STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Bowling Green	550 High Street Bowling Green, KY 42101

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview, record review, and review of facility policy, the facility failed to ensure confidentiality of medical records for one (Resident (R) 83) of 11 residents sampled during medication pass. Facility staff failed to ensure that R83's medical information was secured when unattended, so as to prevent unauthorized access to the record. The findings include:Review of a facility policy, titled Resident Rights, last revised 01/31/2025, revealed residents have the right to privacy and confidentiality. Further review of the policy revealed the unauthorized release, access, or disclosure of resident information is prohibited.Review of a Face Sheet revealed the facility admitted R83 on 07/16/2020 with diagnoses including chronic obstructive pulmonary disease, anxiety disorder, and depression.Observation of medication pass, on 09/02/2025 at 7:20 PM with Certified Nurse Aide (CNA)1, revealed the computer screen on the medication cart was left open, displaying R83's medical information, while CNA1 was in a resident room and the medication cart and computer was unattended. During the time that the resident's medical information was visible on the unattended computer, at least two persons were noted walking in the hall.In an interview with CNA1 on 09/02/2025 at 7:35 PM, she stated she normally closes the computer fully when it is unattended. CNA1 added that leaving the computer open was inappropriate, because anyone walking by could read the information displayed on it.In an interview with the Administrator on 09/05/2025 at 3:30 PM, she stated her expectation was that all nurses and medication technicians would close the computer when stepping away from the medication cart so as to protect residents' privacy (confidentiality of personal information).

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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(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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for two (R68 and R83) of eight residents reviewed for infection control. Staff failed to use personal protective equipment (PPE) for R68, who was on contact precautions. In addition, staff failed to perform hand hygiene when indicated, including before and after resident contact/care for R83. The findings include: 1. Review of a facility policy titled, Infection Control, revised 01/31/2025, revealed the facility intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Review of a facility policy titled, Transmission Based Precautions (TBP), revised 01/31/2025, revealed TBP were initiated when a resident developed signs and symptoms of a transmissible infection or had a laboratory confirmed infections; and was at risk of transmitting the infection to other residents. Per the policy, TBP were used only when the spread of infection could not be reasonably prevented by less restrictive measures. Further review of the policy revealed that it did not specify the specific PPE that was to be used for residents who were on Contact Precautions (measures intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment). Review of a Face Sheet revealed the facility admitted R68 on 08/09/2025 with diagnoses including chronic kidney disease (CKD), pyuria, and klebsiella pneumoniae/ ESBL (extended-spectrum beta-lactamase, a bacteria found in urine). Review of a urine culture laboratory result, dated 08/31/2025, revealed the organism klebsiella pneumoniae/ ESBL was found in R68's urine. Review of a physician order, dated 09/02/2025, revealed R68 was placed into contact precautions, related to the ESBL in her urine. Review of R68's Comprehensive Care Plan for a problem of Infection Control, created 09/02/2025, revealed the resident was placed on contact precautions related to ESBL in her urine. Per the care plan, interventions included the use of PPE as indicated. Observation on 09/03/2025 at 11:09 AM revealed a PPE Contact Precautions sign posted on R68's door, which stated that a gown and gloves were to be donned prior to entering the resident room. A PPE cart was present in the hallway with PPE available for use. Further observation at this time revealed the admission Director, who was inside R68's room, was not wearing any PPE. During this observation, the admission Director was observed to give R68 a beverage and adjust the resident's pillow. Interview with the Admissions Director (AD) on 09/03/2025 at 11:23 AM, revealed she had stepped in R68's room to check on the resident. The AD stated she did not provide any direct care, and therefore, did not think the PPE was necessary. Further interview with the AD revealed she should have put on a gown and gloves prior to entering R68's room, The AD noted that it was important to wear the required PPE so that staff did not bring something (i.e. infection/communicable disease) out to other (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. During an interview with the Infection Prevention (IP) nurse on 09/04/2025 at 3:45 PM, she stated staff was educated on the importance of wearing the proper PPE when a resident was placed in isolation. She stated she thought the AD was confused, as she was not providing direct care to R68. The IP stated that she expected staff to pause and take into consideration why the resident was on precautions to begin with; however, sometimes staff lacked understanding. Further interview with the IP revealed that there could always be a negative outcome to other residents or staff such as the spread of something (infection/communicable disease) to other residents. During an interview with the Director of Nursing (DON) on 09/05/2025 at 3:00 PM, she stated she expected everyone to wear the proper PPE. She stated you could potentially spread whatever was going on with the resident to other residents. She stated management did try to communicate well through team chats as to why the residents were in isolation. She stated she tried to be up front with her staff, especially direct care staff on her expectations, why the resident was in isolation, and what a worst-case scenario could be. During an interview with the Administrator on 09/05/2025 at 3:19 PM, she stated she expected that, when a staff observed an isolation sign outside a resident's room, they would wear the appropriate PPE. 2. Review of a facility policy, titled Infection Control. last revised 01/31/2025, revealed all personnel will be trained on the infection control policies and practices upon hire and periodically thereafter. Review of a facility policy, titled Medication Administration General Guidelines, dated 09/2018, revealed hands are to be washed with soap and water after administration and with any resident contact. Per the policy, antimicrobial sanitizer may be used in place of soap and water Observation of medication pass on 09/02/2025 at 7:20 PM revealed Certified Nurse Aide (CNA) 1 exited room [ROOM NUMBER] without performing hand hygiene after passing medication to a resident. CNA1 next proceeded to the medication cart in the hallway, where she prepared R83's medication. CNA1 then entered R83's room, administered medications, and exited R83's room. CNA1 failed to perform hand hygiene at any time during this observation of R83's medication pass. After exiting R83's room, CNA1 then entered another resident's room to wash her hands. In an interview with CNA1 on 09/02/2025 at 7:35 PM, she confirmed that she did not perform hand hygiene prior to preparing and/or administering R83's medications. She added that she did not immediately perform hand hygiene after leaving R83's room because it was easier to wash her hands in the next room since those residents were asleep, and it was close to where she left the med cart. She stated she saw no problem with exiting one resident's room and then entering another resident room without washing or sanitizing her hands. In an interview with the DON on 09/05/2025 at 3:00 PM, she stated hand hygiene is extremely important and should be performed between each resident. She stated you could potentially spread whatever was going on with one resident (i.e. communicable disease/infection) to other residents. The DON added that she tried to be up front with her staff, especially direct care staff on her expectations, as well as what a worst-case scenario could be. In an interview with the Administrator on 09/05/2025 at 3:30 PM, she stated hand hygiene should be completed any time you leave a room and after any interaction with a resident.