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	11/01/2024

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

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 38845 Based on observation, interview and record review, the facility failed to provide a continent resident timely assistance for toileting that resulted in an incontinence episode for 1 of 1 residents reviewed for toileting. (Resident C) Finding includes: During an observation, on 10/30/2024 at 12:20 P.M., Resident C was in a small dining room sitting in a reclining chair. The resident asked CNA 10, who walked by her, to take her to the bathroom. CNA 10 responded I'll see what your aides are doing now. At 12:21 P.M., the resident started to moan and stated Please help!, while trying to reposition herself in the reclining chair. Resident C was observed to bang her right hand down numerous times on the armrest of the chair while still moaning. CNA 10 observed to entered the dining room and asked Resident C,What's going on?, Resident C replied,I need to go to the bathroom. CNA 10 indicated Well, we are about to eat. Resident C indicated, I know but I have asked for 1/2 hour to go to the bathroom and they say I can't go by myself. CNA 10 left the dining room without assisting Resident C to the bathroom. Resident C was observed trying to position herself in the reclining chair and moaning. CNA 10 returned to the dining room with Resident C's lunch tray and sat down beside Resident C and was observed to start feeding the resident. The resident was still moaning. After she had assisted Resident C with her meal, CNA 10 then pushed Resident C out of the dining room and sat her by the nurse's desk. Resident C was heard saying, Please help me. Another staff member walked by and asked her what she needed. Resident C indicated she needed to go to the bathroom. The staff member said she would find her nurse when the resident indicated,I want to go to the ladies room-they just walk past me. During an observation, on 10/30/2024 at 12:53 P.M., Resident C was in her room in the reclining chair, moaning and saying she wanted to go home and wanted to got to the bathroom. Resident C indicted her pants were wet. CNA 10 indicated, We have to check with the nurse first. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 10/30/2024 at 12:57 P.M., Resident C was in her reclining chair moaning and still had not been assisted to the bathroom. During an observation, on 10/30/2024 at 12:59 P.M., Resident C was placed in a hoyer (mechanical device for transfers) lift and transferred to her bed. Her brief was checked and noted to be wet with wetness observed extending up towards the back of the brief. During an interview, on 10/30/2024 at 1:10 P.M., QMA 8 indicated if a resident was saying they needed to go to the bathroom, she would take them. During this interview, LPN 9 interupted and indicated Resident C's family had requested she be kept up in the chair until after lunch. LPN 9 was informed Resident C had been in the dining room moaning and had requested to go to the bathroom several times and LPN 9 just reiterated Resident C was to be left in her chair until after the lunch meal. During an interview, on 10/30/2024 at 1:11 P.M., LPN 9 indicated, She (Resident C) usually is wet, she is incontinent. During the interview with LPN 9, the Administrator approached the nurse's desk and asked if Resident C had been toileted. She was informed the resident had been laid down in bed to check her for incontinence. The Administrator asked LPN 9 if the resident had been offered a bed pan. LPN 9 indicated she did not know. The nurse and Administrator were informed the resident was not offered a bed pan when she was laid down in bed. LPN 9 then indicated, Why would we offer the bed pan when she was wet. The Administrator instructed the staff to put the resident on the bed pan at this time. She indicated they should have taken the resident to her room and offered a bed pan when she had requested to go to the bathroom During an interview, on 10/30/2024 at 1:12 P.M., C.N.A 11 indicated she did not know anything about keeping the resident up in her chair until after lunch. A Bowel and Bladder Retraining Record, dated 10/23/2024 to 10/27/2024, indicated Resident C had a total of 5 incontinent episodes during the assessment time frame but was not always incontinent of her bladder. A current Care Plan, dated 10/172024 and revised on 10/24/2024, indicated the resident was at risk for complications associated with urinary incontinence. Interventions included, but were not limited to: obtain labs; provide assistance with peri care after incontinence as needed; report any changes in bladder status to nurse- low urine; output, foul smelling urine; discolored urine; Pain; Bladder distention; Frequency; Urgency; and Fever. On 11/1/2024 at 3:40 P.M., the Administrator provided the policy titled,Resident Rights, dated 6/1/2025 and revised on 9/15/2023, and indicated the policy was the one currently used by the facility. The policy indicated .3. The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness, and dignity 3.1-9(a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49229 Based on record review and interview, the facility failed to notify the physician of an elevated heart rate and seizure activity and missed medications for 2 of 7 residents reviewed for pharmaceuticals. (Resident N and E) Findings include: 1. The record for Resident N was reviewed on 10/30/2024 at 11:45 A.M. Diagnoses included, but were not limited to: unspecified dementia, anxiety, depression, hypertension, diabetes mellitus, atrial fibrillation and chronic venous hypertension. Physician Orders for Resident N, dated 1/2/2024, included Eliquis (anticoagulant) 2.5 mg (milligrams) 1 tablet twice