STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	**09/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF MADISON	**431 LARKIN SPRING RD MADISON, TN 37115**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facilty policy review, medical record review, observation and interview, the facility failed to treat 1 (#1) of 24 residents with dignity during the noon meal on 9/14/2020 related to a Licensed Practical Nurse(LPN) standing while assisting Resident #1 with her meal. The findings include: Review of the facility policy Assistance with Meals, dated 6/27/18, showed .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals . Review of the medical record showed Resident #1 was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], showed Resident #1 had a Brief Interview Memory Score of 13, indicating the resident was cognitively intact. Continued review showed Resident #1 required supervision with eating with a 1 person physical assist. Observation of Resident #1 on 9/14/2020 at 12:36 PM showed LPN #1 stood to assist Resident #1 with her meal. During an interview on 9/14/2020 at 5:08 PM, LPN #1 confirmed she was standing while assisting Resident #1 with the noon meal. During an interview on 9/14/2020 at 7:30 PM, the Administrator confirmed LPN #1 was to sit while assisting residents with their meals.

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

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.