STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185335	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of South Louisville	1120 Cristland Road Louisville, KY 40214

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety. Observations revealed dented canned food items in the storage area, available for use. Additionally, observation revealed staff failed to practice hand hygiene during plating of meals. The findings include:1. Review of a policy from the dietary services company contractor titled, Receiving, revised 02/2023, revealed, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. The policy revealed the Procedures included, 1. The Dining Services Director or designee receives all items and checks each against the order; 2. The Dining Services Director or designee signs and dates the delivery slip from the vendor. Omissions or damaged goods will be noted on the delivery receipt; 3. The Dining Services Director or designee will inspect all refrigerated and frozen supplies for safe transport including, proper temperature maintenance, acceptable quality, and store immediately. If quality is unacceptable, the item(s) will be immediately returned for credit; and 4. All canned goods will be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal, as appropriate.During an observation of the kitchen dry storage area and a concurrent interview on 02/23/2026 beginning at 9:28 AM, one 4-pound, dented can of chunk light chicken in water was observed with a dent on the top and bottom of the can. Observations of the can storage rack in the food preparation area revealed one 7-pound can of classic apple with a dent on the top seal and one 6.6-pound can of mandarin oranges with a dent on the top and bottom seal. The Dietary Manager (DM) stated they had a new person stocking that started the previous week, and he had never worked in the kitchen and was learning the process. She stated regular staff should check the cans before they went out, and new staff may not be checking the cans for dents as they should be.During an observation of the can storage rack and a concurrent interview on 02/25/2026 at 10:30 AM, there were three 50-ounce cans of tomato soup that were dented at the seal with a received date of 02/20/2026, one 50-ounce can of cream of chicken soup was dented at the seal with a received date of 02/10/2026, and one 46-ounce can of vegetable juice was dented on the side with a received date of 12/16/2025. [NAME] #3 stated that when the food delivery truck came in, the staff member who put away the cans screened the canned food items for dents and put them in the dented can room. [NAME] #3 stated that the 46-ounce can of vegetable juice with handwritten date of 12/16/2025 was the date the can came in. [NAME] #3 stated they could not use the dented can and could not give it to a resident because they may get sick.During an interview on 02/26/2026 at 2:41 PM, the Director of Nursing (DON) stated she expected dented cans to be thrown out immediately.During an interview on 02/26/2026 at 2:55 PM, the Administrator stated screening for dented cans should be completed and dented cans should be separated and checked for safety. He stated that he expected dented cans to not be used for any meal preparation.2. Review of an undated facility policy titled, Handwashing for Food Safety, revealed, Here are crucial moments when you should remember to wash your hands, which included, Before, during and after you prepare a meal, Especially after handling raw meat, poultry, seafood or eggs or their juices.During an observation of the lunch meal tray line on (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	02/25/2026 at 11:23 AM, [NAME] #3 touched her eyeglasses then pulled her phone out of her right pants pocket, then placed the phone back in the right pants pocket. Without performing hand hygiene after touching her eyeglasses, cellphone, and clothing, she then pulled tongs down by the tips that contacted food and served bread using those tongs.During an interview on 02/25/2026 at 12:34 PM, the Dietary Manager (DM) stated that anytime staff changed to a new task, they should wash their hands. She stated personal phones were not allowed in the kitchen. She stated she expected dietary staff to wash their hands if they touched a phone or their face.During an interview on 02/26/2026 at 2:41 PM, the Director of Nursing (DON) stated that she expected hand hygiene to be completed before touching any produce, food, or tray line, after the removal of gloves, after they touched their phone, and prior to touching utensils.During an interview on 02/26/2026 at 2:55 PM, the Administrator stated he expected staff to follow the facility process regarding hand hygiene, after touching their face or phone, and prior to using tongs.

