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	01/23/2026

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to develop a facility assessment that adequately addresses informed staffing decisions to ensure that there are sufficient number of staff with the appropriate competencies and skill sets necessary to care for its' residents needs as identified through residents assessments and plans of care. Interview on 01/23/2026 at 10:40 AM with CEO he stated the facility assessment had total number per week for nurses and nurse aides required depending on census, but did not address specific numbers required on a daily basis to determine residents care needs. Based on interview, review of facility policy, and review of the Signature Healthcare of [NAME] County Facility Assessment, it was determined the Facility Assessment failed to address all required components. The Facility Assessment failed to address the facility census in its determination of staffing needs. It also failed to consider specific staffing needs, including a breakdown of licensed nurses and nurse aides, for each resident unit in the facility and adjust as necessary based on changes to its resident population. Further, the Facility Assessment failed to consider specific staffing needs (including breakdown of licensed nurses and nurse aides) for each shift, such as day, evening, night, and adjust as necessary based on changes to its resident population for each resident in the facility. In addition, the facility failed to ensure that all required disciplines, including the Director of Nursing (DON) and direct care staff, were involved in the development of the Facility Assessment. The failure to complete a thorough Facility Assessment of staffing needs, which included all required components, had the potential to affect all residents of the facility.Findings include:Review of the facility's policy titled, Signature HealthCare of [NAME] County Facility Assessment, date assessment with Quality Assurance and Performance Improvement (QAPI) 04/15/2025, revealed the Facility Assessment was to utilize evidence-based, data-driven methods, determine what resources were necessary to care for the facility's residents competently during both day-to-day operations and emergencies. Continued review of the policy revealed the facility considers census, resident acuity, preferences, and staff competencies to determine the number and competency requirements of staff to meet each resident's needs for day, evening, and night shifts.Review of the Facility Assessment on 01/22/2026 at 1:57 PM revealed the number of licensed nurses providing direct care to be 23 (Average Full Time Equivalent [FTE]) per day for year-end [[NAME]] 2024. The number of nurse aides was determined to be 30 (Average FTE) per day [NAME] 2024. There was no documentation of the facility census used to determine staffing levels. The Facility Assessment did not outline licensed nurse and nurse aide levels for specific units, time of day, or considering weekends. No adjustments were outlined in the Facility Assessment to account for staffing needs for each resident, for each shift, and weekends to modify for the resident population.An interview on 01/23/2026 at 8:25 AM with the Staff Development Coordinator (SDC) revealed she was just learning about the Facility Assessment and how it impacted staffing for the facility. Further interview with the SDS revealed she had not participated in developing the current Facility Assessment.During an interview on 01/23/2026 at 10:20 AM with the Scheduler and Chief Executive Officer (CEO)/Administrator, the Scheduler stated she had only been (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

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the position for a couple of months and did not participate in the Facility Assessment. During the interview, the CEO/Administrator confirmed he did not have a scheduler participate in developing the Facility Assessment.Interview on 01/23/2026 at 10:40 AM with the CEO/ Administrator revealed that when the Facility Assessment is created, it is based on facility census and number of staff required for a week. He confirmed the number of licensed nurses providing direct care was determined to be 23 for a seven-day period, explaining that this was taking into consideration where each nurse worked three days a week on a 12-hour schedule. Per the Administrator, the nurse aides were determined to require 30 in a seven-day period, with each working three days a week on a 12 hour schedule. He stated, Signature Corporate managers and myself work to develop the Facility Assessment. The Director of Nursing [DON] and other management staff are not involved in developing the Facility Assessment. The CEO/Administrator stated, The breakdown of required licensed nurses and nurse aides are posted daily at the entrance to each unit. When the Facility Assessment is developed, we do not put the unit breakdowns in the Facility Assessment. The staffing numbers (hours per resident day [HPRD]) are not included in the Facility Assessment. The CEO/Administrator added, If someone came to review the Facility Assessment and did not have accurate staffing numbers and facility census, that would not provide a true representation of our staffing needs and resident requirements based on the daily census. The CEO/Administrator added, This is something I can address with corporate to assist in making the Facility Assessment more transparent in how the Facility Assessment addresses staffing needs.