STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of McCreary County Rehab And	58 Cal Hill Spur Pine Knot, KY 42635

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review and facility policy, the facility failed to ensure its staff implemented and provided care in accordance with the resident's written care plan interventions for 1 of 26 sampled residents (Resident (R47). R47 sustained a tibial (bone in the lower leg) fracture.The findings include:Review of the facility's policy titled, Comprehensive Care Plan last reviewed 01/31/2026, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident. Per review that care plan was to include measurable objective and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. Continued policy review revealed the Licensed Nurses and/or Interdisciplinary Team (IDT) developed and maintained a comprehensive care plan for each resident that identified the highest level of functioning the resident might be expected to attain. Each resident's Comprehensive Care plan was designed to: incorporate identified problem areas and incorporate risk factors associated with identified problems. The care plan was to be revised as necessary with changes. Review of R47's Face Sheet revealed the facility admitted the resident on 07/30/2024, with diagnoses that included hemiparesis and hemiplegia following a right dominant side cerebral infarct (stroke). Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/05/2025, revealed the facility assessed R47 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15. This score indicated the resident was moderately cognitively impaired. Review of the facility's Comprehensive Care Plan (CCP) for R47 dated 07/30/2024, revealed a problem area was developed and initiated 08/05/2024, for self-care deficit related to impaired physical functioning and medical conditions. Per review, the goal was for R47 not to experience any adverse outcomes related to her need for assistance with activities of daily living (ADLs). Further review of the CCP revealed the facility noted R47 required assistance of two staff for all transfers. Additional review revealed the CCP was updated 10/25/2025 for use of a mechanical lift for R47's transfers (after R47's fall and subsequent tibial fracture). Review of the Nurse Progress Notes for R47 revealed on 10/17/2025 at 1:44 PM, R47 had bruising on the right leg which was painful when touched, and had slight redness to the right inner ankle, which was warm to the touch. Continued review of the Nurse Progress Notes revealed on 10/18/2025 at 3:36 PM, R47 refused to shower due to the pain in her right leg. Review of the Nurse Progress Notes dated 10/21/2025 at 6:31 PM, documented by Licensed Practical Nurse (LPN) 1, revealed R47 was observed to have bruising to her right lower leg and pain with any movement. The Nurse Practitioner (NP) was notified with a new order received to obtain x-rays of the resident's leg, ankle, and foot. Further review of the Nurse Progress Notes revealed on 10/22/2025 at 12:00 AM, the x-rays were performed at 9:30 AM, and the results dated 10/22/2025, noted the resident had an acute right distal tibia fracture. Review of the Interdisciplinary Team (IDT) Note dated 10/22/2025 at 12:21 PM revealed the Social Services Director (SSD), Assistant Director of Nursing (ADON), Director of Nursing (DON), and Administrator held a meeting to discuss R47's x-ray results and reviewed the resident's care plan. Per review of the IDT Note, R47 was lowered to the floor by a CNA (Certified Nurse Assistant) after her legs gave way on 10/14/2025. R47 had no complaints at that time. Continued (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of McCreary County Rehab And	58 Cal Hill Spur Pine Knot, KY 42635

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 0656 Level of Harm - Actual harm Residents Affected - Few	review of the Note revealed the NP was notified and ordered x-rays which were obtained and determined R47 had an acute appearing distal tibia fracture. Further review revealed the NP ordered an opioid pain medication, pain monitoring every shift and prn (as necessary), a boot for R47's RLE (right lower extremity), and to make a referral for the resident with an orthopedic physician. Additional review revealed R47's care plan was reviewed and an intervention added for the resident to be transferred with a mechanical lift. Review of CNA 8's employee file revealed the facility's documentation included a Violation of Conduct and Behavior Policy, which noted the CNA was educated to immediately notify the floor nurse of any falls, and even if the resident was assisted to the floor, was also considered a fall. CNA 8 was also educated to follow the residents' care profiles for ADL's before transferring any residents. In interview on 05/12/2026 at 2:03 PM, CNA 8 stated she was aware she was to look at the residents' care plans for their transfer information. She stated she had looked at R47's care plan previously; however, she did not recall specifically what the resident's care plan directed staff to do for transfers at the time of the incident on 10/14/2025. CNA 8 stated