reviewed to ensure delivery of appropriate care, being alert for changes in condition related to new orders, and need to notify the physician for adverse effects from new orders or potential order changes as needed ...1. Each resident will have physician's orders to guide the facility in caring for and treating each resident...." 3.1-41(a)(1)			
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 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.			

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	Based on observation, interview, and record review, the facility failed to address a Registered Dietitian's (RD) recommendations timely, related to significant weight loss, for 1 of 3 reviewed for nutrition. (Resident 22) Finding includes: A record review for Resident 22 was completed on 3/8/2024 at 1:30 P.M. The resident's diagnoses included, but were not limited to: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. An RD Progress Note, dated 8/28/2023, indicated Resident 22 had a significant weight loss in 30 days of 6.6%. She consumed a regular diet and ate an average of 50% of her meals with some refusals documented. Resident 22's weights were as follows: 8/25/2023 - 125.4 pounds (#), 7/26/2023 133#, 6/2/2023- 132.6#, 5/4/2023- 128#, and 1/3/2023- 120#. The RD recommendations, on 8/28/2023, were to add fortified foods with the meals and to continue monitoring intakes, labs, weight, skin, and medications. An RD Progress Note, dated 9/17/2023, indicated Resident 22 continued to have a significant weight loss for 30 and 90 days related to poor intakes. The note indicated the resident's care had been changed to Palliative Care and she continued to receive a regular diet. The resident's weights were as follows: Weight on 9/11/2023 122.5#, 8/25/2023 - 125.4#, 7/26/2023 133#, 6/2/2023- 132.6#, 5/4/2023- 128#, and 1/3/2023- 120#. The RD recommendation, on 9/17/2023, was for the resident to continue to receive fortified foods. In addition, the RD added a recommendation for Glucerna health shakes, 120	F 0692	It is the intent to address Dietician recommendations timely. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #22 re-assessed by Dietician and recommendations addressed. 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 Dietician recommendation completed an address 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; Policy reviewed and found to be sufficient. completed. Re-education of Nursing staff for completion of the addressing Dietician recommends, completed 3.13.2024. Conducted by the Administrator. 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 audit of 5 random Dietician recommendations addressed conducted by Dietician/ designee weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then	04/08/2024

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	milliliters (ml), three times a day in between meals and at bedtime to assist with weight gain. An RD Progress Note, dated 10/12/2023, indicated Resident 22 continued to lose weight and now had a significant weight loss in 90 days of 15.48%. The RD recommended to continue fortified foods and start Glucerna 120 ml three times a day between meals and at bedtime to assist with weight gain, and continue to monitor intake, labs, weight, skin, and medications. An RD Progress Note, dated 2/16/2024, indicated the resident displayed a significant weight loss in 180 days of 12.23% due to varied intakes. The RD recommended to continue fortified foods and start Glucerna 120 ml three times a day between meals and bedtime to assist with weight gain and continue to monitor intake, labs, weight, skin, and medications. The Medication Administration Record (MAR) for the months of September 2023, October 2023, November 2023, December 2023, January 2024, February 2024, and March 2024, indicated there was no order for Glucerna 120 ml three times a day between meals and at bedtime. A Care Plan related to being at risk for alteration in nutritional status, dated 12/13/2022, included the following interventions: "RD to evaluate and provide recommendations annually and as needed, routine weight to monitor for significant weight loss, observe changes of intake; ability to self- feed; weigh gain or loss; lab results and report findings to the Physician and RD." During an observation, on 3/8/2024 at 2:23 P.M., Resident 22 was in the assisted dining room, feeding herself lunch. There was a glass of		committee will determine if auditing needs to continue to be conducting.	

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	chocolate milk, a glass of juice and a cup of a hot beverage on her meal tray. During an observation, on 3/11/2024 at 8:50 A.M., the resident was in the assisted dining room feeding herself her pancakes. She consumed approximately 50% of her food. She also had chocolate milk, orange juice and a hot beverage. During an observation on 3/12/2024 at 9:14 A.M., the resident was in the assisted dining room eating breakfast. She had only consumed a few bites of scrambled eggs and had chocolate milk, juice and a hot beverage. During an interview on 3/8/2024 at 10:40 A.M., RN 5 indicated when a resident received a Physician's Order for a supplement, the order was placed in the MAR (Medication Administration Record) with a place to document the amount to be given and amount consumed. During an interview on 3/8/2024 at 11:25 A.M., RN 5 indicated the nurses passed out the supplements between meals. She only provided supplements between meals for Resident 8 & 46 as they were the only residents with orders for a nutritional supplement. During an interview on 3/8/2024 at 2:09 P.M., the lead Dietitian indicated if a nurse told her a resident had weight loss or gain, or they were doing a quarterly assessment, she would look at the time frame for the assessment and calculate the percentage of weight loss/gain and write a progress note and document the percentage. If she was to do a full MDS assessment, she would document under the "observation" tab. She indicated after she made recommendations, she navigated to the " Event "tab and input her			

