

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare at Hillcrest		STREET ADDRESS, CITY, STATE, ZIP CODE 3740 Old Hartford Road Owensboro, KY 42303	

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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>52040</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure residents and/or their representatives right to be informed of and participate in treatment.</p> <p>The facility failed to ensure consent for physical contact was obtained for two residents, Resident (R)203 and R209. R203's representative stated she had not been involved in the care planning for the resident. Record review revealed no documented evidence for physical contact consent between R203 and R209 located in the Electronic Medical Record (EMR) for R203.</p> <p>The findings include:</p> <p>Review of the facility policy, Resident Rights, reviewed 01/31/2025, revealed all residents had the right to be treated with respect and dignity, and those rights were to be promoted by the facility. Continued policy review revealed federal and state laws guaranteed certain basic rights to all residents of the facility. Further review revealed those rights included a resident's right to participate in decisions and care planning.</p> <p>1. Review of the face sheet for R203 revealed the facility admitted the resident on 07/07/2023, and discharged the resident on 11/01/2024. Per EMR review, R203's diagnoses included unspecified dementia, anxiety disorder, and Alzheimer's Disease.</p> <p>Review of the Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 10/02/2024, revealed the facility assessed R203 to have a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated severe cognitive impairment.</p> <p>2. Review of the face sheet for R209 revealed the facility admitted the resident on 01/04/2024, and discharged the resident on 09/20/2024. Continued EMR review revealed R209 had diagnoses that included unspecified dementia with other behavioral disturbance, unspecified psychosis, and anxiety disorder.</p> <p>Review of the MDS Assessment, with an ARD of 09/17/2024, revealed the facility assessed R209 to have a BIMS score of eight out of 15, indicating moderate cognitive impairment.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R209's EMR revealed a Progress Note dated 01/24/2024, which documented the resident having shadowing/fixation behavior. Continued review of the 01/24/2024 Progress Note revealed the Medical Director had been notified of R209's new behavior of shadowing other residents. Per review, the doctor had increased R209's Risperdal (an antipsychotic medication) to 1 milligram (mg) twice a day (BID). Further review of the 01/24/2024 Progress Note revealed MR after speaking with R209's daughter, the daughter stated resident had been known to have that behavior. In addition, review of the Progress Note revealed R209's daughter stated the resident previously targeted a family member she was close to and followed them around and had to be by their side at all times. Review of the Progress Note further revealed the daughter stated her son used to have a lock on his room because of this shadowing behavior by her mother.</p> <p>Review of the Progress Note for R209 dated 01/25/2024, documented by the Director of Nursing (DON), revealed the interdisciplinary team (IDT) reviewed a recent change of condition in the resident. Per review; the change in condition was related to R209 having shadowing behaviors towards other resident which per R209's family were normal behaviors for the resident.</p> <p>Review of the Progress Note for R209 dated 08/24/2024, documented by Licensed Practical Nurse (LPN) 7 revealed during rounds the nurse had to continuously get R209 out of the bed with R203. Continued review of the Note revealed R209 had also been told she could not stand over her (R203) while she was sleeping and stare at her. Further review revealed the LPN would be reporting to management the information regarding R209's increasing non compliance of this issue.</p> <p>Review of the Progress Note for R209 dated 08/26/2024, documented by LPN 8 revealed at the start of her shift while she had been performing medication (med) pass R209 had been standing over roommate (R203). Continued review revealed the Note's writer documented Was informed by a State Registered Nursing Assistant (SRNA) that R209 kept trying to get in bed with roommate the prior night. Further review revealed When I went to check back in on resident (R209) the resident was in bed with roommate, and got back in R203's bed three more times. In addition, review revealed R209 was taken to the dining area so roommate could sleep tonight. Review further revealed after R209 seemed to have calmed down, staff tried to let the resident lie on her own bed; however, she got back in roommate's bed and identified the roommate as her wife.</p> <p>Review of the Progress Note for R209 dated 08/27/2024, documented by LPN 9 revealed R209 continued obsessive and repetitive behavior towards roommate through shift. Further review of the Note revealed R209 followed roommate continuously, touching and grabbing roommate repetitively.</p> <p>Review of Progress Note for R209 dated 08/27/2024, documented by LPN 4 revealed the resident was found lying on her roommates bed during bed check. Continued review of the Note revealed R209 was checked and changed and the resident then proceeded to try and climb in roommate's bed again. Further review revealed R209 kept trying to go back down to room to climb in bed with roommate; hard to redirect.</p> <p>Further review of R203's EMR for the timeframe of 08/24/2024 to 08/27/2024, reveal no documentation noting the events described in R209's EMR. In addition, review of R203's EMR revealed no documented evidence of notification to the resident's representative related to the physical contact noted in R209's EMR, nor of documentation of consent by R203's representative for physical contact with R209.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's, Summary of Investigation for Description of Occurrence revealed on 08/24/2024, staff found (R209) in bed with her roommate (R203) with both fully clothed. Continued review revealed neither resident was upset and they were separated. Further review revealed the facility's findings noted, Investigation revealed no sexual aggressiveness, rather it revealed companionship. Additionally, review revealed the facility's investigation determined it was unsubstantiated.</p> <p>In interview with the Director of Nursing (DON) and facility's Corporate Representative on 04/18/2025 at 10:20 AM, they stated there was no policy regarding residents who wanted physical contact (to share bed) or a form to sign related to. They said if a resident was unable to give consent then their representative was to be contacted and it would be documented in either the progress notes or under a care conference. They reported if residents were to be found in the same bed, with no sexual contact just in bed together, the family should be notified. They further stated it was not acceptable for the facility to make the decision that it was comforting for the residents, without the family/resident representative consent.</p> <p>In interview with R203's daughter/representative on 04/18/2025 at 11:09 AM, she stated she was notified by a nurse aide that her mother's roommate had been getting in bed with her (R203). She reported she was her mother's (R203's) Power of Attorney (POA) and said she was never notified by the facility, that R209 was getting in bed with her mother. She said she would never give consent for bed sharing. She further stated she believed it should have been her decision, as POA, not the facility's to decide if it was comforting to her mother to have R209 in bed with her.</p> <p>In interview with State Registered Nursing Aide (SRNA) 21 on 04/18/2025 at 12:40 PM, she stated she did not remember R203 and R209. The Aide stated however, one morning she came in and heard R203 yelling get off me and witnessed R209 lying on top of her (R203). She said she got R209 back into her own bed and reported the incident to the unit manager. She further stated that was the only time she had witnessed that type of event.</p> <p>In interview with the Administrator on 04/18/2025 at 12:50 PM, he stated he remembered both R203 and R209, who had both resided on the facility's dementia unit. He said he recalled R209 getting focused on people. The Administrator reported he did remember one time when R209 got in bed with R203; however, did not recall if R203's family was notified and did not recall it being called comfort measures. He further stated a resident's family should always be notified of anything like that.</p>		