that on 10/14/2025, she had been transferring R47 from had wheelchair to her bed, and as she helped the resident into a standing position her legs (R47's) gave out. She explained she assisted R47 to the floor first, then picked the resident lifting her onto her bed. The CNA stated R47 had not complained of pain at the time. CNA 8 stated she had not reported the incident to anyone as she thought since she assisted R47 to the floor, it was not considered a fall. She stated she had transferred R47 numerous times by herself without any difficulty. CNA 8 further stated, after the incident, she had been off until the following week and upon returning to work became aware that R47 was having difficulty with her RLE. She stated (after learning that information) she informed LPN 1 of the incident on 10/14/2025 involving R47. During interview with CNA 10, she stated she had been called to R47's room by CNA 8 to assist her with getting the resident off the floor into the bed. She stated they used the Hoyer lift (brand of mechanical lift) to get R47 up off the floor and onto the bed. CNA 10 stated after she assisted CNA 8 with getting R47 on the bed, she reported the incident/fall to LPN 1. She stated she had cared for R47 prior and per R47's care plan the resident was a two person assist for transfers. CNA 10 further stated she would look at care plan for information on a resident's care needs prior to providing care. In interview on 05/13/2026 at 9:44 AM, LPN 1, who was on duty on 10/14/2025, stated she was not made aware of the incident involving R47 until the following week. She stated she was not sure of what type of transfer assistance R47 needed at the time of the incident, as she did not go into residents' rooms when CNAs were providing their care. LPN 1 stated she recalled initially when R47 had the redness, bruising and swelling of her right foot, the NP had been notified, and they thought the resident might have had a blood clot or cellulitis in her RLE. She stated when CNA 8 notified her of the incident involving R47 on 10/21/2025, she immediately informed the ADON and the DON. In interview on 05/13/2026 at 10:15 AM, the prior DON stated as soon as she was notified by LPN 1, of the incident involving R47, she informed the LPN to do vital signs and perform a skin assessment. She stated an investigation was also initiated. In interview on 05/13/2026 at 10:22 AM, the prior ADON, stated as soon as the DON made her aware of the incident involving R47, they immediately initiated an investigation. She stated the Administrator was also notified and the IDT met. The prior ADON stated R47's care plan at the time of the fall was for a two person assist with transfers. She further stated that when the IDT met after the fall R47's care plan was updated for usage of a mechanical lift with all transfers for R47. The prior ADON stated all staff were educated to follow the care plan interventions as required, as well as what was considered a fall, and reporting all falls. In interview on 05/14/2026 at 3:27 PM, the current DON stated she started on 03/24/2026. She stated she had been updated the past couple of days on the incident involving R47. The DON stated when a fall occurred, her expectation was for staff to assess for injuries, ensure resident safety, report to supervisors, and contact the physician. She stated staff were then to document the fall (to include care plan interventions, progress notes, and event note). The current DON explained a nurse would open the event in the resident's electronic medical record (EMR) and neuro checks would be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of McCreary County Rehab And	58 Cal Hill Spur Pine Knot, KY 42635

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 0656 Level of Harm - Actual harm Residents Affected - Few	triggered in the event which included pain, interventions, etc. She stated nursing staff should update the resident's care plan after a fall, then the IDT and she (DON) would check the event reports the next morning and go over each fall to review the fall as a team. The current DON stated they checked the resident's care plan and made sure the care plan had been updated. She stated falls were gone over in orientation, such as what was a fall, which included if a resident was assisted to the floor and how to report falls. The DON further stated she expected the resident's care plan to be updated immediately as soon as feasible after a change in condition (such as a fall) or decline. At the time of the incident R47 had been care planned for two person assist with transfers, however CNA8 transferred R47 from her wheelchair to the bed without assistance of another staff member.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of McCreary County Rehab And	58 Cal Hill Spur Pine Knot, KY 42635