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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 and facility policy review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective, person-centered care for 1 of 2 residents sampled for respiratory services (Resident (R) 76). Record review revealed the baseline care plan for R76 did not address the resident's CPAP (continuous positive air pressure) equipment use. The findings include:Review of facility policy, Baseline Care Plan Policy, reviewed 01/30/2026, indicated, A Baseline Care Plan is 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. The policy also indicated, 1. The Baseline Care Plan will be developed and implemented within 48 hours of a resident's admission, with the following: i. Initial goals based on admission orders ii. Physician orders iii. Dietary orders iv. Therapy services v. Social Services vi. Preadmission Screening & Resident Review (PASRR) recommendations, if applicable.Review of facility document Resident Face Sheet, indicated the facility admitted Resident #76 on 02/15/2026 with diagnoses including obstructive sleep apnea.Review of Resident #76's Orders, revealed the following orders dated 02/15/2026: CPAP/BiPAP (bilevel positive air pressure), with home settings to be used daily from 6:00 PM to 6:00 AM. CPAP/BiPAP: Remove in the morning and clean mask/equipment after use (once each morning). CPAP/BiPAP: Head of bed elevated to alleviate shortness of breath while lying flat (every shift). CPAP/BiPAP: Change tubing monthly.Review of Resident #76's admission Observation dated 02/15/2026 indicated CPAP was included under respiratory devices.Review of Resident #76's 48-Hour Baseline Care Plan revealed it did not indicate the resident's use of a CPAP device.During an interview on 02/26/2026 at 10:54 AM, Registered Nurse (RN) #24 stated the facility completed a 48-hour baseline care plan at admission that should include pertinent information such as special equipment. He stated the use of a CPAP device should have been included if it was on the admission orders.During an interview on 02/26/2026 at 12:16 PM, RN #15 stated she entered the CPAP order for Resident #76 and confirmed the use of a CPAP device should have been included in the baseline care plan since it was part of the admission orders.During an interview on 02/26/2026 at 11:16 AM, Licensed Practical Nurse (LPN) #5, who was also the Unit Manager, stated the admitting nurse completed the baseline care plan and Minimum Data Set (MDS) staff reviewed it the next day. She confirmed the baseline care plan should include activities of daily living (ADL) care, special equipment, oxygen, and respiratory equipment. She reviewed Resident #76's baseline care plan and confirmed it did not include CPAP use.During an interview on 02/26/2026 at 11:35 AM, the MDS Coordinator stated the baseline care plan should include respiratory equipment if present on admission. She reviewed Resident #76's baseline care plan and confirmed the resident's use of a CPAP device was not included but should have been.During an interview on 02/26/2026 at 1:41 PM, the Director of Nursing (DON) stated the admitting nurse completed the baseline care plan, and the MDS nurse reviewed it the following morning to ensure it was appropriate. She stated the baseline care plan would not necessarily say CPAP but should include respiratory equipment. She reviewed Resident #76's baseline care plan and confirmed that the resident's use of a CPAP device was not included. She stated that she recalled discussing CPAP device settings with the resident and thought it was addressed in the clinical meeting but confirmed it was not included on the baseline care plan and should have been listed under respiratory equipment.During an interview on 02/26/2026 at 2:37 PM, the Administrator stated baseline care plans must be completed within 48 hours and should include any respiratory equipment ordered at admission.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record and policy review the facility failed to ensure a resident with pressure ulcers received care consistent with professional standards of practice to promote healing for 1 of 2 residents (Resident (R) 84). Observations revealed an ordered pressure relieving device not in place as ordered.The findings include: Review of facility policy titled, Skin Integrity, reviewed 01/31/2026, revealed, The facility will ensure that based on the comprehensive assessment of a resident, and 2. A resident with impaired skin integrity receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infections and prevent avoidable skin integrity issues from developing.Review of facility document, Resident Face Sheet revealed the facility admitted Resident #84 on 12/17/2025. According to the Resident Face Sheet the resident had a medical history that included diagnoses of displaced intertrochanteric fracture of left femur (upper thigh bone), need for assistance with personal care, and protein-calorie malnutrition.Review of the 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/2026, revealed