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	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Bremen	316 Woodies Lane Bremen, IN 46506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31719 Based on interview and record review, the facility failed to ensure a resident was transferred, as ordered. (Resident C) Finding includes: On 6/11/24 at 12:46 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to; heart failure, end stage renal disease, insulin dependent diabetic and right hip fracture (prior to admission-due to a fall at home) and malnutrition. An Activities of Daily Living (ADL) Care Plan, dated 4/3/24, indicated the resident had a self care deficit related to impaired physical functioning and medical conditions. The interventions included, but were not limited to: .provide the amount of assistance resident needs for completion of ADL care, dated 4/26/24, resident is non-weight bearing to right lower extremity . A Care Plan related to health related complications - hip fracture with complications of pressure ulcer, falls and pain, dated 4/3/24 had interventions including but not limited to .assist resident to T & R [turn & reposition] as needed, Dietary supplements as ordered, Follow weight bearing precautions as ordered, refer to Orthopedic MD [Medical Doctor] as needed and Therapies as ordered. An x-ray report, dated 4/25/24, indicated the resident had an older fracture of the right femur and a newer fracture of the same bone, just below the older fracture. The fractures were repaired with screws. A Physician Order, dated 4/26/24 at 9:30 A.M., indicated thte resident was to be NWB [non weight bearing] and would required a mechanical lift machine for transfers. An Event Note, dated 5/9/24 at 09:13 A.M., indicated .Resident lowered to floor with transfer to wheel chair resident denies pain. Assisted up from floor with 3 assist There were no injuries assessed for the resident after she was lowered to the floor. A Discharge Summary, dated 5/9/24, indicated the resident required Hoyer (mechanical) lift transfers and was non weight bearing to the right hip. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 9:02 A.M., CNA 2 indicated she was the CNA who had tried to transfer Resident C from her bed to a wheelchair. CNA 2 indicated she lifted the resident by herself and had not pivoted the resident, when she realized the resident was slipping from her hold, so she lowered the resident to the floor. She indicated she was aware the residents was non weight bearing status and did not let resident's leg bear any weight. She indicated she positioned the resident, on the floor, so she would not be hurt. She indicated there were no CNA (instruction/assignment) sheets, as the facility used an electronic tablet she could refer to, to determine how the residents were to be transferred. She indicated the resident was not a Hoyer lift or a stand lift and she had transferred her from the bed to the wheel chair multiple times. During an interview on 6/12/24 at 9:40 A.M., the Administrator indicated the Discharge Summary form, dated 5/9/24, indicated the resident was a Hoyer lift at the time of the transfer, in which the resident was lowered to the floor. CNA 2 had not worked after the order was received and she was unaware of the change. The Administrator indicated CNA 2 had not reviewed her tablet to ensure she would be using the correct procedure to transfer Resident C. On 6/12/24 at 1:35 P.M., the Director of Nursing provided a policy titled, Physician Orders, dated 6/1/15 and revised on 11/16/23, and indicated the policy was the one currently used by the facility. The policy indicated . It is the standard of this facility that physician orders are followed .Guideline: 4. During physician visits and or rounding, physician orders will be discussed with the physician and licensed staff for need for changes such as new orders, discontinuing orders, or changing current orders On 6/12/24 at 2:26 P.M., the Administrator provided a policy titled, Falls, dated 6/1/15 and revised on 9/15/23, and indicated the policy was the one currently used by the facility. The policy indicated .The intent of this policy is to ensure the facility provides an environment that is free from accidents hazards, as possible, over which the facility has control to prevent avoidable falls. This citation relates to Complaint IN00434550. 3.1-45(a)(2)