STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185327	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Spencer County	625 Taylorsville Road Taylorsville, KY 40071

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policies and procedures, the facility failed to ensure an allegation of abuse was reported immediately, but no later than two hours after the allegation was made for two of four sampled residents (Residents (R) 3 and R4).On 3/30/2026 at 3:32 PM, staff found R4 in R3's bed and reported the incident immediately to the Director of Nursing (DON), who was in the facility at the time of the incident. However, the incident was not reported to the Office of Inspector General (OIG) until 04/03/2026, 4 days after the incident. Review of the facility's plan of correction (POC), the facility's education records, and interviews with staff determined the facility implemented their plan of correction as alleged prior to the initiation of this survey with compliance date of 04/03/2026.The findings include:Review of the facility's policy, Resident Rights, revised 01/31/2026, revealed, All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility.Review of the facility's policy, Abuse, Neglect, and Misappropriation of Property, revised 01/31/2026, revealed, The facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law. Further review of the policy revealed, All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than two (2) hours after the allegation is made. The policy stated, .all allegations and incidents of abuse, or neglect, as defined in this policy, will be reported ?immediately' as defined in this paragraph.Continued review of the facility's policy clearly stated the following guidelines for reporting: Any abuse allegation must be reported to State within 2 hours from the time the allegation was received.Review of the facility's investigation Initial Report, dated 03/30/2026, revealed the incident occurred on 03/30/2026 at approximately 3:32 PM and the Administrator was notified on 03/30/2026 at 3:55 PM. Continued review revealed the facility's investigation indicated the Kentucky Cabinet for Health and Family Services (DCBS), the Attorney General, and the Ombudsman were all notified on 03/30/2026; however, there were no times indicated for their notifications. The initial report also indicated neither of the residents' family members wanted to contact local law enforcement. Further review of the initial report revealed on 03/30/2026 at 3:32 PM, R4 and R3 were found by staff in R3's bed. Both residents were immediately separated and assessed by licensed nursing staff, which indicated no physical injuries, no signs of distress, no acute medical intervention was required, and no changes in baseline behavior were observed. The initial report also indicated both R3 and R4 were placed on one-to-one supervision, and an investigation was initiated. This document was signed by the Administrator.Review of the facility's investigation Five (5) Day Follow Up, dated 04/03/2026, revealed no concerns were identified after a comprehensive skin assessment had been completed on R3 and R4, there were no injuries noted, no adverse psychosocial symptoms or distress was noted after R3 and R4 were assessed for psychosocial impact, and both residents remained at baseline following the incident. The facility investigation indicated the incident as reported to DCBS and to the Office of Inspector General (OIG), but there was no date and time identified. The report further documented both residents were interviewed, but since both suffer severe cognitive impairment, they (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not provide a reliable account of the incident, but neither resident reported any distress or harm, nor did they display any signs and symptoms of distress or psychosocial harm. Review of the facility's investigation summary, dated 03/30/2026, provided at the time of the survey, revealed the facility immediately separated the residents, one-to-one supervision was implemented for both R3 and R4, all staff were re-educated on abuse and the required reporting of abuse, all residents with a BIMS score above 8 were interviewed with no indications of abuse, all residents with a BIMS score of 8 or below had a comprehensive skin assessment completed, with no indications of abuse, and all staff working the date of the incident were interviewed with witness statements taken. The facility's investigation included all the staff interviews, the resident interviews, the residents' skin assessments, and a list of all employees who signed the form confirming the abuse and reporting of abuse education they received immediately following the incident. Further review of the provided facility's investigation in the Witness Statement section, revealed CNA 1 stated that she called for the nurse when she saw two (2) residents in R3's bed. CNA 1 stated she was unsure exactly what was going on, but she got the nurse. Review of LPN 1's witness statement revealed she stated she was alerted by CNA 1 to come to R3's room, and when she went in, she saw R3 and R4 both in R3's bed. LPN 1 went on to state nothing appeared to be forced or coerced, and she alerted another nurse and the DON for assistance. Per continued review of the facility's investigation all staff who provided witness statements did