STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365351	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Galion	935 Rosewood Dr Galion, OH 44833

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure Resident #44 ' s guardian was informed about the potential charges for therapy and the beginning of services, which affected one (#44) of three residents reviewed for therapy, and the facility failed to ensure informed consent was obtained prior to initiating dental services for Resident #44. This affected one resident (#44) of three residents reviewed for ancillary services. The facility census was 51. Findings Include:1.) Review of the Resident #44's medical record revealed an admission date of 03/09/17 with diagnoses including Parkinson's disease, dysphagia, dementia, moderate protein calorie malnutrition, anxiety, depression, heart failure, adult antisocial behavior, adult failure to thrive, and liver disease.Review of Resident #44's guardianship paper dated 10/06/22 revealed his daughter was the court appointed guardian.Review of Resident #44's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed he was rarely or never understood. Review of Resident #44's physician order from 01/17/25 to 02/18/25 revealed an order for occupational therapy evaluation and order to treat five times a week for four weeks.Review of Resident #44's occupational discharge summary revealed he was seen from 01/16/25 to 02/18/25.Review of Resident #44's physician orders from 02/04/25 to 03/18/25 and from 03/18/25 to 04/01/25 revealed an order for speech therapy evaluation and order to treat three times a week. Review of Resident #44's speech therapy discharge summary revealed he was seen from 02/04/25 to 04/01/25.Review of Resident #44's order from 02/20/25 to 03/20/25 revealed an order for physical therapy to treat five times a week for two weeks. Review of Resident #44's physical therapy discharge summary revealed he was seen from 02/20/25 to 03/20/25.Review of Resident #44's billing statement dated 03/01/25 revealed he was charged $250.50 for occupational therapy and related charges.Review of Resident #44's billing statement dated 04/01/25 revealed he was charged $316.02 for occupation and speech therapy and related charges.Review of Resident #44's billing statement dated 05/01/25 revealed he was charged $355. 09 for speech and physical therapy and related charges.Review of Resident #44's medical record from 01/01/25 to 05/01/25 revealed no evidence his guardian was notified of the ordered therapy evaluations and treatments or the charges they would accrue.Interview on 09/10/25 at 3:35 P.M., with the Administrator revealed prior to the start of therapy they call families who are privately paying and discuss therapy and the charges that they will receive.Interview on 09/15/25 at 10:13 A.M., with the Administrator revealed she had not found evidence Resident #44's guardian had been notified of therapy orders or charges.2.) Review of Resident #44's ancillary consent form dated 03/16/17 revealed the resident's wife consented to vision, podiatry, and audiology for residents with Medicaid. Review of Resident #44's guardianship paper dated 10/06/22 revealed his daughter was the court appointed guardian. Review of Resident #44's census revealed he switched from Medicaid to private pay on 12/01/24. Review of Resident #44's medical record from 12/01/24 to 03/17/25 revealed no evidence consent was obtained for dental services as a non-Medicaid resident and no evidence the guardian was notified of a dental visit. Review of Resident #44's dental form dated 03/17/25 revealed the dentist examined the resident. Interview on 09/16/25 at 12:40 P.M., with the Administrator verified an updated informed consent form had not been obtained after Resident #44 switched to private pay. She reported billing occurred through the ancillary services themselves and not the facility. This deficiency represents noncompliance investigated under Complaint Number 1314302.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, and staff interview, the facility failed to complete physician ordered laboratory work required prior to an appointment for Resident #17, resulting in the appointment needing to be rescheduled. The facility failed to complete neurological assessments for Resident #1, after a fall with a head injury. This affected two (#1 and #17) of three residents reviewed for quality of care and treatment. The facility census was 51.Findings include: 1. Review of Resident #17's medical record revealed an admission date of [DATE] with diagnoses including Alzheimer's disease, dementia, chronic obstructive pulmonary disease, and chronic heart failure.Review of Resident #17's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition.Review of Resident #17's progress note dated [DATE] revealed she returned from