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to develop and implement a comprehensive care plan for each resident, which includes measurable objectives and time frames to meet a resident's medical nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. This includes revisions as necessary with changes to create a person-centered care plan for each resident for two (2) of 93 sampled residents. (sampled residents 8, and 74.Review of the care plan for Resident (R) 8 did not match the most current orders or needs of the residents. Observation on 01/21/2026 of the R8's room and property revealed R8's wheelchair was without an anti-tipping device, and there were no non-skid strips on the floor and the resident's bed had two (2) half rails used for mobility, the order was for the right side only.Review of the care plan for R74 revealed no history of PTSD nor specific triggers for adverse behaviors, although it was commonly known.Based on observation, interview, record review, and review of the facility's policy, the facility failed to revise the comprehensive care plan as necessary with changes to create a person-centered care plan for two (Resident (R) 8 and R74) of 20 sampled residents. R8's care plan was not revised to reflect current orders for one half rail used for mobility. R74's care plan was not revised when the facility became aware of a diagnosis of post-traumatic stress disorder (PTSD) and failed to address specific triggers for adverse behaviors which were known to the facility.Findings included:Review of the policy titled Comprehensive Care Plans (CCP), last revision dated 02/09/2024, revealed the comprehensive care plan will be revised as necessary with changes.1. Review of R8's Face Sheet revealed he was admitted on [DATE] with diagnoses that included mild dementia, arthritis of his right knee, and a history of falls. Review of R8's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/14/2025 revealed the resident was identified at risk for falls and care planned for this area.Review of R8's orders revealed an order created on 01/12/2026 for the resident's bed to be against the wall. In addition, an order for a mobility bar on the right side only of the resident's bed was also created on 01/12/2026.Review of R8's most recent Care Plan (CP), effective through 01/22/2026, revealed R8 had a risk of falls with multiple interventions listed. Review of the CP revealed that it did not indicate the use of mobility bars while in bed. The CP was not revised to reflect the 0/12/2026 order for a mobility bar only on the right side of the resident's bed.Observation on 01/20/2026 at 1:44 PM, during the initial observation of R8's room, revealed R8 was in his bed with half-sized rails on each side of his bed.During an interview on 01/22/2026 at 8:58 AM with Registered Nurse (RN) MDS1, she stated that the computer kept a historical record of all interventions. She confirmed the hard copy provided to the State Survey Agency (SSA) was the most recent and captured only current and active interventions. She added that all clinical staff had access to the care plan in some form.During an interview on 01/23/2026 at 10:21 AM with Licensed Practical Nurse (LPN) MDS2, she stated that she had worked in this role for less than two years. She participated in the quarterly and annual MDS reviews and knew that if a resident had a new order, a care plan update was necessary. During an interview on 01/23/2026 at 1:23 PM with RN MDS1, she stated that she was involved in an interdisciplinary team (IDT) meeting every morning, which included department heads from each discipline. They discussed concerns, and if new orders had been obtained, a nurse would ensure the order was in, and she would make sure the CP reflected the change.During an interview on 01/23/2026 at 11:07 AM with the Director of Nurses (DON), she stated that CPs were created at the time of admission and that if there are areas of concern that had not been captured already, they would be discussed during the IDT meeting the next working day. The DON stated, Updating the CP is the responsibility of the MDS/CP Nurses, but we all review this and can make corrections. Further interview with the DON revealed she was not sure why the care plan was not updated.During an interview on 01/23/2026 at 12:37 PM with the Administrator, he stated that he expected the CP to be (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed and reviewed for accuracy. 