STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155474	A. BUILDING -- B. WING	04/01/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/01/2024 Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530 At this Emergency Preparedness survey, Signature Healthcare of Bremen was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 82 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 50. Quality Review completed on 04/03/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/01/2024 Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530	K 0000	Signature Bremen respectfully request desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Lewis	Administrator	04/18/2024

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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	At this Life Safety Code survey, Signature Healthcare of Bremen was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and resident rooms 301-309. Battery powered smoke alarms were located in resident rooms 101-124, and in resident rooms 201-216. The facility has 82 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 50. All areas where the residents have customary access were sprinklered, all areas providing facility services were sprinklered Quality Review completed on 04/03/24			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 33 of 33 battery operated smoke alarms in	K 0300	K 300 What corrective action(s) will be accomplished for those residents found to have been affected by the	04/19/2024

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	resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on records review with the Director of Plant Operations and Administrator on 04/01/24 between 10:15 a.m. and 1:01 p.m., Weekly testing of battery smoke detectors were presented during the survey, however testing between February 19th and March 29th 2024 were not available for review. During observation of battery smoke detectors between 1:12 p.m. and 3:04 p.m., manufacturers instructions indicated that weekly testing of the battery smoke detectors are required. Based on interview at the time of record review, the Administrator and Director of Plant Operations initially stated that battery smoke detectors were listed as a monthly inspection on the online program 'TELS' and did not know it was a weekly inspection. Findings were discussed with the Director of Plant Operations and Administrator at exit conference. 3.1-19(b) 2. Based on interview and observation, the facility failed to ensure proper maintenance and functions		deficient practice. The Plant Ops Director installed the battery in the battery smoke detector in the lounge area near resident room 207 on 4-1-24. No events occurred, and no residents were affected. 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. The Plant Ops Director completed a full audit of batteries and operational testing of all battery powered smoke detectors on 4-2-24 and no further issues were found. All residents had potential, no events occurred, and none affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. On 4-2-24 the Regional Plant Ops Director in-serviced the Plant Ops Director on the requirements for maintenance and testing of battery powered smoke detectors. On 4-1-24 the Tels online p.m. program system task for testing of battery powered smoke detectors was updated to be conducted weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Audits are in place for weekly check of Battery-Operated smoke detectors operation and battery checks. These will be	

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	for 1 of 33 battery operated smoke alarms in the facility. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect a Findings include: Based on records review with the Director of Plant Operations and Administrator on 04/02/24 between 1:12 p.m. and 3:04 p.m., the battery smoke detector located in the lounge area near resident room 207 had a battery smoke detector installed on the ceiling. When observed, the battery compartment of the device was open and the battery had been removed. When pressing the test button, the smoke detector did not activate meaning the device was not working. Based on interview at the time of observation, the Director of Plant Operations stated he was unsure why the battery had been removed from the device and would replace it as soon as possible. The battery was replaced before the end of the survey. Findings were discussed with the Director of Plant Operations and Administrator at exit conference. 3.1-19(b)		conducted by the Director of Plant Operations weekly for , then weekly for 4 months, or until substantial compliance is achieved. The checks will then continue as a recurring weekly task. The audits will be submitted to the Quality Assurance Process Improvement Committee. After the stated time the QAPI committee will determine the need for auditing.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Director of Plant Operations and the Administrator on 04/01/24 between 1:12 p.m. and 3:04 p.m., there was a ceiling penetration in the copier room near the main entrance next to the escutcheon plate of a sprinkler head. The penetration was approximately 1/2" long. Based on interview at the time of observation, the Director of Plant Operations acknowledged the hole next to the sprinkler head	K 0353	K 353 It is the intent of Signature Healthcare Bremen to maintain ceiling structure with no ceiling penetration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No events occurred and no residents were affected. The ceiling tile and escutcheon for the sprinkler head penetration in the copier room near the main entrance were repaired on 4-2-24 by the Plant Ops Director. How other residents having the potential to be affected by the same deficient practice will be	04/19/2024

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	and stated it should be filled in. Findings were discussed with the Director of Plant Operations and Administrator at exit conference. 3.1-19(b)		identified and what corrective action(s) will be taken. On 4-11-24 The regional Plant Ops director in-serviced the Plant Ops director on ceiling penetrations. On 4-11-24 The Plant Ops Director completed an audit of the entire facility, and no further issues were found. All residents had potential, no events occurred, and none were affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The ceiling throughout the facility was inspected by Director of Plant Operations on 4-11-24 and is on a weekly preventative maintenance schedule. 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 is in place for weekly checks of ceiling for penetrations and will be conducted by the Director of Plant Operations weekly for , then weekly for 4 months, or until substantial compliance is achieved. The audits will be submitted to the	

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			Quality Assurance Process Improvement Committee. After the stated time committee will determine the need for auditing.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			