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	recommendations and she filled out an excel spread sheet with her recommendations and provided a copy of the spread sheet to the Director of Nursing. After looking at the clinical record for Resident 22, she confirmed there was no order for the Glucerna noted. On 3/12/2024 at 8:46 A.M., the Administrator provided a policy titled, "Medical Nutrition Therapy: Assessment and Care Planning", revised 9/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...The RD or other clinically qualified nutrition professional's recommendations for changes in nutrition plan of care will be communicated to the licensed nursing team and Dining Services via the summary recommendation sheet. 3.1-46(a)(1)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an			

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	unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, record review, and interview, the facility failed to ensure the physician responded to pharmacy recommendations timely, for 1 of 5 residents reviewed for unnecessary medication use. (Resident 2) Finding includes: During the initial tour of the facility, on 3/6/2024 between 9:45 A.M. - 11:00 A.M., Resident 2 was observed lying in his bed asleep. The resident was noted to be very thin with severely contracted wrists.	F 0756	It is the intent for address Pharmacist recommendation timely. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #2 record reviewed, and pharmacy recommendations completed timely. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	04/08/2024

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	The clinical record for Resident 2 was reviewed on 3/8/24 at 10:23 A.M. Diagnoses included, but were not limited to: Spastic quadriplegic cerebral palsy, insomnia, major depressive disorder, recurrent, generalized anxiety disorder, bipolar disorder and depression. The current Physician's Orders for medications for Resident 2 included the following: - aripiprazole tablet (an antipsychotic medication) 20 mg (milligrams) tablet, one tablet once a day, and aripiprazole 5 mg, one tablet once a day. There were instructions to give the two tablets together to equal 25 mg of aripiprazole to treat the resident's Bipolar disorder. - citalopram tablet (an antidepressant) 40 mg, one tablet once a day for depression - Wellbutrin XL- bupropion hcl (an antidepressant) extended release 24 hr tablet, 150 mg, one tablet once a day for depression. A Pharmacy Recommendation, dated 8/27/2023, referenced the current doses and order dates of the three psychoactive medications and requested the physician consider a dose reduction. The recommendation form included a place for the physician to mark the response to the recommendation. There was no documentation on the form of the physician's response. A Psychiatric Progress Note, dated 11/9/2023, was presented by the Regional Executive Director. The Regional Executive Director indicated the resident was initially seen by the facility's in-house contracted psychiatric services on November 9, 2023. The in-house psychiatric services indicated the resident should continue taking 20 mg of aripiprazole, 40 mg of citalopram and 150 mg of bupropion hcl due to "treatment		action(s) will be taken; An audit of resident's records completed for pharmacy recommendations. Recommendations followed up on timely. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. Re-education of Nursing staff for timely completion of the pharmacist recommendations, completed 3.13.2024. Conducted by the Administrator. 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 audit of 5 random pharmacy recommendation for timely follow up by DON/designee for a weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	resistant depression." The regional executive Director indicated the primary care physician would have been responsible for responding to pharmacy recommendation in August 2023. There was no documentation provided of any response to the recommendation prior to 11/9/2023 - 3 months after the recommendation was made. A facility policy, titled, "Medication Management" was provided and identified as current by the Administrator on 3/12/2024 at 8:45 A.M. The policy included a procedure for the consultant pharmacist to analyze and present findings regarding proper monitoring of medication therapy to the appropriate healthcare disciplines, but there was policy regarding the timing of the response by the physician regarding the pharmacist's recommendations. 3.1-25(i)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			

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	unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to follow a Physician's Order for the use of Ativan (anti-anxiety medication), and limit an Ativan "as needed" (prn) order to 14 days, for 1 of 5 residents reviewed for unnecessary medications. (Resident 49) Finding includes:	F 0758	Our intent is to follow the physician orders for all medications administered. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #49 has been assessed and no ill effects noted.	04/08/2024