a day for atrial fibrillation (an irregular heart rhythm that begins in the heart's upper chambers or atria). A current Care Plan, reviewed 8/21/2024, indicated Resident N had a diagnosis of atrial fibrillation. Interventions included but were not limited to: observe for and report heart palpitations, irregular heartbeat and tachycardia (a heart rate that is faster than a hundred beats per minute), and notify physician with any significant changes. A Nursing Progress Note, dated 10/22/2024 at 10:10 A.M., indicated RN 1 assessed Resident N for anxiety and found Resident N to have a heart rate of 211. A Nursing Progress Note, dated 10/22/2024 at 10:20 A.M., indicated Resident N's heart rate was now 176 bpm (beats per minute). A Nursing Progress Note, dated 10/22/2024 at 10:30 A.M., indicated Resident N had a heart rated of 181 bpm. A Nursing Progress Note, dated 10/22/2024 at 11:10 A.M., indicated Resident N had a heart rate of 100 bpm. There was no documentation the physician was notified of Resident N's elevated heart rates. During an interview, on 10/31/2024 at 2:20 P.M., RN 1 indicated a change in condition for a resident included but was not limited to: a change in vital signs, out of range blood sugars or deterioration in the resident's physical assessment. During an interview, on 10/31/2024 at 2:28 P.M., LPN 1 indicated if a resident had a change in condition, the nursing staff would notify the physician, the Director of Nursing (DON) and the resident's representative or family. 45120 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review for Resident E was completed on 10/30/2024 at 2:07 P.M. Diagnoses included, but were not limited to: Lennox-Gastaut syndrome (severe form of epilepsy), severe intellectual disabilities, autistic disorder and schizophreniform disorder. Resident E was admitted to the facility on [DATE]. A record review for Resident E was completed on 10/30/2024 at 2:07 P.M. Diagnoses included, but were not limited to: Lennox-Gastaut syndrome (a rare, severe and lifelong form of epilepsy that starts in early childhood), severe intellectual disabilities, autistic disorder, schizophreniform disorder, and epilepsy. An Admission Minimum Data Set (MDS) assessment, dated 8/23/2024, indicated Resident E had severe cognitive disability and received medications of an antipsychotic, antianxiety and antidepressant. Physician Orders included, but were not limited to: -Clobazam (anti-seizure medication) 20 milligrams at bedtime starting 8/29/2024, given in the morning from 8/17/24-8/28/24. -Fycompa (anti-seizure medication) 30 milliters equals15milligrams at bedtime starting on 8/ 817/2024. -Lamotrigine (anti-epileptic medication) 200 milligrams 2 tabs twice daily starting 8/17/2024. -Rufinamide (anti-convulsant medication) 40 milligrams per milliliter 40 milliliters equals 1600mg twice daily starting 8/17/2024. A review of the August the Medication Administration Record (MAR) indicated the following medication had been missed when signed out for Resident E: -Fycompa had missed doses on 8/17/2024, 8/18/2024, 8/19/2024, 8/23/2024, 8/25/2024, 8/26/2024, 8/28/2024 and 8/31/2024. A Nursing Progress Note, dated 8/20/2024 at 2:09 P.M., indicated Resident E had three noted seizures and the seizure activity was quickly reversed using a magnet. A Nursing Progress Note, dated 8/22/2024 at 4:08 P.M., indicated Resident E had seizure activity tonic-clonic (tonic: a stiffening phase, clonic: a twitching or jerking phase) lasting less than one minute twice during the shift. A Nursing Progress Note, dated 8/29/2024 at 5:58 P.M., indicated Resident E experienced a seizure, which lasted about 10 seconds. The magnet bracelet was used which reversed the seizure activity immediately. A review of the September MAR indicated the following medication had been missed when signed out for Resident E: -Fycompa had missed doses on 9/7/2024, 9/17/2024, 9/27/2024, 9/28/2024, 9/29/2024 and 9/30/2024. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note, dated 9/03/2024 at 8:46 P.M., indicated staff had observed a small seizure that the resident came out of within seconds. A Nursing Progress Note, dated 9/29/2024 at 9:26 P.M., indicated the pharmacy was contacted related to Resident E's medication, Fycompa, needing refilled. The pharmacist indicated the medication was currently out of stock. The pharmacist indicated the medication may be available 9/30/2024 at 10:00 A.M. A review of the September MAR indicated the following medication had been missed when signed out for Resident E:-Fycompa doses were missed on 10/4/2024, 10/13/2024, 10/18/2024, 10/19/2024, 10/21/2024, 10/30/2024 and 10/31/2024. A Nursing Progress Note, dated 10/05/2024 at 10:37 P.M., indicated Resident E had multiple episodes of seizures from 9:30 P.M. to 10:00 P.M., with a duration of one minute and intervals of 2-3 minutes between seizure activity. A Nursing Progress Note, dated 10/07/2024 at 6:00 P.M., indicated a CNA had reported Resident E had experienced a possible seizure in the shower room with symptoms of staring off and not answering questions. A Nursing Progress Note, dated 10/22/2024 at 9:43 P.M., indicated Resident E was watching a movie and had a seizure. The nurse applied the magnet and Resident B responded well. A Nursing Progress Note, dated 10/29/2024 at 3:41P.M., indicated Resident E was in the shower room and a CNA stated, his head was lying on the sink when she turned around and notice [sic] he was having a seizure. A Nursing Progress Note, dated 10/30/2024 at 3:15 P.M., indicated Resident E had a seizure with minimal movement lasted 15 seconds with no adverse effects noted. During an observation, on 10/31/2024 at 8:33 A.M., Resident E was observed having an active seizure while in the television lounge. A Nursing Progress Note, dated 10/31/2024 at 2:28 P.M., indicated Resident E was out of his Fycompa and had missed a dose. A Nursing Progress Note, dated 10/31/2024 at 2:43 P.M., indicated Resident E had a less than 15 second seizure. A Nursing Progress Note, dated 11/01/2024 at 7:54 A.M., indicated Resident E had a short seizure while a CNA was assisting him with morning care. During an interview, on 10/31/2024 at 2:11 P.M., LPN 12 indicated she had not notified the MD of Resident B missing his doses of Fycompa or seizure activity. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy was provided by the Executive Director, on 11/1/2024 at 2:09 P.M. The policy titled, Notification of Change of Condition, indicated, .To ensure appropriate individuals are notified of changes in condition .1. The facility must inform the resident, consult with the resident's physician; and notify consistent with his or her authority, the resident representative[s] when there is: b. A significant change in the resident's physical, mental, or psychosocial status. c. Needs to alter treatment significantly 2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3. The resident and/or representative [if applicable], and medical provider should be notified of a change in condition. The medical provider will provide guidance related to the change of condition 3.1-5(a)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45120 Based on observation, record review and interview, the facility failed to develop a care plan for seizures for 1 of 8 residents reviewed for medication. (Resident E) Finding includes: A record review for Resident E was completed on 10/30/2024 at 2:07 P.M. Diagnoses included, but were not limited to: Lennox-Gastaut syndrome (severe form of epilepsy), severe intellectual disabilities, autistic disorder and schizophreniform disorder. Resident E was admitted to the facility on [DATE]. A record review for Resident E was completed on 10/30/2024 at 2:07 P.M. Diagnoses included, but were not limited to: Lennox-Gastaut syndrome, severe intellectual disabilities, autistic disorder, schizophreniform disorder, and epilepsy. An Admission Minimum Data Set (MDS) assessment, dated 8/23/2024, indicated Resident E had severe cognitive disability and received medications of an antipsychotic, antianxiety and antidepressant. He had an active diagnosis of seizure disorder Current Physician's Orders for medications to treat seizures included, but were not limited to: -Clobazam 20 milligrams at bedtime starting 8/29/2024, given in the morning from 8/17/24-8/28/24. -Fycompa 30milliters equals15milligrams at bedtime starting on 8/ 817/2024. -Lamotrigine 200 milligrams 2 tabs twice daily starting 8/17/2024. -Rufinamide 40 milligrams per milliliter 40 milliliters equals 1600mg twice daily starting 8/17/2024. -Clonazepam 1mg three times a starting 8/16/2024. A Nursing Progress Note, dated 8/20/2024 at 2:09 P.M., indicated Resident E had three noted seizures and was quickly reversed with the seizure using magnet. A Nursing Progress Note, dated 8/22/2024 at 4:08 P.M., indicated Resident E had seizure activity tonic-clonic lasting less than 1 minute twice during the shift. A Nursing Progress Note, dated 8/29/2024 at 5:58 P.M., indicated Resident E experienced a seizure which lasted about 10 seconds. The magnet bracelet was used which reversed seizure immediately. A Nursing Progress Note, dated 9/03/2024 at 8:46 P.M., indicated staff observed a small seizure that the resident came out of within seconds. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident E received 2 doses of clonazepam on 10/23/2024 based on the narcotic signature sheet. A Nursing Progress Note, dated 10/05/2024 at 10:37 P.M., indicated Resident E had multiple episodes of seizures from 9:30 P.M. to 10:00 P.M., with a duration of one minute and intervals of 2-3 minutes. A Nursing Progress Note, dated 10/05/2024 at 11:14 P.M., indicated Resident E was seen at the beginning of the shift being closely monitored. Resident B was in an active tonic seizures. Resident E was responsive and oriented to people around 10:00 P.M., and was to name nurses and CNAs on duty. About ten minutes Resident E stopped responding to verbal and tactile stimuli and was staring blankly in between an episode of seizures. Resident E was picked up from the EMS (emergency medical services) around 10:20 P.M. A Nursing Progress Note, dated 10/06/2024 at 5:37 A.M., indicated Resident E was returned to the facility at 1:34 A.M. for seizures. A Nursing Progress Note, dated 10/07/2024 at 6:00 P.M., indicated a CNA witnessed during a shower Resident E maybe having a seizure with symptoms of staring off and not answering questions. A Nursing Progress Note, dated 10/22/2024 at 9:43 P.M., indicated Resident E was watching a movie and had a seizure. The nurse applied the magnet and Resident E responded well. A Nursing Progress Note, dated 10/29/2024 at 3:41P.M., indicated Resident E was in the shower room and a CNA stated his head was lying on the sink when she turned around and notice he was having a seizure. A Nursing Progress Note, dated 10/30/2024 at 3:15 P.M., indicated a seizure with minimal movement lasted 15 seconds with no adverse effects noted. During an observation, on 10/31/2024 at 8:33 A.M., a surveyor witnessed an active seizure while Resident E was in the television lounge. A Nursing Progress Note, dated 10/31/2024 at 2:43 P.M., indicated Resident E had a less than 15 second seizure. A Nursing Progress Note, dated 11/01/2024 at 7:54 A.M., indicated Resident E had a short seizure this morning while CNA was assisting with morning care. There was no current care plan for seizures for Resident E. During an interview, on 11/1/2024 at 12:27 P.M., the Executive Director indicated Resident E should