2. Review of the Face Sheet for R74 revealed he was admitted on [DATE] with diagnoses that included psychotic disorder with delusions, major depressive disorder, vascular dementia with unspecified severity and mood disturbance, psychotic disorder with hallucinations, cognitive communication deficit, and anxiety. He had an appointed State Guardian and a sister who were listed as contacts. Review of R74's admission paperwork, dated 06/12/2023, revealed no identified military history or history of trauma.Review of a [NAME] Healthcare Psychiatric consult note, dated 05/27/2025, revealed R74 has a previous diagnosis of PTSD related to the Vietnam War in 1965, for which he received outpatient treatment and medications. This record was provided to SSA by the RN MDS1 nurse. Further review of R74's record revealed that this was the first time that a PTSD diagnosis was noted.Review of R74's CP, with the last dated conference on 12/01/2025, revealed an identified behavioral problem and listed the etiology of vascular dementia, anxiety, and hallucinations. As of 07/25/2023, behavior was identified as a problem; however, there was no evidence it was revised to reflect the resident's diagnosis of PTSD and was not specific to reported agitation or outbursts that could be associated with PTSD, such as loud sudden noises, or violent movies with gunfire.During an interview on 01/22/2026 at 3:04 PM with R74's State Guardian, she stated she had heard R74 was a veteran but had never observed the official paperwork. She approved contact with the resident's family. Interview on 01/22/2026 at 3:21 PM with R74's family member (FM74) confirmed the resident had been in the Air Force for about three years but could not elaborate on how it affected him.During an interview on 01/23/2025 at 1:23 PM with RN MDS1, she stated that she was made aware of R74's PTSD history in review of the 05/27/2025 psychiatric consult note. She also stated that he had known triggers such as loud, sudden noises, and in review of the current care plan, she confirmed that it was not specific to that diagnosis or concern. She stated that not making sure that everyone had access to this information in a care plan could cause an increase in his behavior, worsen his psychological condition, and cause the resident distress. She stated the care plan needed to be specific to the needs of this resident.During an interview on 01/23/2026 at 08:50 AM with the Activity Director (AD), she stated she was aware that he did not like sudden noises and war-type movies and that she avoided those with him. She stated that this was common knowledge with the staff, but that she did not recall seeing anything specific to PTSD on his care plan. She added that the care plan is the way the staff is made aware of specific care needs. Not having that information could mean that the residents may not get everything they need.During an interview on 01/23/2026 at 11:07 AM with the DON, she stated she had observed an incident of increased stress with a movie that was on television, and now that they are aware that it could cause him distress, they no longer put him in that situation. She stated that now everyone just knows, through word of mouth and shared during huddle meetings. She stated that when an area is identified, the care plan is usually updated by the CP/MDS nurse or herself. She could not explain how this was omitted.During an interview on 01/23/2026 at 12:37 PM with the Administrator, he stated that the CP/ MDS nurses and the clinical management team reviewed care plans in the IDT meetings daily. The Administrator stated that the CP should have reflected this, and it was the responsibility of the clinical management team to make sure it was correct, specifically the DON and CP/MDS Nurses. He stated that with loud noises, the resident has exhibited more manic type behaviors, adding that not having this information updated on the CP had the potential to cause unnecessary distress to the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure nursing staff followed the standard of care for medication administration medications in a safe manor for one of 93 sample residents. (sample R 8).Review of R8's medication list revealed an allergy to acetaminophen, but the resident continued to receive acetaminophen in different prepared medication.Based on interview, record review, and review of facility documents and policy revealed the facility failed to ensure nursing staff followed the standard of care for medication administration medications in a safe manor for one (Resident (R) 8) of five sampled residents reviewed for unnecessary medications. R8's medication list revealed an allergy to acetaminophen; however, the residents had orders for acetaminophen in two different prepared medications.Findings included:Review of the Medication Administration Policy, revised 06/24/2025, revealed Medications are administered as prescribed in accordance with the manufacturer's specifications, good nursing principles and practices, and only by persons legally authorized to do so. The policy stated to note any allergies or contraindications the resident may have prior to medication administration.Review of the Charge Nurse job description, dated 03/2021, revealed that the responsibility of this role was to ensure compliance with all written policies and procedures established by the facility and to verify that all nursing personnel work in compliance with the procedures outlined in the Nursing Policies