the facility assessed Resident #84 with a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #84 required partial to moderate assistance with transferring from the bed to the chair or the chair to the bed. The MDS further indicated Resident #84 was always incontinent of bowel and bladder. Continued review revealed the MDS indicated Resident #84 was at risk for developing pressure ulcers, had one or more unhealed pressure ulcers, and one unstageable pressure ulcer due to coverage of the wound bed with slough and/or eschar. The MDS indicated Resident #84 had a pressure-reducing device for their chair.Review of a Physical Therapy Treatment Encounter Note, dated 12/30/2025 at 12:36 PM, revealed Physical Therapist (PT) #17 changed the resident's wheelchair cushion to a [Brand name, an air-cell based cushion to reduce pressure points] cushion to help with improve sitting tolerance.Review of Resident #84's Care Plan included a problem area, created 01/07/2026, for skin integrity that indicated the resident had a pressure ulcer to the sacrum. Interventions directed staff to implement pressure reducing devices such as a mattress and a cushion to the wheelchair as needed, 01/07/2026; and [Brand name, air-cell based cushion] cushion to wheelchair, 01/16/2026.Resident #84's undated C.N.A. Care Report [Certified Nursing Assistant Care Report, a report used by CNAs to direct resident care] revealed the resident used a wheelchair for mobility, required the assistance of one staff member for ambulation and transfers, and was incontinent. The C.N.A. Care Report included a handwritten note, [Brand name, air-cell based cushion] or gel equivalent, and LAL [low air loss] mattress.Resident #84's Physician Order Report, with orders for the timeframe from 12/17/2025 through 02/25/2026, revealed an order, dated 01/16/2026, for a [Brand name, air-cell based cushion] cushion to the resident's wheelchair, every shift day and night.A Medication Administration Record [MAR], dated 02/2026, did not include the transcription of the physician's order for the Brand name, air-cell based cushion.A nurse practitioner's Progress Notes, dated 01/14/2026 at 12:51 PM, 01/21/2026 at 1:28 PM, 01/28/2026 at 1:13 PM, 02/04/2026 at 2:15 PM, 02/11/2026 at 1:38 PM, and 02/18/2026 at 1:29 PM revealed Resident #84 was on a chair cushion due to a high risk of pressure ulcer formation.An observation and interview, on 02/23/2026 at 11:06 AM, revealed Resident #84 sitting up in a wheelchair, and the wheelchair did not have a cushion in the seat.An observation and interview, on 02/24/2026 at 1:25 PM, revealed that Resident #84 sat in a wheelchair with no cushion in the seat. Family Member (FM) #18 stated they brought in a cushion from home for the resident to sit on and did not know why the resident did not have a cushion in the wheelchair.An observation, on 02/25/2026 at 8:37 AM, revealed a cushion in Resident #84's chair; however, it was not the ordered (Brand name) air-cell based cushion.During an interview on 02/25/2026 at 11:53 AM, FM #18 stated the cushion Resident #84 had in the wheelchair was the one they (family) supplied for the resident. During an interview on 02/25/2026 at 1:50 PM, CNA #18 stated that Resident #84 had a wound on their buttocks and used an air mattress and a cushion in their (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. CNA #18 stated Resident #84 had always had a cushion in their wheelchair, and CNAs did not document if cushions were in place.During an interview on 02/25/2026 at 2:00 PM, Licensed Practical Nurse (LPN) #20 stated if a resident had an order for a (Brand name, air-cell based cushion) cushion, it should appear on the MAR, and she would check for those things during her rounds. LPN #20 stated when they received an order for a cushion, management would bring the cushion to the floor staff and nurses should look every day to ensure the resident had the ordered cushion. LPN #20 stated whoever implemented the orders would put the order in the electronic medical record (EMR), and then make sure the device was there. LPN #20 stated once the device was implemented, nurses were responsible to document that it was in place.During a telephone interview on 02/25/2026 at 2:13 PM, Registered Nurse (RN) #15, who was the facility's Wound Care Nurse, stated she tried to implement orders as she entered them in the EMR, and she also had help from other staff to implement orders. RN #15 stated usually if she entered an order into the EMR the order would be put on the MAR. RN #15 stated if she put the order in the EMR, she would get the equipment and put that equipment in the resident's room. RN #15 stated staff removed the cushion when they cleaned the wheelchair, and sometimes the cushion would not make it back to the resident's room. RN #15 stated that it could very well have been a data entry error on her part that the order did not appear on the MAR for the nurses to document on. When asked who made sure care plan approaches were implemented, RN #15 stated she was usually the one who ensured