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review and facility policy review, the facility failed to ensure its staff provided adequate supervision and assistance to prevent injury for 1 of 26 sampled residents (Resident (R47), which resulted in the resident sustaining a fracture. The findings include: Review of the facility's policy titled, Accidents and Incidents last reviewed 01/31/2026, revealed the intent was to ensure the facility provided an environment that was as free from accidents and incidents that were avoidable, the facility investigates these occurrences with applicable documentation and appropriate reporting, as applicable. Review of the facility's policy titled, Notification of Change of Condition last reviewed 01/31/2026, revealed the policy was to ensure appropriate individuals were notified of changes in condition. Additional review revealed the medical provider would provide guidance related to the change in condition. Review of R47's Face Sheet revealed the facility admitted her on 07/30/2024, with diagnoses of hemiplegia and hemiparesis following a cerebral infarct (stroke) of the right dominant side. Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/05/2025, revealed the facility assessed R47 as having a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating moderate cognitive impairment. Review of the Comprehensive Care Plan (CCP) for R47 revealed the facility identified a problem area initiated 08/05/2024, for the resident related to self-care deficit regarding impaired physical functioning and medical conditions. Per review, the CCP goal was for R47 to not experience any adverse outcomes related to requiring assistance with activities of daily living (ADLs). Further review of the CCP revealed the facility care planned R47 as requiring assistance of two staff for all transfers. Review of R47's Nurse Progress Note dated 10/21/2025 at 6:31 PM, documented by LPN 1, revealed R47 had bruising to her right lower leg and pain with movement. Per continued review of the 10/21/2025 Note, the nurse had made NP 1 aware, and a new order was received to obtain an x-ray of the foot, ankle, and leg. Review of R47's Nurse Progress Note dated 10/22/2025 at 12:00 AM, revealed the outside contracted radiology performed the ordered x-rays at 9:30 AM. Continued review of R47's medical record revealed the x-ray report results dated 10/22/2025, noted the resident had a right distal acute tibia fracture (lower leg fracture). Further review revealed the results had been relayed to the Physician and NP, a new order for Norco (an opioid pain medication) 7.5/325 milligrams (mg) every six hours was received. Review further revealed the NP was in the facility at the time, and ordered a walking boot/splint to R47's RLE (right lower extremity/leg) for six weeks; for the resident to be non-weight bearing for six weeks, and for a referral to be placed to orthopedics. Additional review revealed R47 was seen by an outside orthopedic physician on 10/23/2026. Review of the Interdisciplinary Team (IDT) Note dated 10/22/2025 at 12:21 PM, revealed the Administrator (ADM), Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Social Services Director (SSD) had met to discuss R47's x-ray results. Per review, R47 had been previously noted to have been lowered to the floor by Certified Nursing Assistant (CNA) after the resident's legs gave way on 10/14/2025. Review of the IDT Note revealed R47 had no complaints at that time, and a few days later the resident presented with redness and right lower leg. Continued review of the Note revealed the NP ordered a doppler, Tylenol, and antibiotics for possible cellulitis, as R47 previously had a fever and was tested for covid, flu, respiratory syncytial virus (RSV) and a urinalysis (UA) was performed, which all resulted in being negative. Further review revealed after the doppler resulted as negative, R47 had been noted with some bruising where it once had been red, and the NP ordered x-rays at that time. Review of the Note revealed the NP also ordered for R47 to remain non-weightbearing during that time. The x-rays results noted an acute appearing distal tibia fracture. According to the Note, R47 had been receiving Tylenol 650 mg every four prn (as necessary) with good results noted. Review revealed R47 was to continue having pain monitoring every shift and prn, a new order for a boot to her right lower extremity (RLE) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of McCreary County Rehab And	58 Cal Hill Spur Pine Knot, KY 42635

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 0689 Level of Harm - Actual harm Residents Affected - Few	and Hydrocodone/Aspirin (an opioid pain medication) 7.5/325 mg every six hours as needed for pain. Further review revealed R47 had been seen on 10/23/2025, by the orthopedic physician, with the orders continued for the boot, to remain non-weight bearing for six weeks, and to repeat the x-ray in one month. Review further revealed R47 continued wearing a boot to her RLE as of 05/14/2026. Additional review revealed no documentation of a root cause identified for R47's fall. During interview on 05/12/2026 at 2:03 PM, Certified Nurse Assistant (CNA) 8 stated on 10/14/2025, she had been transferring R47 from the wheelchair to the bed, and when she assisted the resident to a standing position her (R47's) legs gave out. CNA 8 stated she used her knee behind R47 and assisted the resident to the floor. She