and Procedures Manual.Review of the procedural resource manual used by nursing staff titled [NAME] and [NAME] Clinical Nursing Skills and Technique, 10th Edition, printed in 2022, Chapter 21.1 titled Administering Oral Medications revealed that the nursing assessment included clarification of incomplete or unclear orders before administration of any medication. The nurse was expected to assess the patient's medical and medication history and the history of allergies. It also revealed that when allergies are present, the resident should wear an allergy bracelet. Per the manual, the nurse was expected to ask the patient to describe allergies and any allergic reactions. Chapter 21.1, titled Implementation, revealed that the nurse was directed to follow the seven rights of medication administration. The seven rights referenced were the right medication, dose, route, time, client, documentation, and reason.Review of R8's Face Sheet revealed he was admitted on [DATE] with multiple co-morbidities, including acute and chronic kidney failure, heart failure, history of pulmonary embolism, and a history of falls. It also revealed a documented allergy to hydrocodone and acetaminophen that would result in a rash.Review of R8's 01/21/2026 Medication Administration Record (MAR) listed an allergy to hydrocodone - acetaminophen. Further review of R8's MAR revealed the resident was currently prescribed oxycodone (Percocet - an opioid which also contains acetaminophen), five milligrams (mg) every six hours, by mouth, as needed for pain (PRN), as well as acetaminophen 650mg every four hours by mouth, PRN.During an interview on 01/22/2026 at 09:25 AM with the Nurse Practitioner (NP), she stated that when it was ordered on the computer, it presented a drop-down box to denote the severity of the allergy. She stated she felt R8 had a sensitivity to hydrocodone but not the acetaminophen and believed it may have been more of an intolerance versus a true allergy, adding that Oxycodone was ordered in the place of the hydrocodone. She added that if a resident received a medication to which they were truly allergic, it could lead to a reaction as severe as anaphylaxis that could be life-threatening.During an interview on 01/23/2026 at 09:20 AM, the Registered Pharmacist (RPh) from the facility's contracted pharmacy, stated that there was a sensitivity listed to hydrocodone and acetaminophen, but it was not specific as to what the sensitivity was. The RPh indicated the resident was previously prescribed Lortab (hydrocodone and acetaminophen) The RPh added that the record was not specific as to which (or both) of the two medications the resident was sensitive to. He stated that hydrocodone was not automatically linked to acetaminophen, as it could be prescribed with ibuprofen or alone. Therefore, it could be listed as an allergy, separate from the acetaminophen, but it could not be prescribed separately by a Nurse Practitioner (NP). The RPh then stated he had no record of clarification for this sensitivity. Since it (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not clarified which drug was the concern, and if the Lortab was flagged as a sensitivity, the acetaminophen would have flagged each time any prescription was given that contained that contained that drug, such as in R8's current prescriptions of Percocet or Tylenol that were currently prescribed. The RPh had no explanation as to why this information was not part of the pharmacy record. He stated that if the resident had a true allergy to any medication prescribed, it could result in mild to severe reactions, including death.During an interview on 01/23/2026 at 11:07 AM with the Director of Nursing (DON), she stated that when a drug is listed as an allergy, the pharmacy system will flag it so that it draws attention to the pharmacy, indicating that the Nurse Practitioner (NP) should reassess the order. The DON revealed her expectation that the nurses who administered medications would review the allergy list before administering a medication and follow up with the pharmacy and NP to clarify the order. She would expect this to be documented. She stated that it was the nurse's responsibility to review, question, and follow up on any medication concerns before administering any medications. Further interview with the DON revealed that administering a medication to which a resident was allergic, depending on severity, could result in an anaphylactic response.During an interview with the Administrator on 01/23/2026 at 12:37 PM, he stated that he expected the clinical staff to follow all policies related to medication administration and to work according to their job descriptions. He stated he had worked as a medication technician in the past and was familiar with the five rights of medication administration, which included the right patient, drug, dose, route, and time. He added that, depending on the severity of the allergy, it could be an intolerance or a true allergy that could result in the death of the resident. He expected the nurses administering the medications would question the order and follow up appropriately, as well as document it in the record.