care plan approaches to pressure ulcers were implemented. RN #15 stated she was usually the one who placed the cushions in the resident's room. During an interview on 02/25/2026 at 3:58 PM, the Director of Nursing (DON) stated they ordered a (Brand name, air-cell based cushion) cushion for Resident #84 in 02/2026. The DON stated that she took the resident's cushion and cleaned the cushion on Monday, 02/23/2026, and on 02/24/2026 the was still wet. The DON stated Resident #84 had a gel cushion they put in the resident's chair as well. The DON stated she expected nurses to check that the cushion was placed appropriately. The DON stated she expected that orders be entered so that the orders appeared on the MAR. The DON stated she was sure they ordered the cushion in 02/2026, but understood that the cushion was not in Resident #84's room.During an interview on 02/26/2026 at 9:13 AM, CNA #21 stated Resident #84 had an area on their buttocks that was healing, and the resident had been using a cushion for a while. CNA #21 stated they cared for Resident #84 on Tuesday, 02/24/2026, and the resident had a black foam cushion then. CNA #21 stated Resident #84 usually had a square black cushion, and she was not sure why Resident #84 did not have the square black cushion in their wheelchair.During an interview on 02/26/2026 at 11:41 AM, the DON stated she was not sure what had happened to Resident #84's cushion that had been in the wheelchair and why it had not been in place on Monday, 02/23/2026, or Tuesday, 02/24/2026. The DON stated she believed that there was an issue with the way the order was entered and if the order had been entered correctly the nurses would have known to look for Resident #84's cushion and would have realized when the resident did not have it. During an interview on 02/26/2026 at 11:56 AM, the Administrator stated that the care plan was to be a general guide of how staff cared for the residents. Administrator stated the nurse managers should ensure orders were on the MAR for the nurses to verify. The Administrator stated he expected that when staff got a resident up to a chair, staff made sure the resident had some type of pressure-reducing cushion.

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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, and review of facility policy review and records, the facility failed to ensure medication was securely stored for 1 (Resident #22) of 3 residents reviewed for accident hazards. The facility also failed to ensure medication carts were free from loose pills and debris, which affected 1 (West Wing Cart #1) of 3 medication carts observed.The findings included:Review of facility policy, Medication Storage, Storage of Medication, dated 01/2025, revealed Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy revealed the Procedures included, 4. Medications should be stored so that various routes of administration are separated. Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, and suppositories, 9. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in an area separate from medications, and 16. Medication storage areas should be kept clean, well lit, organized and free of clutter. Review of facility policy, Medication Administration, dated 06/24/2024, revealed, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. The policy revealed the Guidelines included, 6. Medications should be administered at the time they are prepared. 1. Review of the facility document, admission Record indicated the facility admitted Resident #22 on 07/03/2023. Further review revealed the resident had a medical history that included diagnoses of atherosclerosis (build of fatty deposits inside artery walls causing them to harden and narrow) of native arteries (original arteries [vessels] within the body) of other extremities with ulceration (painful, open sores) and type 2 diabetes mellitus. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/24/2025, revealed the facility assessed Resident #22 with a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #22 was at risk for developing pressure ulcers/injuries and had a total of three venous or arterial ulcers present. The MDS also revealed Resident #22's treatment included applications of dressings to their feet. Review of the facility's comprehensive care plan for Resident #22 revealed a focus area initiated 02/11/2026, that indicated the resident had an arterial ulcer to the left third toe. Interventions directed staff to change dressings per physician orders (initiated 02/11/2026). Review of Resident #22's Physician Order Report, dated 02/24/2026, contained an active order, dated 02/09/2026, for povidone iodine (an antiseptic and germicide) 10% solution to be painted on the third toe arterial ulcer once daily. The Physician Order Report also included an active order, dated 02/09/2026, for povidone iodine 10% solution to be painted on the left great toe arterial ulcer once daily. The Physician Order Report further included an active order, dated 02/24/2026, for Wound Care, with instructions to cleanse the