have his seizure medications without a disruption in administration. A policy regarding care plans was requested but not received prior to the survey exit. 3.1-35(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 38845 Based on observation, interview and record review, the facility failed to ensure showers were provided for 8 of 17 residents reviewed for ADL's (Activities of Daily Living). (Residents H, J, L, C, N, P, M & Q) Findings include: 1. The record review for Resident H was completed on 10/31/2024 at 10:34 A.M. Diagnosis included, but were not limited to dementia, anxiety, need for assistance with personal care and dysphagia. A Quarterly Minimum Data Set (MDS) assessment, dated 8/21/2024, indicated Resident H resident was dependent on staff for showers. Shower documentation for Resident H, dated 10/1/2024 thru 10/31/2024, indicted the resident had only received a shower on 10/13/2024 and 10/19/2024. A current Care Plan, dated 9/13/2024, indicated the resident needed staff assistance with bed mobility, transfers and toileting. During an interview, on 11/1/2024 at 8:45 A.M., the Director of Nursing indicated the resident should have received two showers a week. 2. During an interview, on 10/30/2024 at 11:41 A.M., Resident J indicated he did not always receive a shower two times a week. A record review for Resident J was completed on 10/31/2024 at 10:16 A.M. Diagnoses included: Parkinson's disease, dementia, anxiety and neurogenic bladder. A Quarterly MDS assessment, dated 8/2/2024, indicated the resident had impairment to his upper and lower extremity on one side and was dependent on staff for toileting, showering and transfer needs. The shower documentation, dated 10/1/2024 thru 10/31/2024, indicated Resident J had only received a shower on 10/5/2024. During an interview, on 11/1/2024 at 8:45 A.M., the Director of Nursing indicated the resident should have received two showers a week. 3. The record for Resident L was completed on 10/31/2024 at 11:26 A.M. Diagnoses included, but were not limited to Alzheimer's disease, hypertension, depression dementia and need for assistance with personal care. An Admission Minimum Data Set (MDS) assessment, dated 8/4/2024, indicated the resident required substantial/maximum assists for showering. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower documentation, dated 9/1/2024 thru 10/31/2024, indicated Resident L only received showers on the following dates: - 9/92024 - 9/19/2024 - 9/29/2024 - 10/5/2024 - 10/24/2024 During an interview, on 11/1/24 at 8:16 A.M., the Director of Nursing indicated the resident should have received had two showers a week. 45120 4. During an observation, on 10/30/2024 at 2:16 P.M., Resident C was observed with greasy hair with the comb tracts visible. During an observation, on 10/31/2024 at 8:52 A.M., Resident C was observed to be in the hallway with her hair combed back with comb tracts visible. Her hair was dirty and greasy. During an observation, on 11/1/2024 at 11:11 A.M., Resident C was observed in the dining room. Her hair was greasy. A record review for Resident C was completed on 10/30/2024 at 11:14 A.M. Diagnoses included, but were not limited to: Hemiplegia affecting the right dominant side, cerebral infarction, schizophrenia, bipolar disorder, and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 10/8/2024, indicated Resident C required substantial/maximal assistance with showering and had impairment of an upper and lower extremity. A Care Plan, dated 4/15/2024 and revised on 10/20/2024, indicated Resident C required assistance with her with activities of daily living (ADL) including bed mobility, eating and toileting related to her hemiplegia and multiple sclerosis diagnosis. Bathing documentation indicated Resident C only received showers on the following days: 10/3/2024 shower 10/5/2024 complete bed bath 10/7/2024 shower 10/11/2024 shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/14/2024 shower 10/21/2024 shower 10/24/2024 shower 49229 5. The record for Resident N was reviewed on 10/30/2024 at 11:45 A.M. Diagnoses included, but were not limited to: unspecified dementia, anxiety, depression, hypertension, diabetes mellitus, atrial fibrillation and chronic venous hypertension. A current Care Plan, reviewed on 8/21/24, indicated Resident N had a history of refusal of care such as refusing showers multiple times in a row. Interventions included but were not limited to: explain care process prior to delivery of care as needed, approach resident in a calm and unhurried manner to deliver provide services and provide education as needed on the benefits and risks of receiving recommended care. The medical record for Resident N lacked documentation for showers or shower refusal for the dates of 10/3/2024 through 10/30/2024. During an interview, on 10/30/24 at 12:30 P.M., Resident N indicated she did not get help with showers but indicated she normally cleaned herself up in the bathroom at the sink. During an interview, on 10/30/2024 at 12:18 P.M., CNA 1 indicated the residents received a shower twice a week. During an interview, on 10/31/2024 at 2:20 P.M., the Administrator indicated there were no printed shower sheets and all showers were documented in the electronic medical record (EMR). During an interview, on 10/31/2024 at 10:45 A.M., CNA 2 indicated residents received showers every day or when they asked. If a resident refused a shower, the aide notified the DON and documented the refusal in the EMR. During an interview, on 11/1/2024 at 11:30 A.M., the Administrator indicated she was unaware of the meaning of other bath in the EMR. During an interview, on 11/1/2024 at 11:30 A.M., the Corporate Nurse indicated she was unaware of the meaning of other bath in the EMR. 6. During an interview, on 10/30/2024 at 10:25 A.M., Resident P's representative indicated Resident P had not received a shower since his admission to the facility. During an observation and interview, on 10/30/2024 at 10:35 A.M., Resident P had disheveled hair and beard scruff 1/4 inch long. Resident P indicated he liked a clean-shaven face except for his mustache. (continued on next page)

