STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185277	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Heritage Hall Rehab & Well	331 South Main Street Lawrenceburg, KY 40342

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 1 out of 23 sampled residents, Resident (R) 81.Record review of R81's Baseline Care Plan did not address R81's primary language of Tagalog.The findings include:Review of the facility's policy titled, Baseline Care Plan, dated 09/23/2022 and last reviewed on 01/31/2025, revealed, A Baseline Care Plan will be developed and implemented to promote continuity of care and communication among facility stakeholders to increase resident safety and safeguard against adverse events that are most likely to occur right after admission.Review of R81 Face Sheet revealed the facility admitted R81 on 06/30/2025 with a diagnosis of a right femur fracture.Review of R81's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of date 07/03/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight out of 15, indicating R81 was moderately cognitive impaired. Review of R81's Provider's History and Physical, dated 05/13/2025, revealed the family history was unobtainable due to language barrier.Review of R81's 48-hour Baseline Care Plan, with a completed date of 06/30/2025, revealed R81's communication was understood. Review of R81's Nurse Progress Note, dated 06/30/2025, revealed Daughter at bedside to translate.Review of R81's Provider Progress Note, dated 07/01/2025, revealed family was being used as an interpreter to communicate with provider. During an interview on 07/30/2025 at 1:20 PM with State Registered Nurse Aide (SRNA) 9 and SRNA11, they stated they were made aware of residents with language barriers by report, their computer system, and the nurse. During an interview on 07/30/2025 at 1:25 PM with Registered Nurse (RN) 5, she stated the admitting nurse was responsible for completing the baseline care plan upon admission. She stated the baseline care plan should address language barriers that were present on admission.During an interview on 07/30/2025 at 1:30 PM with Licensed Practical Nurse (LPN) 5, she stated the admitting nurse was responsible for completing the baseline care plan upon admission. She stated the Minimum Data Set (MDS) Nurse was responsible to complete the comprehensive care plan. She stated she was the nurse who admitted R81, and he was able to understand some words. Therefore, she stated she marked R81 as able to communicate.During an interview on 07/31/2025 at 11:00 AM with the Director of Nursing/Infection Prevention Nurse (DON/IP), she stated the baseline care plan was completed by the admitting nurse. During an interview on 07/31/2025 at 1:27 PM with the Administrator, she stated it was her expectation that baseline care plans were completed upon admission so staff could communicate with residents.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was not 5 percent or greater. Observation of medication administration on 07/31/2025 at 8:00 AM, revealed 2 medication errors out of 33 medication observations to result in a 6.06 percent medication error rate.The findings include:Review of the facility's policy titled, Medication Administration, dated 01/2025, revealed, Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the label. The policy also stated, Verify medication is correct three times before administering the medication. When pulling medication package from the med cart, when dose is prepared, and before dose is administered.Review of R16's Face Sheet revealed the facility admitted the resident on 07/10/2025 with a diagnosis of cellulitis of the left lower leg.Review of R16's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/17/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 10 out of 15, indicating R16 was moderately cognitively impaired.Review of R16's Physician's Orders, dated 07/15/2025, revealed an order for metformin (given to reduce blood sugar) 1000 milligrams (mg) to be given twice a day and an order for metoprolol (given to lower blood pressure) 25 mg once a day.Observation on 07/31/2025 at 8:00 AM revealed Registered Nurse (RN) 4 prepared Resident (R) 16's medications, which included only one metformin 500 mg tablet. Further observation revealed RN4 dropped R16's metoprolol tablet, causing it to break. RN4 then gathered up the pieces to administer to R16, leaving approximately 0.25-0.5 part of the tablet on her medication cart. An unknown amount was administered to R16.During an interview on 07/31/2025 at 11:00 AM with the Director of Nursing/Infection Prevention Nurse (DON/IP), she stated it was her expectation that the facility did not have any medication errors, and if they did, they were identified and addressed appropriately.During an interview on 07/31/2025 at 1:27 PM with the Administrator, she stated it was her expectation that when medication errors occurred, they were identified and addressed for patient safety.