STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185052	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Summit Manor Rehab & Welln	400 Bomar Heights Columbia, KY 42728

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policy, the facility failed to provide a safe, clean, and well-maintained environment. Multiple maintenance concerns were observed throughout the facility that had the potential to all residents. The findings include:Review of the facility's policy titled Home-like Environment, last revised 09/05/2025, revealed the resident has a right to a safe, clean, and homelike environment.Observation, on 03/24/2026 at 8:34 AM, revealed a handrail leading into the kitchen that was not securely attached, with screws coming out of the wall. Also, there was a separate handrail end which was not attached securely to the wall mount and jiggled. Observation on 03/24/2026 at 9:05 AM; 03/25/2026 at 2:45 PM; and 03/26/2026 at 7:25 AM, revealed a water hose lying in the flowerbeds at the entrance to the facility. A white styrofoam cup was observed on the ground outside of a resident's window. Observation, on 03/24/2026 at 9:36 AM, revealed the entry door to the kitchen area on the [NAME] Way Hall revealed scratches and worn areas, and a piece missing from the bottom corner on the handle side. Continued observation revealed the nurses' station had damaged wood paneling, with 11 areas where pieces were chipped or missing. Observation, on 03/24/2026 at 9:47 AM, revealed resident room [ROOM NUMBER]'s flooring where previous heating/cooling units had been removed, had holes and damaged sections that exposed the concrete beneath. Continued observation revealed stained flooring at the base of the toilet and under the sink in the attached bathroom.Observation, on 03/24/2026 at 9:50 AM, revealed the wall paint at the end of the 100 hall was bubbling and chipping. Also, the door frame at the entry to the first floor was observed to be rusted both on the inside and outside. Further observation, at the end of the 100 Hall near the exit door beside resident room [ROOM NUMBER], revealed ceiling tiles were discolored and appeared to be water stained. Observation, on 03/24/2026, at 10:15 AM, revealed the wall leading to the resident dining room on the first floor had visible black scuff marks. Further observation revealed baseboards within the dining room that had black scuff marks. Also, the glass door leading to the residents' smoking area had visible scratches on the surface. Additionally, floor tiles at the exit from the resident dining room to the resident smoke area, were damaged, with one tile missing a corner piece. Observation, on 03/24/2026 at 10:30 AM, revealed a cabinet in a resident shower room on the second floor with a missing handle. Continued observation in the same resident shower room revealed a wall corner guard with multiple strips of tape appearing to be holding it in place. Observation, on 03/24/2026 at 10:45 AM, of a second resident shower room on the second floor revealed a wall clock not mounted to the wall. The clock was resting on two cloth hooks.Observation, on 03/26/2026 at 11:40 AM, revealed an approximate six- inch by six- inch floor tile in resident room [ROOM NUMBER] had been removed. The underlying concrete was exposed.Observation, on 03/26/2026 at 11:50 AM, revealed dried white paint splatter on the floor at the entry to resident rooms [ROOM NUMBERS]. Observation, on 03/26/2026 at 11:57 AM, revealed rust on a heating/cooling unit outside resident room [ROOM NUMBER]. Continued observation revealed discolored paint and chipping off the wall. Observation also revealed rust and chipped paint on the exit door, next to the heating cooling unit. Observation, on 03/26/2026 at 3:25 PM, revealed a pool table in the first-floor resident dining room. (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pool table was missing a corner guard leaving exposed edges. Also, the raised garden bed outside of the dining area had structural deterioration, including a failing base. The bottom of the raised garden bed appeared to be rotted and detached from the sides and partially laying on the ground. Observation, on 03/26/2026 at 4:25 PM, revealed a heating and air unit in resident room [ROOM NUMBER] which had a missing bottom door revealing visible dust and debris.In an interview, on 03/26/2026 at 4:25 PM, Resident (R)82, stated the heating and air unit in her room was missing the bottom part exposing the floor underneath. There was a visible area that exposed dust and debris. R82 stated if she were able, she would clean it herself because she liked her home to be clean. In an interview, on 03/24/2026 at 10:55 AM, Certified Nursing Assistant (CNA) 5 stated the cabinet in the residents' shower room had been broken for many years. CNA 5 stated repairs were not consistently completed after being reported to the maintenance department, via the logbooks. During an interview, on 03/26/2026 at 12:18 PM, the Housekeeping Manager stated she was aware of the scuff marks on the walls and baseboards but had not documented the issue in the maintenance logbook to notify the maintenance department. She stated the staff notified her or her team of any areas that needed to be cleaned. The Housekeeping Manager stated scuff marks looked bad, but acknowledged the scuff marks had not been addressed in the facility. The Housekeeping Manager stated it was her expectation for housekeeping staff to maintain a clean environment to ensure resident safety and reduce fall hazards.In an interview, on 03/26/2026 at 2:00 PM, the Dietary Manager (DM) stated she had concerns regarding the safety of the handrails in the kitchen area. She stated the handrails were not useful due to their condition. The DM stated that in the current condition the handrails could pose a fall risk. She stated the issue had been brought to the attention of maintenance; however, repairs had never been carried out.In an interview, on 03/26/2026 at 3:43 PM, the Maintenance Director stated there were no outstanding work orders documented in the maintenance logbook. He stated, any facility staff member could document an issue or concern in the logbook, which was located at each nurse's station for the maintenance department to address. The Maintenance Director stated the department typically painted scuffed walls during the second week of each month; however, as of the interview, painting had not been completed for the month of March. He further stated the facility did not have any documented work orders related to the rusted door frames. The Maintenance Director stated the damage to the raised garden bed had occurred during the winter months and had not yet been removed or repaired. Additionally, he stated there were only two employees in the maintenance department and it was hard to be in every room, every day.In an interview, on 03/26/2026 at 3:59 PM, the Director of Nursing (DON) stated it was her expectation the housekeeping and maintenance departments keep the facility safe and clean for residents. The DON further stated loose, or unsecured handrails could present a safety risk if residents attempted to use them to prevent a fall. Additionally, The DON stated the facility did not have a formal process in place to ensure completion of maintenance work orders. She stated staff was expected to continue monitoring for unresolved issues and notify her if repairs had not been completed, at which time she would follow up with the maintenance department.In an interview, on 03/26/2026 at 5:25 PM, the Administrator stated it was her expectation the facility be maintained in good repair, including routine painting of hallways at least monthly. She stated the facility did not have a formal system to track and ensure completion of maintenance work orders. However, she stated staff was expected to report unresolved maintenance issues, and she would follow up with the maintenance department if concerns were brought to her attention. The Administrator stated she was aware of the unsecure handrails in the kitchen but was not aware if the maintenance department had ever done any repairs to ensure resident safety.