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	155474	A. Building B. Wing	11/01/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 10/31/2024, Resident P was seated on his bed, with the same clothes as worn on 10/30/24 and the resident's face still had beard stubble. The medical record for Resident P was reviewed on 10/30/2024 at 12:20 P.M. The diagnoses included but were not limited to: encephalopathy, alcohol use, urinary tract infection, acute renal failure, hypertension, acute vision loss bilateral eyes and diabetes mellitus. An Admission Minimum Date Set (MDS) assessment, dated 10/10/2024, indicated the resident required partial assistance with showering and bathing. A current Care Plan, initiated on 10/3/2024, indicated Resident P had a self-care deficit related to impaired physical functioning and medical conditions. Interventions included but were not limited to: provide frequent encouragement, along with prompting and assistance as needed and to provide the amount of assistance resident needs for completion of Activity of Daily Living (ADL) cares. The medical record for Resident P indicated the resident refused a shower on 10/12/2024. The record lacked documentation of any other refusal of showers and lacked documentation Resident P received any showers from 10/5/2024 through 10/30/2024. 7. The medical record for Resident M was reviewed on 10/30/2024 at 2:19 P.M. The diagnoses included but not limited to: Alzheimer's disease, acute kidney failure, ventral hernia, urinary tract infection, frequent falls, depression, other artificial opening of the urinary tract, post-traumatic stress disorder, sepsis, neuromuscular dysfunction of the bladder, neurogenic bladder and obstructive uropathy. A Discharge MDS assessment, dated 9/27/2024, indicated Resident M had memory problems and was severely cognitively impaired. The MDS indicated the resident required partial assistance with showering and bathing. A current Care Plan, reviewed on 10/14/2024, indicated Resident M had a self-care deficit related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of ADL cares. Interventions included but were not limited to: provide frequent encouragement, along with prompting and assistance as needed and provide the amount of assistance resident needs for completion of ADL cares. The shower documentation for Resident M indicated he had only received two showers, one on 10/20/2024 and 10/24/2024 from October 2 - 30, 2024. 8. During an observation and interview, on 10/30/2024 at 11:00 A.M., Resident Q had very greasy hair and the resident was unsure when he last showered. During an observation, on 10/31/2024 at 3:00 P.M., Resident Q still had very greasy hair. During an interview, on 10/30/2024 at 12:18 P.M., CNA 1 indicated residents received a shower twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 10/31/2024 at 10:45 A.M., CNA 2 indicated the residents received showers every day or when they asked. If a resident refused a shower, the aide notified the DON and documented the refusal in the EMR. The medical record for Resident Q was reviewed on 10/31/2024 at 10:13 A.M. Diagnoses included but were not limited to: encephalopathy, alcohol abuse, delirium, dementia, inguinal hernia, difficulty in walking, depression and anxiety. The Admission MDS assessment, dated 10/10/2024, indicated the resident was severely cognitively impaired. The MDS assessment indicated Resident Q required substantial assistance with showering and bathing. A current Care Plan, dated 10/3/2024, indicated Resident Q has a self-care deficit related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of ADL cares. Interventions included but were not limited to: provide frequent encouragement, along with prompting and assistance as needed, encourage resident to participate if they are able and provide the amount of assistance resident needs for completion of ADL cares. There was only one shower documented, on October 6 for Resident Q from 10/3/2024 through 10/30/2024 and no refusals of showers were documented. During an interview, on 11/1/2024 at12:35 P.M., the Executive Director indicated the showers were documented in the electronic health record chart. There were no paper shower sheets utilized for documentation. She indicated residents' frequency was their preference and the standard was a minimum of two showers per week. She indicated the residents' frequency of showers preference should be recorded in the activities of daily living (ADL) care plan. A policy was provided, on 11/1/2024 at 10:29 A.M., by the Executive Director. The policy, titled, Activities of Daily Living [ADL's], indicated, .Direct healthcare staff will assist, support and encourage the resident to maintain adequate ADL while attempting to allow the resident to ne able to maintain as much independence as possible with their ADL such as the following: Bathing .For those residents who are unable to perform their own activities of daily living, the facility will provide the needed assistance for completion of cares This citation relates to Complaint IN00445742. 