not see anything happening between R3 and R4, nor did anyone notice any behaviors or changes in their mood leading up to the incident.Review of the facility's, Resident Face Sheet, for R4 revealed the facility admitted R4 on 03/07/2025 with the diagnoses including generalized muscle weakness, cognitive communication deficit, depression, and mild dementia. Review of R4's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed R4's with a Brief Interview for Mental Status (BIMS) exam score of seven, which indicated severe cognitive impairment. Review of the facility's, Resident Face Sheet, for R3 revealed the facility admitted R3 on 12/15/2025 with the diagnoses including mild cognitive impairment, aphasia, dysphagia, generalized muscle weakness, and cognitive communication deficit. Review of R3's Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed R3 with a Brief Interview for Mental Status (BIMS) score of one, which indicated severe cognitive impairment.Observation on 04/10/2026 at 1:13 PM revealed R3 sitting in his wheelchair outside his room, with Registered Nurse (RN) 1 who was his one-to-one supervision for that shift. Interview with R3 was attempted, but his statements were confused and not appropriate. Observation on 04/10/2026 at 1:26 PM revealed R4 sitting in her wheelchair in front of her television, with her one-to-one supervision sitting in the recliner beside her. Continued observation revealed R4 spoke to the staff person for approximately ten (10) minutes longer, but the conversation was nonsensical. An interview with CNA 1 was attempted on 04/10/2026 at 12:48 PM, with voice message left but there was no return call. An interview with LPN 1 on 04/10/2026 at 11:23 AM, on 03/30/2026 at 3:32 PM, revealed someone alerted her about R3 and R4. LPN1 stated she walked into the room and found R4 laying in R3's bed and she (LPN 1) stated she stuck her head outside R3's room and alerted the DON and asked for assistance. LPN 1 stated both residents have low BIMS scores, and both are terrible historians, and within a few minutes, neither resident was able to recall what happened, or they reported they could not remember. LPN 1 stated that neither R3 nor R4 have ever displayed any sexual acting out behaviors. She stated she reported the incident immediately to the DON. LPN 1 stated that R3 and R4 were both put on one-on-one supervision and currently are still under strict supervision.An interview with the DON on 04/10/2026 at 1:28 PM revealed she stated she was in her office on 03/30/2026 around 3:30 PM, and heard her name from one of the aides, and immediately ran out to R3's room. The DON stated she immediately notified her supervisor, the Clinical Care Consultant and the facility's Administrator, once the residents were separated. The DON stated she also notified the residents' family members as well as the physician, and new orders were implemented for one-on-one supervision for R3 and R4. When asked when notifications of this incident were required to be made, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON stated they should be made immediately, or at least within two (2) hours of when the allegation was received. The DON stated this is important because it could possibly hinder their investigation, they could possibly receive tags from OIG, and it could lead to disciplinary action, if notifications were not made to State within two (2) hours. The DON went on to state law enforcement would also need to be contacted in some cases.An interview with the Administrator on 04/10/2026 at 3:34 PM revealed he stated he was immediately notified by the DON about the incident via telephone. He stated the DON called the Clinical Care Consultant, but he and the Clinical Care Consultant were together at a sister facility, participating in a mock survey. He stated they immediately went to the facility and assessed the residents, which was approximately 30 minutes after they were notified. The Administrator stated nursing had already started their skin assessments, resident interviews, and staff interviews when he and the Clinica Care Consultant arrived at the facility. The Administrator stated he was unaware that the Clinical Care Consultant did not notify State of incident. He stated this incident should have been reported to State within two (2) hours of the allegation being made, and there could be major consequences when that is not completed within the two (2) hours. The Administrator stated that when he and the Clinical Care Consultant were completing the Five (5) Day Follow Up for their investigation, they discovered that no notification had been made to State at that time. He stated the Clinical Care Consultant made the notification at that time, on 04/03/2026. An interview with the Clinical Care Consultant on 04/10/2026 at 3:45 PM revealed she stated she and the Administrator were at a different facility working through a mock survey when they were notified by the DON of the allegation. She stated they immediately went to the facility and started the investigation, in which residents were assessed and appeared to be fine, no distress or concerns were noted. The Clinical Care Consultant stated as they were completing the Five (5) Day Follow Up for the investigation, she and the Administrator both realized that neither of them had made the required notification to State.