arterial ulcer to left third toe with wound cleanser and paint the wound with povidone iodine as needed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 02/23/2026 at 2:24 PM in Resident #22's room, six opened bottles of povidone iodine topical solution 10% covered with residual stains outside the bottle were observed atop Resident #22's bedside table. At the time of observation, Resident #22 stated they had wounds on their backside, and staff changed the dressings three to four times a week. During an observation on 02/24/2026 at 9:30 AM inside Resident #22's room, a 16 fluid (fl) ounce (oz) bottle of povidone iodine 10% solution was observed atop Resident #22's bedside table. During a concurrent observation and interview on 02/24/2026 at 2:18 PM inside Resident #22's room, there was a bottle of povidone iodine atop the resident's bedside table. Registered Nurse (RN) #13 stated that the bottle of povidone iodine was used for wound dressings and was a medication. RN #13 stated the bottle should have been stored in the treatment cart. During an interview on 02/24/2026 at 2:24 PM, Licensed Practical Nurse (LPN) #14 stated wound care supplies should have been locked up inside the treatment cart. LPN #14 stated there should not be any medications inside Resident #22's room. LPN #14 stated wound dressing supplies, which included povidone iodine, were prepared outside the room at the treatment cart, and the bottle should not have been brought or kept in the room. LPN #14 stated there was a potential for harm towards other residents, and they could have developed allergic reactions if exposed. During a telephone interview on 02/25/2026 at 2:00 PM, RN #15, the Certified Wound Care Nurse, stated wound care supplies were supposed to be kept inside the treatment cart. RN #15 stated the povidone iodine should not have been inside Resident #22's room. RN #15 stated that the povidone iodine was a medication and could potentially have caused stomach issues and led to toxicity for confused residents if they drank it. During an interview on 02/26/2026 at 10:45 AM, the Director of Nursing (DON) stated the povidone iodine should not have been inside Resident #22's room. The DON stated for medications to be stored in a resident's room, a doctor's order was required, and the medication should be hidden from view. The DON stated the only reason the bottles of povidone iodine would be in the room was if either the nurse had started wound care or had forgotten to remove it after wound care was completed. The DON stated there was potential for confused, wandering residents to drink the medication and have potential allergic reactions. During an interview on 02/26/2026 at approximately 1:30 PM, the Administrator stated treatment supplies and medications should be locked in treatment carts or the supply room. 2. An observation on 02/25/2026 at 2:43 PM of [NAME] Wing Cart #1 with the Assistant Director of Nursing (ADON) revealed two loose pills with debris from pills and trash in the second drawer of the cart, behind the medication cards and one loose pill in the third drawer with debris from pills and trash. The medication cards were tightly packed in both drawers. During an interview on 02/25/2026 at 2:35 PM, Certified Medication Aide (CMA) #23 stated that each nurse was responsible for keeping the medication carts clean and organized. During an interview on 02/25/2026 at 2:43 PM, the ADON stated there should not be loose pills or trash in the medication carts, and it was each nurse's responsibility to keep the carts clean. The ADON stated the medication cards were in the drawer too tight, which could cause pills to come out of the cards accidentally. She stated overflow medications should be kept in a separate area to allow (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more room for the cards that were in use, and that would prevent pills from accidentally being popped out of the cards. During an interview on 02/25/2026 at 2:50 PM, Registered Nurse (RN) #22 stated that each nurse was responsible for the medication cart to be clean and organized. She stated there were so many cards in the drawer that it was very hard to get them in and out, and that caused the loose pills in the drawer. She stated loose pills should be removed and disposed of, but she had not noticed them. She stated the cart should be clean and not have trash and dust from pulls in the drawers. During an interview on 02/26/2026 at 1:41 PM, the Director of Nursing (DON) stated medication carts needed to be clean and organized by the nurse. She stated the cart drawers should not be so full that they caused medications to come out of the package. She stated that loose pills, dust from pills, or trash should not be left in the carts. During an interview on 02/26/2026 at 2:37 PM, the Administrator stated medication carts needed to be clean and organized by the nurse and stated they should not be so full that they caused medications to come out of the package. He stated that loose pills, dust from pills, or trash should not be left in the carts.