3.1-38(a)(2)(A)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38845 Based on record review and interview, the facility failed to ensure physician ordered medications were administered for 2 of 10 residents whose medications were reviewed. (Residents J & L) Findings include: 1. The record for Resident J was completed on 10/31/2024 at 10:16 A.M. Diagnoses included: Parkinson's disease, dementia, neurogenic bladder and diabetes and pain in joints. Current Physician Orders for Resident J included: Hydrocodone (narcotic pain medication) 5/325 mg (milligrams) 1 tablet every 6 hours for pain at midnight, 6:00 A.M., noon and 6:00 P.M. Resident J's narcotic Controlled Drug Record for the Hydrocodone, dated October 2024, indicated he had not received the 4 scheduled doses on 10/25/2024 and the midnight dose on 10/26/2024. During an interview, on 11/1/2024 at 8:45 A.M., the Administrator indicated the resident should have received the medication. 2. The record for Resident L was completed on 10/31/2024 at 11:26 A.M. Diagnoses included, but were not limited to Alzheimer's disease, hypertension, depression, dementia and chronic cluster headaches. Resident L's current Physician Orders' included: Lyrica (controlled pain medication) 50 mg 1 capsule three times a day for pain. The Controlled Drug Record for Resident L's Lyrica (pregabalin) 50 mg three times daily indicated the following missed doses: - 1 dose on 10/14/2024, 10/16/2024, 10/17/2024 and 10/2024. During an interview, on 11/1/2024 at 8:47 A.M., the Administrator indicated the residents should have received the medications. On 10/31/2024 at 2:33 P.M., the Administrator provided the policy titled,Controlled Medication, dated 5/30/2024, and indicated the policy was the one currently used by the facility. The policy indicated .4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage a. Date and time of administration. b. Amount administered. c. Signature of the nurse administering the dose. 5. Administer the controlled medication and document dose administration on the MAR On 11/1/2024 at 3:15 P.M., the Administrator indicated she could not provide a policy for following physician orders. This citation relates to Complaint IN00445742. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-37

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49229 Based on observation, interview and record review, the facility failed to ensure routine medications were available and dispensed according to physician's orders for 3 out of 8 residents reviewed for medication administration. (Residents M, L and C) Findings include: 1. The medical record for Resident M was reviewed on 10/30/2024 at 2:19 P.M. The diagnoses included but were not limited to: Alzheimer's disease, acute kidney failure, ventral hernia, urinary tract infection, frequent falls, depression, other artificial opening of the urinary tract, post-traumatic stress disorder, sepsis, neuromuscular dysfunction of the bladder, neurogenic bladder and obstructive uropathy. Physician Orders for Resident M included Mupirocin ointment 2% 1 application topically twice a day, dated 8/31/2024 until 10/30/2024, and Clonazepam 0.25 mg 1 tablet by mouth twice a day, dated 10/3/2024. The October MAR indicated Resident M did not receive Mupirocin as ordered on the following dates: 10/18/2024 Evening dose due to medication unavailable, 10/19/2024 Morning and evening doses due to medication unavailable, 10/21/2024 Evening dose due to medication unavailable, 10/22/2024 Morning dose due to medication unavailable, 10/23/2024 Evening dose due to medication unavailable, 10/25/2024 Morning dose due to medication unavailable 10/29/2024 Morning dose due to medication unavailable. The October MAR indicated Resident M did not receive Clonazepam as ordered on the following dates: 10/19/2024 Morning dose missed due to medication not available, 10/21/2024 Morning dose missed due to medication not available, 10/22/2024 Morning dose missed due to medication not available, 10/23/2024 Both doses missed due to medication not available, 10/24/2024 Morning dose missed due to medication not available, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/25/2024 Morning dose missed due to medication not available, 10/26/2024 Morning dose missed due to medication not available, 10/27/2024 Morning dose missed due to medication not available, 10/29/2024 Morning dose missed due to medication not available. During an interview, on 11/1/2024 at 12:45 P.M., QMA 1 indicated the medication should always be double-checked with the MAR prior to administration. 38845 2. The record for Resident L was completed on 10/31/2024 at 11:26 A.M. Diagnoses included, but were not limited to Alzheimer's disease, hypertension, depression, dementia and chronic cluster headaches. Resident L's current Physician Orders included: Lyrica (controlled medication) 50 mg 1 capsule three times a day for pain. The Controlled Drug Record for Lyrica (pregabalin) 50 mg three times daily indicated the following: - an extra dose was received on 10/8/2024. - 1 dose was missed on 10/14/2024, 10/16/2024, 10/17/2024 and 10/2024, - an extra dose was received on 10/23/2024. The Medication Administration Record (MAR), dated 10/1/2024 thru 10/31/2024, indicated the schedued Lyrica medication was not available on the following days: 10/5/2025 for the 7:00 A.M. to 11:00 A.M. shift and the 11:15 A.M. to 3:00 P.M. shift. On 10/7/2024 for the 7:00 A.M. to 11:00 A.M. shift. During an interview, on 11/1/2024 at 8:47 A.M., the Administrator indicated the resident should have received the medication and should not have received the extra doses. 