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review and review of the facility's policy, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents. Observation on 07/29/2025 at 6:22 AM revealed 2 of 2 medication carts located on the short-term rehab unit were unlocked and no staff was in the area. Additional observation on 07/31/2025 at 8:00 AM-8:18 AM, during medication administration on the short-term rehab unit, Registered Nurse (RN) 4 walked away from the medication cart that was left at the nurses' station to administer medication inside resident rooms on three different occasions without locking the medication cart.The findings include:Review of the facility's policy titled, Storage of Medication, dated 01/2025, revealed the medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Further review revealed only the above-mentioned persons had access to medication carts and medication rooms. Per the policy, cabinets and supplies should remain locked when not in use or attended by persons with authorized access. Observation on 07/29/2025 at 6:22 AM during performance of the initial facility walk-through on the Rehabilitation Unit, designated as Unit B and Unit C, revealed two medication carts were unattended, no staff were visible in the area, and both medication carts were unlocked. Further observation revealed the drawers were able to be opened, and medications were observed in drawers.In an interview with Licensed Practical Nurse (LPN) 1 on 07/29/2025 at 6:26 AM, she stated she was assigned to medication cart Peaceful and was aware the cart had been left unlocked and unattended on the unit. LPN1 stated staff became distracted when the State Survey Agency (SSA) Surveyors entered the facility, and she had forgotten to lock it. LPN1 stated the medication cart should have been secured before she walked away. She stated it was important to keep the medication cart locked at all times when unattended so that nobody could steal the drugs.During an interview on 07/29/2025 at 6:15 AM with RN1, she stated he usually kept her medication cart locked but had walked away from it for a second. She stated it should be locked when unsupervised to keep other people from getting into the medications. Observation on 07/31/2025 at 8:00 AM to 8:18 AM, during medication administration on the Rehabilitation Unit, Registered Nurse (RN) 4 walked away from the medication cart that was left at the nurses' station to administer medication inside resident rooms on three different occasions without locking the medication cart.During an interview on 07/31/2025 at 8:18 AM with RN4, she stated the medication cart should be locked when unattended.During an interview with the Director of Nursing (DON) on 07/31/2025 at 3:30 PM, she stated the expectation was that all medication carts be locked when not within visible sight of the nurse. In further interview, she stated it was important to keep medication carts locked to prevent drug diversion by staff, theft of medications by family, visitors and residents.During an interview on 07/31/2025 at 1:27 PM with the Administrator, she stated it was her expectation that medication carts were kept locked so the medications were secured and unauthorized persons could not access medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) signage for Enhanced Barrier Precautions (EBP), and review of the facility's policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four of nine residents investigated for infection control, Resident (R) 55, R16, R40, and R30.The findings include:Review of the facility's policy titled, Infection Control, dated 01/31/2025, revealed the objective of the facility's infection control policies and practices was to maintain a safe, sanitary, and comfortable environment for personnel, residents, and the public and to help prevent and manage transmission of diseases and infections.Review of the CDC's signage for Enhanced Barrier Precautions [EBP], undated, which the facility used, revealed providers and staff must wear gloves and gown for high-contact resident activities.Review of the facility's policies revealed the facility did not have individual polices for EBP or the safe cleaning and reprocessing of reusable resident-care equipment.1. Review of R55's Face Sheet revealed the facility admitted the resident on 07/13/2025 with diagnoses including Parkinson's disease and left side paralysis following a stroke. Review of R55's, Comprehensive Care Plan, revealed the resident required EBP related to an indwelling foley catheter.Review of R55's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 07/21/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of three out of 15, indicating the resident was severely cognitively impaired.Review of R55's, Physician Order Report, dated 