stated she then picked R47 up by the back of her pants and under her legs and lifted her up on to the bed. CNA 8 explained R47 had not complained of pain at that time. She stated she did not report the fall to anyone as she thought since she assisted the to the floor it was not considered a fall. CNA 8 stated she had transferred R47 numerous times by herself without difficulty. She stated she was aware of needing to look at residents' care plans for their transfer information. The CNA stated she had looked at R47's care plan and did not recall specifically what the care plan directed for the resident's transfers at that time (October 2025). She stated she was off until the following week and became aware of R47 having difficulty with her right lower extremity upon return to work. CNA 8 further stated she then informed LPN 1 of the incident on 10/14/2025, of her transfer of R47. However, review of R47s care plan revealed at the time of the fall she had been care planned for two person assist with all transfers. In interview on 05/13/2026 at 10:51 AM, CNA 10 stated she was called to R47's room (on 10/14/2025) by CNA 8 to assist with getting the resident back to bed. She stated when she arrived at R47's room, the resident was on the floor, with her back against the bed. CNA 10 stated they used the Hoyer lift (brand of mechanical lift) to get R47 back to bed and then reported the incident/fall to LPN 1. However, LPN 1 was adamant that it was not reported to her. During interview on 05/13/2026 at 9:44 AM, Licensed Practical Nurse (LPN) 1, who had been on duty on 10/14/2025, stated she had not been made aware of the incident with R47 until the following week. She stated she was unsure of the type of transfer assist R47 required at the time of the incident. LPN1 stated she recalled initially when the redness, bruising and swelling of R47's foot was noted. She stated NP 1 was made aware, and they thought R47 might have had a blood clot or cellulitis in the right lower extremity. The LPN stated when she made her aware of the incident on 10/21/2025, she immediately informed the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). During interview on 05/13/2026 at 10:15 AM, the prior DON stated as soon as she was made aware of the incident involving R47 by LPN 1, she informed the LPN to do a skin assessment. She additionally stated she told LPN 1 to obtain R47's vital signs and an investigation was initiated. During interview on 05/13/2026 at 10:22 AM. the former ADON stated as soon as she was made aware of the incident involving R47 by the DON, they immediately initiated an investigation. She further stated the IDT met, and the Administrator was made aware. During interview with NP 1 on 05/13/2026 at 3:38 PM, she stated R47 had not been able to stand for a long time due to weakness. NP 1 stated R47 had osteoporosis, but she was not aware of how long the resident had that diagnosis. In interview on 05/14/2026 at 3:27 PM, the current DON stated she started working as DON on 03/24/2026. She stated in the past couple of days she had been updated on the incident involving R47. The current DON explained when a fall occurred, her expectation was for staff to assess the resident for injuries, ensure the resident's safety, report to supervisors, and contact the physician. She stated her expectations included for staff to then document the fall (to include care plan interventions, progress notes, and event note). The current DON stated the nurse would open the event note in the resident's electronic medical record (EMR). which included pain, interventions, etc. She stated nursing should update the resident's care plan, then the IDT and she would check the event reports the next morning. The current DON stated that she and the IDT would go over each resident, reviewing the fall as a team, and checking the care plan to ensure it had been updated. She stated if a fall happened on the weekend, the on-call manager was to be contacted, and the ADON and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185211	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of McCreary County Rehab And	58 Cal Hill Spur Pine Knot, KY 42635

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 0689 Level of Harm - Actual harm Residents Affected - Few	DON checked on the weekend. The current DON stated if a fall occurred on a weekend a supervisor came in and verified the implementation of care plan updates were in place, on weekdays the IDT checked for the interventions. She stated in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings they went over topics such as falls, wounds, infections, etc. tracking systems-looking for patterns and things specific to a resident, such as the certain time of day. The current DON further stated falls were discussed in the employees' orientation, such as, what a fall was, which included assisting a resident to the floor, how to report a fall, and implementation of interventions. She additionally stated she expected the resident's care plan to be updated immediately as soon as feasible after a change in condition (including a fall) or decline in condition.