3. The record review for Resident C was completed on 10/30/2024 at 2:27 P.M. Diagnoses included but were not limited to: dementia, acute pain due to trauma, low back pain, and chronic kidney disease. Physician Orders for Resident C included the following: Valsartan (anti hypertensive medication) 40 mg 1 tablet every 12 hours at 8:00 A.M. and 8:00 P.M. The Medication Administration Record (MAR) for October 2024 indicated the Valsartan medication was not administered on the following dates: - 10/18/2024 1 dose of the medication was documented as not available. - 10/20/2024 1 does of the medication was documented as not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/19/2024 2 doses of the medication was documented as not available. During an interview, on 11/1/2024 at 8:47 A.M., the Administrator indicated the medications that were unavailable should have been pulled from the Pyxis (emergency dispensing machine) or the pharmacy should have been called for a STAT (immediate) delivery. During an interview, on 11/1/2024 at 1:58 P.M., the Administrator indicated the facility has no policy on medications being unavailable. The Administrator indicated that the nurse should call pharmacy and then notify the attending physician when a medication is unavailable On 10/31/2024 at 2:33 P.M., the Administrator provided the policy titled,Controlled Medication, dated 5/30/2024, and indicated the policy was the one currently used by the facility. The policy indicated .4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage a. Date and time of administration. b. Amount administered. c. Signature of the nurse administering the dose. 5. Administer the controlled medication and document dose administration on the MAR This citation relates to Complaint IN00445742. 3.1-25(a) 3.1-25(e)(2) 3.1-25(e)(3)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 49229 Based on observation, record review and interview, the facility failed to ensure an antianxiety drug was not adiministered for an excessive duration for 1 of 8 residents reviewed for pharmaceutical services (Resident M). Finding includes: The medical record for Resident M was reviewed on 10/30/2024 at 2:19 P.M. The diagnoses included but were not limited to: Alzheimer's disease, acute kidney failure, ventral hernia, urinary tract infection, frequent falls, depression, other artificial opening of the urinary tract, post-traumatic stress disorder, sepsis, neuromuscular dysfunction of the bladder, neurogenic bladder and obstructive uropathy. Physician's Orders for Resident M included Ativan (an antianxiety medication) 2 mg 1 tablet by mouth twice a day as needed, initiated on 7/29/2024, and Clonazepam (an antianxiety medication) 0.25 mg 1 tablet by mouth twice a day, initiated on 10/3/2024. The PRN Clonazepam did not have a stop date for the medication use. A current Care Plan, reviewed 10/14/2024, indicated Resident M was at risk for drug related side effect due to psychotropic medication. Interventions included but were not limited to: anti-anxiety medication - observe for sedation, drowsiness, ataxia(drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision and skin rash; psychotropic drug committee to attempt dose reduction per physician's orders and consult with psychiatry/psychologist as needed. The October Medication Administration Record (MAR) indicated Resident M received Clonazepam as ordered from 10/3/2024 through 10/31/2024. The October MAR indicated Resident M also received as needed Ativan on the following dates: 10/9/2024, 10/11/2024 through 10/15/2024, 10/21/2024 through 10/25/2024 and 10/27/2024 through 10/31/2024. During an interview, on 10/31/2024 at 2:20 P.M., the Administrator indicated Resident M was on both Ativan and Clonazepam due to all of the resident's behaviors. On 11/1/2024 at 1:00 P.M., the Administrator provided a policy titled, Psychotropic Medications Policy, dated 11/23/2015 and indicated the policy was the one currently used by the facility. The policy indicated . psychotropic drug .include, but are not limited to .anti-anxiety .PRN orders for psychotropic drugs are limited to 14 days .should document their rationale in the resident's medical record and indicate the duration of the PRN order 3.1-48(a)(6)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45120 Based on record review and interview, the facility failed to ensure 1 of 7 residents reviewed for medication use was free from significant medication errors related to omissions and overdosing/underdosing of antiseizure medications. (Resident E) Finding includes: A record review for Resident E was completed on 10/30/2024 at 2:07 P.M. Diagnoses included, but were not limited to: Lennox-Gastaut syndrome, severe intellectual disabilities, autistic disorder, schizophreniform disorder, and epilepsy. An Admission Minimum Data Set (MDS) assessment, dated 8/23/2024, indicated Resident E had severe cognitive disabilities and received medications of an antipsychotic, antianxiety and antidepressant. Physician's Orders for medications included, but were not limited to: -Clobazam (anti-seizure medication) 20 milligrams at bedtime starting 8/29/2024, given in the morning from 8/17/24-8/28/24. -Fycompa (anti-seizure medication) 30milliters equals15milligrams at bedtime starting on 8/ 817/2024. -Lamotrigine (anti-epileptic medication) 200 milligrams 2 tabs twice daily starting 8/17/2024. -Rufinamide (anti-convulsant medication) 40 milligrams per milliliter 40 milliliters equals 1600mg twice daily starting 8/17/2024. -Clonazepam (used for anti-seizure medication) 1mg three times a starting 8/16/2024. Review of the August 2024 narcotic signature sheet indicated Resident E missed Fycompa doses on 8/17, 8/18, 8/19, 8/23, 8/25, 8/26, 8/28, and 8/31. In addition, the resident received Clobazam twice daily, instead of the ordered daily dose, on 8/23 and 8/29 based on the narcotic signature sheet. Resident E also received 4 doses, instead of the ordered three doses of clonazepam on 8/17/2024, only 2 doses on 8/23/2024, only 2 doses on 8/27/2024, and only 2 doses on 8/30/2024. Review of the September 2024 narcotic signature sheet for Fycompa indicated Resident E missed doses on the following dates: 9/7/2024, 9/17/2024, 9/27/2024, 9/28/2024, 9/29/2024, and 9/30/2024. In addition, Resident E received two doses instead of one dose on the following dates: 9/2/2024, 9/4/2024, 9/8/2024, 9/9/2024, 9/11/2024, 9/12/2024, 9/13/2024, 9/16/2024, 9/18/2024, 9/19/2024, 9/22/2024, 9/23/2024, 9/27/2024, 9/29/2024, and 9/30/2024 based on the narcotic signature sheet. On 9/5/2024, Resident E missed the daily dose of Clobazam altogether. On 9/6/2024, Resident E only received 2 doses of the clonazepam instead of the ordered three doses. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the October 2024 narcotic signature sheets for Fycompa, Resident E missed doses on the following dates: 10/4/2024, 10/13/2024, 10/18/2024, 10/19/2024, 10/21/2024, 10/30/2024, and 10/31/2024. In addition, Resident E received twice the ordered doses of Clobazam on the following dates: 10/5/2024, 10/6/2024, 10/7/2024, 10/14/2024, 10/16/2024, 10/17/2024, 10/19/2024, 10/20/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/28/2024 10/29/2024, and10/30/2024 based on the narcotic signature sheet. The resident also missed the dose of Clobazam altogether on 10/18/2024 and received only two doses instead of the ordered three doses of clonazepam on 10/23/2024. A Nursing Progress Note, dated 10/28/2024 at 7:26 A.M., indicated the pharmacy was contacted related to Resident E's Clobazam medication and the pharmacy indicated the medication was to be delivered tto the facility later in the afternoon. A Nursing Progress Note, dated 10/31/2024 at 2:28 P.M., indicated the physician was notified that Resident E was out of his Fycompa medication. The pharmacy indicated the medication would be delivered to the facility soon but the medicaiton had not yet arrived. The physician was updated regarding the missed dose of Fycompa. A Nursing Progress Note, dated 10/31/2024 at 2:43 P.M., indicated Resident E had a less than 15 second seizure. A Nursing Progress Note, dated 11/01/2024 at 7:54 A.M., indicated Resident E had a short seizure this morning while a CNA was assisting him with morning care. During an interview, on 10/31/2024 at 9:12 A.M., the facility pharmacy indicated Resident E's Fycompa 340 milliliters (11-day supply) was ordered last on 10/11/24 and delivered on 10/14/24, ordered 9/27/24 and received 9/30/24, and ordered 8/19/24. The Clobazam 20mg medication was ordered on 9/11/24 and 10/28/24. During an interview on 10/31/2024 at 1:52 P.M., RN 13 indicated she had called the pharmacy for the past two days to inquire about the Fycompa the pharmacy had still not sent the medication. LPN 12 looked in the medication cart for the Fycmpa and the medication was still not available. During an interview, on 10/31/2024 at 2:11 P.M., LPN 12 indicated she had not notified the MD of Resident E missing multiple doses of Fycompa. She indicated the order for Clobazan had been changed to daily a while back and she did not know why it was still being administered twice daily. A policy was requested regarding medicaion errors on 11/1/2024 at 9:17 A.M. and a policy was not provided prior to the survey exit. 3.1-48(c)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38845 Based on observation, interview and record review, the facility failed to ensure urinary catheter equipment was positioned and maintained in a sanitary manner for 1 of 2 residents reviewed for catheter use. (Resident J) Finding includes: During an observation, on 10/30/2024 at 11:41 A.M., Resident J's catheter tubing and urine collection bag was lying on the floor under his wheelchair. During an interview, on 10/30/2024 at 11:43 A.M., CNA 11 indicated the tubing and the drainage bag should not be on the floor. During an observation, on 10/31/2024 at 10:20 A.M., Resident J's urine collection bag was lying on the floor. During an observation, on 11/1/2024 at 9:10 A.M., Resident J was in the dining room with the urine collection bag lying on the floor. During an interview, on 10/30/2024 at 11:43 A.M., CNA 11 indicated the tubing and the drainage bag should not be on the floor. On 10/30/2024 at 11:59 A.M., Resident J was brought into the dining room with the urinary catheter tubing and drainage bag dragging on the floor. During an observation, on 10/30/2024 at 3:42 P.M., Resident J's urinary collection bag and tubing were lying on the floor. The record for Resident J was completed on 10/31/2024 at 10:16 A.M. Diagnoses included: Parkinson's disease, dementia, neurogenic bladder and diabetes. A Quarterly Minimum Data Set (MDS) assessment, dated 8/2/2024, indicated Resident J had an indwelling catheter and was frequently incontinent of his bowels. A Physician's Order, initiated on 8/21/2024, indicated; Foley/Supra-pubic Catheter size 14 french, 30 cc (cubic centimeters) balloon to straight drainage and privacy bag at all times. A Physician's Order, initiated on 8/29/2024, indicated the catheter bag was to be secured with a Tube Tie adhesive holder every shift, and was to be replaced if not there. A current Care Plan, initiated on 9/24/2024, with a revision date of 10/10/2024, indicated Resident J had a UTI (urinary tract infection). Interventions included: administer antibiotic as ordered, observe for side effects of the antibiotic and encourage fluids. (continued on next page)

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	11/01/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current Care Plan, initiated on 7/1/2024 and revised on 10/10/2024, indicated Resident J was at risk for potential complications related to the use of an indwelling urinary catheter. Interventions included, but were not limited to: observe for abdominal pain, observe for changes in characteristics of urine, observe or retention and provide catheter care. A policy for the use of a catheter was requested on 10/31/2024 but one was not provided. 3.1-18(a)