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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. Observation on 1/21/2026 revealed staff entering a resident's room to deliver food trays. The trays were uncovered and then left while personal care was provided to a resident who was on Enhanced Barrier Precautions. No Protective Personal Equipment was observed in use for two of 93 sampled residents. (Sampled Resident 11, 27).Observation on 1/21/2026 revealed that staff obtained a finger stick blood sugar and brought the dirty machine to the cart, laying it on the cart without a barrier. The nurse wiped the machine with a Clorox wipe, one time, and did not leave it wet according to the facility policy or manufacturer's recommendation. One of 93 sampled Residents (sampled Resident 102) Based on observation, interview, and review of manufacturer's instructions and facility policy, the facility failed to maintain an infection prevention (IP) program designed to help prevent and manage the transmission of diseases and infections for two (Resident (R) 11 and R102) of 20 sampled residents, as well as one supplemental resident (R27.) Staff failed to thoroughly cleanse and disinfect a soiled glucometer in accordance with facility policy and manufacturer's instructions. In addition, staff failed to utilize personal protective equipment (PPE) as required when providing care to a resident on Enhanced Barrier Precautions (EBP).Findings include:Review of the Infection Control (IP) Policy, last revised 01/31/2025, revealed that the facility's Infection Control Policy and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infection.1. Review of the Glucometer Cleaning and Disinfecting Policy, revised 01/24/2024 and reviewed on 01/15/2026, revealed licensed staff were expected to follow the manufacturer's guidelines and recommendations for the cleaning and disinfecting of the glucose monitoring machine.Review of the Assure Platinum Glucometer Cleaning and Disinfecting Competency, dated 02/01/2024, revealed that after cleaning, the glucometer should stay wet from the approved cleaning product for three minutes.Review of the Clorox Healthcare Germicidal Wipes label revealed the recommendation for effective cleaning related to Candida Auris, Clostridium Difficile, and Mycobacterium Bovis; any hard surface cleaned should remain wet for three minutes. For Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV), any hard surface must remain wet for one minute.Observation on 01/21/2026 at 11:03 AM revealed Registered Nurse (RN) 5 used an Assure Platinum brand glucometer to perform glucose monitoring for R102. After performing the test, the nurse placed the soiled glucose monitor on the 400-hall medication cart, without a barrier. RN5 then cleaned the machine with an approved Clorox wipe. She wiped (wet) the machine with a single motion for nine seconds. RN5 then laid the glucometer on a clean paper towel to dry before she returned it to the drawer in the resident's room. RN5 did not use a timer to ensure that the minimum wet (dwell) time necessary for disinfection was met. During an immediate interview with RN5, she stated that the old rule was to leave the machine wet with the cleaning solution for three minutes, but now it was only for one minute, and that it would take at least one minute for the wet surface to dry. She stated she received this training from the new RN Staff Development Coordinator/Infection Preventionist (SDC/IP, RN)2. She emphasized the importance of cleaning the monitor between users, as per the policy, to prevent the spread of germs that could make the resident ill.During an interview on 01/22/2026 at 10:04 AM with SDC/IP1, she stated that the facility had a mandatory skills fair every year for all clinical staff, using handouts, videos, and in-person educational methods. She stated that there had recently been some confusion due to directions for multiple types of glucometers being used in the facility. Directions for the Assure model (observed in use on 01/21/2026 at 11:03 AM), as well as the Even Care model required three minutes of continuous wet surface. However, the newer Freestyle model required only one minute. The wet time required active wiping for the duration of the instructed time. She stated that the facility would be recognizing the previous three-minute wet time and provided signed copies of the updated training that was provided on 01/21/2026 to clinical staff (after surveyor intervention). She stated that each cart has a timer for the nurse to reference (to ensure that the minimum wet time is (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	met). She also stated that each resident had their own glucometer in their rooms, and a dirty machine should not have to come out of the room. However, if a soiled glucometer was cleaned at the medication cart, she expected that before it was placed on the cart, a barrier would be put in place, and a new barrier would be used for a cleaned glucometer. She added it was important to follow the policy and manufacturer recommendations of the machine and cleaning solutions to decrease the risk of cross-contamination and potential illness to the resident.During an interview on 01/23/2026 at 11:07 AM with the Director of Nursing (DON), she stated that she expected that the infection control policy would be followed, adding that when it is not followed, it places the residents and staff at risk of spreading germs