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	05/21/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a staff nurse performed CPR correctly for 1 of 3 residents reviewed for death. (Resident B) In addition, the facility failed to ensure nursing staff who received online Cardiopulmonary Resuscitation (CPR) training completed a hands on component led by an in- person or virtual instructor for 13 of 16 nursing staff members reviewed (Registered Nurses 2, 4, 5 & 6, Licensed Practical Nurses 7, 8, 9, 10, 11, 12 & 13, the Director of Nursing and the Assistant Director of Nursing). This deficient practice resulted in a resident death for 1 of 1 resident reviewed for CPR.This immediate jeopardy began on [DATE] when RN 6 incorrectly performed CPR on Resident B by failing to ensure there was a hard surface underneath the resident prior to initiating and during continued chest compressions. The Director of Nursing and the Administrator (via telephone) were notified of the immediate jeopardy at 2:45 P.M., on [DATE]. The immediate jeopardy was removed on [DATE], but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy Findings include: An observation, on [DATE] at 10:03 A.M., of body camera footage provided by the local police department, of CPR being performed on Resident B by RN 6 was reviewed The body camera video footage, from [DATE] at 7:15 P.M., confirmed RN 6 had failed to perform CPR correctly, ensuring there was a hard surface underneath the resident while she had provided CPR measures to Resident B, including chest compressions. In the video, Resident B was observed on a pressure redistribution mattress with her upper body on the mattress and her lower body off the side of the mattress and her feet on the floor. RN 6 had been observed providing CPR standing over Resident B.A record review for Resident B was completed on [DATE] at 11:17 A.M. Diagnoses included but were not limited to acute on chronic diastolic heart failure, diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD) and conversion disorder with seizures/convulsions.A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident B had severe cognitive impairment and was independent with bed mobility.A Care Plan, initiated on [DATE], indicated Resident B had completed an advanced directive indicating she desired to be a full code. A Nursing Progress Note, on [DATE] at 7:15 P.M., indicated Resident B had complained of not being able to get her breath. RN 6 had left the room to find another nurse to assist her. When RN 6 arrived back at Resident B's room, Resident B was unresponsive without blood pressure or an apical pulse. CPR was initiated by RN 6 and LPN 8 also arrived at Resident B's room to assist with CPR measures. Emergency Medical Services (EMS) were notified and once they arrived, they took over the CPR measures.A Nursing Progress Note, on [DATE] at 7:40 P.M., indicated EMS had called resident B's daughter with an update on the results of the CPR attempt and had informed the daughter of the resident's time of death.During an interview, on [DATE] at 8:17 A.M., RN 6 indicated Resident B should have been moved to a solid surface when she provided CPR.During an interview, on [DATE] at 9:20 A.M., LPN 8 indicated Resident B had not been on a solid surface when RN 6 had provided chest compressions and Resident B should have been moved to a solid surface.Review of a written statement, provided by the responding police officer, indicated he had (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	entered the facility front doors as directed on the dispatch call. He indicated he had been informed there was an unresponsive female and CPR was being performed on the resident. When he entered the front door, he did not see any staff in the area near the front door, nor was there any staff member available to direct him to the resident's room. He indicated a female staff member, later identified as LPN 8, was slowly walking down the hallway and pointed him towards the resident's room. When he arrived at the resident's room, there was one female staff member performing chest compressions on a resident that was partially in her bed. The officer indicated another officer arrived a few seconds after he arrived and the two officers immediately placed the resident onto the floor and the officers took over chest compressions until the EMS staff arrived.On [DATE] at 8:15 A.M., nursing staff CPR certifications were provided. RN 6 had a CPR certification, dated [DATE] and LPN 8 had a CPR certification dated [DATE]. Both certificates were obtained from the online site (name of the online CPR certification website). The curriculum on the website specifically stated hands-on training for CPR was not provided and included a website link of nearby virtual and in person instructors for the hands on virtual skills competency component. Previous CPR certifications could not be provided by the facility for RN 6 or LPN 8. In addition, the following nursing staff members had also obtained their current CPR certifications, without any hands-on training, from the same online provider: Registered Nurses 2, 4, 5 and 6, Licensed Practical Nurses 7, 8, 9, 10, 11, 12 & 13, the Director of Nursing and the Assistant Director of Nursing. During an interview, on [DATE] at 11:47 A.M., the Executive Director indicated nursing staff were not required to have hands-on training as part of the facility's CPR certification process.A current policy was provided on [DATE] at 11:53 A.M., by the Executive Director. The policy titled, CPR Certification, indicated, .The facility's policy is to maintain Cardiopulmonary Resuscitation [CPR] certified personnel on a 24-hour basis.2. CPR training may include hands-on practices and in-person skills assessment or a virtual instructor-led setting, according to accepted national standards.The Immediate jeopardy that began on [DATE] was removed on [DATE] when the facility ensured all nursing staff were re-educated on CPR procedures and all nursing staff had completed a CPR class which included a return demonstration and skills check off component, as required, but the noncompliance remained at the lower scope and severity level of isolated with potential for harm, not immediate jeopardy because the facility needed to continue monitoring and ensure staff competency with CPR procedures. This citation relates to Intake 3000627410 IAC (Indiana Administrative Code) 16.2- 3.1-13 (a)