04/09/2024 to 07/31/2025, revealed an active order in place for EBP.Observation on 07/29/2025 at 8:20 AM revealed the Minimum Data Set (MDS) Nurse entered R55's room which had an Enhanced Barrier Precaution (EBP) sign posted on the door. Further observation revealed the MDS Nurse repositioned the resident in bed without the proper Personal Protective Equipment (PPE). In an immediate interview, the MDS Nurse stated she pulled R55 up in the bed and should have used the appropriate PPE before she assisted the resident. She further stated it was important staff used proper PPE when care was provided to residents on EBP to help prevent the spread of infection. The MDS Nurse stated when staff failed to wear PPE, residents were placed at risk for infection.In an interview with State Registered Nurse Aide (SRNA) 5 on 07/30/2025 at 6:25 PM, she stated EBP were for residents with some type of opening such as catheter or feeding tube. She further stated Personal Protective Equipment (PPE) was required when staff provided care to a resident on EBP.In an interview with SRNA7 on 07/30/2025 6:42 PM, she stated if a resident was on precautions of any type, signage that showed what to wear was posted on the door. SRNA7 stated if a resident was on EBP staff were required to wear the PPE listed on the signage when they provided care. SRNA7 further stated if she just delivered trays or passed water, she was not required to wear PPE. In an interview with Licensed Practical Nurse (LPN) 3 on 07/30/2025 at 6:50 PM, she stated EBP was used for residents that had an opening where infection could be introduced. She further stated, residents with catheters, feeding tubes, and wounds were placed on EBP, and staff were required to wear PPE when they provided any type of direct care. In an interview with the Director of Nursing (DON)/Infection Preventionist (IP) on 07/31/2025 at 3:32 PM, she stated staff received annual infection control training as well as computer modules and frequent in-services throughout the year. The DON stated any resident on Transmission Based Precautions (TBP) or EBP had appropriate signage on their door to alert staff. She further stated it was her expectation that staff followed that signage, and if they were providing direct care to a resident on EBP, a gown and gloves should be worn. When asked if staff should have on PPE when they pulled a resident on EBP up in bed, the DON stated they should. The DON stated it was important staff followed guidelines for donning (putting on) PPE, so residents were protected from potential infection. During an interview with the Administrator on 07/31/2025 at 4:03 PM, she stated she expected staff to put on PPE for any resident on EBP if (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they provided care to that resident. She further stated if staff pulled a resident up in bed that was on EBP, they should have on the proper PPE. The Administrator stated it was important staff used PPE when they cared for residents on EBP because of the potential for infection.2. Review of R16's Face Sheet revealed the facility admitted the resident on 07/10/2025 with a diagnosis of cellulitis of the left lower leg.Review of R40's Face Sheet revealed the facility admitted the resident on 07/19/2025 with a diagnosis of acute respiratory disease.Review of R30's Face Sheet, revealed the facility admitted the resident on 07/13/2025 with a diagnosis of a sacrum fracture.Observation on 07/31/2025 at 8:00 AM to 8:18 AM, during medication administration, revealed Registered Nurse (RN) 4 touched R16's, R40's, and R30's oral medications with her hands, without wearing gloves. Additional observation on 07/31/2025 at 8:00 AM, revealed RN4 dropped R16's metoprolol tablet (used to lower blood pressure) onto her medication cart, without a barrier in place, then picked up the pieces of the tablet and administered it to R16.Additional observation on 07/31/2025 at 8:10 AM, revealed RN4 used a blood pressure cuff on R16 then, accidentally dropped the blood pressure cuff into the trash can in R16's room. RN4 then retrieved the blood pressure cuff and used it on R40, without cleaning it. During an interview on 07/31/2025 at 8:18 AM with RN4, she stated that shared equipment should be cleaned with Clorox wipes between resident use, and she should have worn gloves to administer medication and used a barrier to prepare medications.During additional interview on 07/31/2025 at 11:00 AM with the DON/IP, she stated it was her expectation that infection control prevention be maintained to prevent infection from spreading.During additional interview on 07/31/2025 at 1:27 PM with the Administrator, she stated her expectation for staff was to do their best, not to touch resident medications with their ungloved hands, and if that happened, then the pill should be discarded and replaced for infection control.