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	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 34 corridor doors near the 300-Wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 3 staff and an unknown number of residents. Findings include: Based on observation with the Director of Plant Operations and Administrator on 04/02/24 between 1:12 p.m. and 3:04 p.m., the corridor door to the night pantry next to the Director of Nursing's office within the 300-Wing did not latch into the frame when tested. Based on interview at the time of observation, the Director of Plant Operations confirmed that the door would not latch after testing multiple times. He further stated that the door would have to be adjusted. The finding was reviewed with the Administrator and the Director of Plant Operations during the exit conference. 3.1-19(b)	K 0363	K 363 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 4-2-24 the Plant Operations the corridor door to the night pantry next to the Director of Nursing's office within the 300-Wing so that it would latch into the frame. No events occurred and no residents or staff were affected. 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. On 4-2-24 the Plant Operations an audit of all corridor doors and found no further issues. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. On 4-2-24 The regional Plant Operations Director did in-service the Plant Operations Director on the requirements of	04/19/2024

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			corridor doors to latch into the frame. 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 is in place for weekly check of corridor doors for proper closure and latching. Audits will be conducted by the Director of Plant Operations weekly times 8 then Monthly times 4 or until substantial compliance is achieved. The audits will be reported off to the Quality Assurance Process Improvement Committee. After time committee will determine for auditing until substantial compliance is met.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 1 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0918	K 918 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No event occurred and no residents were affected. On 4-2-24 the Plant Ops and a weekly test of the emergency generator. 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. On 4-2-24 the online p.m. program schedules	04/19/2024

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	Based on records review with the Administrator and Director of Plant Operations (DPO) on 04/01/24 between 10:15 a.m. and 1:01 p.m., a weekly generator visual inspection could not be located for the week of March 10th-March16th. Based on interview at the time of record review, the Director of Plant Operations stated that the weekly inspection was missed and had done two weekly generator inspections the next week. He acknowledged that one inspection had not been completed during the aforementioned time period. Findings were discussed with the DPO and Administrator at exit conference. 3.1-19(b)		were reviewed by the Regional Plant Ops Director and found to be sufficient. No events occurred and no one was affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. On 4-2-24 the Regional Director of Plant Operations re-educated the Plant Ops Director on the requirements for weekly generator testing and documentation. 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 is in place for weekly audit for weekly generator testing and will be completed by the Director of Plant Operations/Designee weekly times 8 then monthly times 4, or until substantial compliance is achieved. The audits will be reported to the Quality Assurance Process Improvement Committee. After time committee will determine for auditing until substantial compliance .	
K 0920 SS=D	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affect approximately 2 residents. Findings include:	K 0920	K 920 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The multi-plug adapter powering a small fan in room 110 was immediately removed from service and given to the social services director for return to the family. No event has occurred no residents or staff have been affected.	04/19/2024

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	Based on observation with the Director of Plant Operations (DPO) and Administrator on 04/01/24 between 1:12 p.m. and 3:04 p.m., resident room 110 contained a multi-plug adaptor powering a small fan.. Based on interview at the time of observation, the Director of Plant Operations did confirm the fan was plugged into an adapter and removed it upon observation. Findings were discussed with the Director of Plant Operations at exit conference. 3.1-19(b)		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. On 4-2-24 The Plant Ops Director completed a full audit of resident care areas to ensure power strips, multi-plug adapters, and extension cords were being used properly and no further concerns were found. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. On 4-2-24 the Regional Plant Ops Director in-serviced the Plant Ops Director on the proper use of power strips, multi-plug adapters, and extension cords. 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 is in place for weekly checks for the proper use of power strips, multi-plug adapters, and extension cords by the Director of Plant Operations/Designee. These will be completed weekly times 8, then Monthly times 4 or until substantial compliance is achieved. The audits will be reported to the Quality Assurance Process Improvement Committee. After the stated time committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155474	A. BUILDING 01 B. WING	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			will determine the need for continued auditing.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on records review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, 11.5.2.3.1 (4) the individual trans-filling the container(s) has been properly trained in the trans-filling procedures. This deficient practice could affect approximately 20 residents and staff near the oxygen storage/transfilling room. Findings include: Based on record review with the Director of Plant Operations (DPO) and Administrator on 04/01/24 between 10:15 a.m. and 1:01 p.m., no documentation was available for review to indicate staff that trans-fill liquid oxygen were properly trained. Based on interview at the time of	K 0927	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No event has occurred no residents or staff have been affected. 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. Education of the staff regarding transfilling of oxygen portable containers began on 4-16-24. What measures will be put into place and what systemic changes	04/19/2024

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	155474	A. BUILDING 01 B. WING	04/01/2024

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	observation, the Administrator stated staff are trained during orientation, however was unable to provide proper documentation during the survey. The Administrator further explained that the trainer who would have gone over transfilling was an education employee who has since left. Findings were discussed with the Administrator and Director of Plant Operations at exit conference. 3.1-19(b)		will be made to ensure that the deficient practice does not recur. Procedure reviewed and found to be sufficient. Re-educated staff regarding transfilling of oxygen completed by Administrator/Designee 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 is in place for weekly audit for transfilling of oxygen education upon hire of new be completed by the Director of Plant Operations/Designee will weekly times 8 then Monthly times 4 or until substantial compliance is achieved. The audits will be reported to the Quality Assurance Process Improvement Committee. After time committee will determine for auditing.	