and causing illness. Regarding the glucose monitors, she added that residents were provided with glucose monitors in their rooms, and a barrier should be used regardless of where the machine was placed, using a clean barrier with a clean machine. She stated there had been some confusion about the amount of time the machines should remain wet because various models were used which had differing manufacturers' recommendations. Further interview with the DON revealed that the facility would be going back to the three-minute wet time process. During an interview on 01/23/2026 at 12:37 PM with the Administrator, he stated he expected that the IP policy would be followed. He stated that he was aware that not following the precautions could allow germs to spread and cause illness.2. Review of the Enhanced Barrier Precautions (EBP) Policy, last revised on 03/25/2024, revealed EBP was indicated for residents who have indwelling medical devices, regardless of negative Multi-Drug-Resistant Organism (MDRO) status. Per the policy titled Enhanced Barrier Precautions, last reviewed 01/31/2025, signage on the resident's door is used to advise staff and visitors of the need for and type of PPE.Observation on 01/21/2026 at 1:12 PM revealed a sign on the door to R11 and R27's shared room, noting that the resident in Bed A (R11) was on EBP. Observation of the sign revealed instructions for the use of a gown and gloves for contact with the affected resident. PPE supplies were located outside the door in a plastic container. At this time, observation revealed State Registered Nurse Aide (SRNA)1 and SRNA2 entered the room to distribute lunch trays to the two roommates, both of whom required feeding assistance. Further observation revealed that both staff failed to don gloves or gowns prior to entering the room with food trays. The staff next removed the plate lids and uncovered the food, then pulled the curtain for Bed A and closed the door. The survey team knocked and entered the room, as the staff remained behind the curtain and called out Patient care. When the staff finished and exited the enclosure, they went to the sink to wash their hands. The staff were not wearing PPE (gloves and gowns), and none was observed in the trash upon exit. As staff attempted to wash their hands, no paper towels were readily available. Immediate interview at this time with both SRNA1 and SRNA2 revealed that the food plates should have remained covered due to the potential for germ exposure, as well as possible food temperature loss. During a follow-up interview on 1/21/2026 at 2:14 PM, SRNA1 stated that her understanding of EBP was that anytime a staff member has contact with a resident, Personal Protective Equipment [PPE] should be worn. She stated that the resident care that was provided was to pull the resident up in bed for his meal. She acknowledged that the action constituted resident contact, and the appropriate PPE should have been worn. She added, I should have known better. SRNA1 stated that she had received infection control education from SDC/IP1. She understood the reason R11 was on EBP was that he had a gastric tube (g-tube), and it was possible to introduce germs to this resident or he to her without the appropriate PPE. An introduction of germs could increase the risk of illness for either party.During a follow-up interview on 01/21/2026 at 2:17 PM with SRNA2, she stated that the reason PPE was to be worn was to prevent tube-feeding and/or germs from getting on her or the resident. She confirmed previous education from SDC/IP1 and stated she was aware of the sign which related the need for PPE. SRNA2 initially stated that PPE was used. SRNA2 then stated that they were only repositioning the resident in bed. When informed that observation revealed that the SRNAs had not used PPE, SRNA2 did not say anything more.During an interview on 01/22/2026 at 10:04 AM with SDC/IP1, she stated that residents who were on EBP were those who had wounds or (continued on next page)

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	01/23/2026

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

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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	indwelling equipment such as gastric tubes. Supplies were kept outside of the resident's room in a plastic bin and were available in the supply room as well. She expected that staff would follow the infection control policy regarding the use of PPE. She also stated that resident food should not be exposed and should have remained covered until it was ready to be eaten, especially if there was resident care, due to the increased risk of germ exposure, which could potentially cause illness.During an interview on 01/23/2026 at 11:07 AM with the DON, she stated that she expected that the infection control policy would be followed, adding that when it is not followed, it places the residents and staff at risk of spreading germs and causing illness. She stated that the resident's EBP status required staff to wear the appropriate PPE anytime there was physical contact with a resident, including being pulled up in bed. She added that supplies were readily available outside the door.During an interview on 01/23/2026 at 12:37 PM with the Administrator, he stated he expected that the IP policy would be followed. He stated that he was aware that not following the precautions could allow germs to spread and cause illness.