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	A record review for Resident 49 was completed on 3/8/2024 at 8:55 A.M. Diagnoses included, but were not limited to: generalized anxiety, major depressive disorder, malignant neoplasm, and hemiplegia of the non-dominant left side. An Admission Minimum Data Set (MDS) assessment, dated 2/2/2024, indicated Resident 49 was cognitively intact. He received an antidepressant and anti-anxiety medications. Resident 49 had moods of feeling down, depressed, or hopeless for 12-14 days of 14 days reviewed; trouble falling asleep or sleeping too much for 12-14 days of 14 days reviewed; feeling tired or having little energy for 12-14 days of 14 days reviewed; trouble concentrating on things, such as newspaper or watching television for 12-14 days of 14 days reviewed; and moving or speaking slowly that other people could have noticed, or being fidgety or restless that moving around more than usual for 12-14 days of the 14 day review period. A Physician's Order, dated 2/22/2024, indicated Ativan 2 milligrams (mg) as needed prior to traveling, and send 2 mg with Resident 49 for travel returning to the facility, through 5/18/2024. The Medication Administration Record (MAR) indicated Resident 49 received Ativan 2 mg on 3/1/2024 at 10:16 P.M., for an "other" reason, and 3/1/2024 at 6:54 A.M., 3/5/2024 at 5:09 P.M., 3/6/2024 at 3:49 A.M., and 3/7/2024 at 4:52 A.M., for behavioral issues. The MAR notes indicated: - 3/1/2024 6:54 A.M. Appointment - 3/1/2024 10:16 P.M. Anxiety - 3/5/2024 5:09 P.M. Anxious - 3/6/2024 3:49 A.M. Anxious - 3/7/2024 4:52 A.M. Restless		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 prn psychoactive medications has been completed and no other deficient practices noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of Nursing staff regarding administration of the medications, completed 3.26.2024. Conducted by Director of Nursing Services. 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 audit of prn medications weekly by DON/designee times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	

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	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A Nurse's Note, dated 2/8/2024 at 1:43 P.M., indicated a clarification with the physician for the as needed Ativan for 14 days at a time, with the next review being 2/18/2024. On 2/18/2024 at 3:47 P.M., a Nurse's Note indicated Resident 49 had severe anxiety and had orders for 2 milligrams of Ativan prior to travel, and 1-2 milligrams when traveling back to the facility. The physician was aware, and orders were received. A Care Plan, dated 1/27/2024 and revised on 3/4/2024, indicated Resident 49 received anti-anxiety medication related to anxiety and cancer diagnosis, and was ordered 2 milligrams of Ativan prior to car rides from and car rides back to the facility. During an interview on 3/12/2024 at 10:42 A.M., LPN 4 indicated Resident 49 took Ativan for anxiety, especially when going to doctor's appointments. Resident 49 definitely needed the medication, and took the medication periodically, and when having a panic attack. A policy was provided, on 3/12/2024 at 12:48 P.M., by the Corporate MDS Coordinator. The policy titled, "Psychotropic Medication Policy", indicated " ...Psychotropic medications will be used appropriately for residents with mental illness and/or related disorders. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior ...1. The facility will make every effort to comply with state and federal regulations related to the use of psychotropic medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects risks and/or benefits. D. PRN [as needed] orders			

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	for psychotropic drugs are limited to 14 days." 3.1-48(a)(2) 3.1-48(a)(4)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure an anticoagulant medication was continued upon readmission after hospitalization, for 1 of 5 residents reviewed for medication use. (Resident 48). Finding includes: During an interview on 3/6/2024 at 2:57 P.M., Resident 48's husband indicated Resident 48 was to be receiving Heparin (anticoagulant) related to a hospitalization for blood clots. A record review was completed on 3/11/2024 at 8:48 A.M. Diagnoses included, but were not limited to: quadriplegia, rheumatoid arthritis, fibromyalgia, and history of deep vein thrombosis and pulmonary embolism. An Admission Minimum Data Set (MDS) assessment, dated 1/25/2024, indicated Resident 48 was receiving an anticoagulant. A Physician's Order, dated 1/18/2024, indicated Resident 48 received Heparin (anticoagulant medication) 5,000 units per milliliter twice daily from 1/18/2024-2/9/2024. A Hospital Progress Note, dated 2/8/2024, indicated lifelong anticoagulation would be	F 0760	It is our intent to administer medications per the physicians' orders. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #48 no longer resides at the facility. 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 anticoagulant medication completed no other deficient practices noted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Policy reviewed and found to be sufficient. completed. Re-education of the nursing staff for medication reconciliation upon admission, completed 3.26.2024. Conducted by the Director of Nursing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	04/08/2024

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	needed per hematology. A Physician Progress Note, dated 2/14/2024, indicated Eliquis would be needed for life. There was no documentation to indicate facility staff clarified readmission medications related to the resident's prior anticoagulant medications to prevent further blood clots. During an interview, on 3/12/2024 at 10:47 A.M., LPN 4 indicated Resident 48 should be on a "clot buster", and follow whatever the doctor ordered for anticoagulation. A policy was provided, on 3/12/2024 at 12:48 P.M., by the Corporate MDS (Minimum Data Set) Coordinator. The policy titled, "Anticoagulation Management Program", indicated " ...The facility shall ensure the residents receiving anticoagulant therapy shall be monitored and followed ...." 3.1-48(c)(2)		quality assurance program will be put into place; An audit of new admission for medication reconciliation DON/designee weekly times 8 then monthly times 4. Audits will be reported to the Quality Assurance Performance Improvement committee monthly. Then committee will determine if auditing needs to continue to be conducting.	