a nephrology appointment with a follow up appointment to take place on [DATE]. The physician requested laboratory test be drawn on [DATE] prior to the appointment.Review of Resident #17's physician order dated [DATE] revealed on [DATE] laboratory test were to be completed. This included a urinary analysis and eight other blood draws.Review of Resident #17's medical record from [DATE] to [DATE] revealed no evidence her ordered laboratory test were completed.Review of Resident #17's progress note dated [DATE] revealed the nephrologists office called and reported her appointment would need to be rescheduled as the ordered laboratory test had not been completed. The appointment was rescheduled for [DATE].Interview on [DATE] at 1:20 P.M. and [DATE] at 11:44 A.M. with Resident #17's family revealed the facility had not completed ordered laboratory test prior to appointments resulting in rescheduled or missing appointments.Interview on [DATE] at 11:39 A.M. with the Director of Nursing (DON) verified Resident #17's laboratory test were not completed as ordered prior to her appointment and the appointment had to be rescheduled. 2. Review of the medical record revealed Resident #1 was admitted on [DATE] and expired on [DATE]. Resident #1 had diagnoses that included but not limited to Alzheimer's disease, neuromuscular dysfunction, dysphagia, type 2 diabetes. schizoaffective disorder/bipolar type, and depressive disorder. Review of physician orders dated [DATE] revealed Resident #1 was ordered Eliquis (anticoagulant). Review of the care plan dated [DATE] revealed Resident #1 was at risk for falls with interventions to assist to recliners with nonskid strips in front of the recliner, bolsters to bed, and encourage to go to central living room.Review of an incident note dated [DATE] at 11:30 A.M. revealed Resident #1 was found lying flat on her back in the dining area. Resident #1 was holding the back of her head. A small bump was noted to the mid occipital region, and no bruising was noted. Vital signs were obtained, and neurological checks were initiated. Review of the neurological assessments form revealed an assessment was to be completed every 15 minutes for four checks, every 30 minutes for four checks, every hour for four checks, every four hours for four checks, and every eight hours until 72 hours after the fall. Review of the neurological assessment for Resident #1 revealed four 15-minute checks were completed from [DATE] at 11:40 A.M. through 12:25 P.M. A 30-minute check was completed at 12:55 P.M. The 30-minute checks for 1:25 P.M. and 1:55 P.M. were not completed. A handwritten note revealed the nurse was off the floor passing medication on another hall. On [DATE] at 2:25 P.M. Resident #1's vital signs were completed but pupils, consciousness, speech, and responsiveness were not assessed. A note revealed an attempt was made to arouse Resident #1, but Resident #1 was sleeping soundly. Review of an incident note dated [DATE] at 7:12 P.M. revealed Resident #1 had a bump to the back of her head that now had some discoloration and bruising. The incident note revealed Resident #1's daughter-in-law was notified Resident #1 had a fall that resulted in a bump to the back of Resident #1's head and there was some discoloration/bruising. Review of a nursing note dated [DATE] at 7:12 P.M. revealed the Medical Assistant (MA) was notified Resident #1 had a fall with a bump and bruising to the back of the head, and neurological checks were at baseline for Resident #1. Review of the modification of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment, no behaviors, no impairment to upper or lower, used a wheelchair, and was dependent on staff for care. The MDS also revealed Resident #1 received anticoagulant medication. Interview on [DATE] at 12:22 A.M., with the Director of Nursing (DON) verified the neurological checks were not completed as indicated on the neurological form for Resident #1. DON verified Resident #1 was on Eliquis and it was concerning that vital signs were completed on [DATE] at 2:25 P.M. but Resident #1 was not able to be aroused to complete the neurological assessment. DON verified the documentation revealed Resident #'1's family and MA were not notified until later in the day that

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure parameters for Resident #1's midodrine (to treat low blood pressure) were entered correctly into the medical record and midodrine was administered according to the parameters ordered. This affected one (#1) of three residents reviewed for medications being administered correctly. The facility census was 51.Findings include: Review of the medical record revealed Resident #1 was admitted on [DATE] and expired on [DATE]. Resident #1 had diagnoses that included but not limited to Alzheimer's disease, neuromuscular dysfunction, dysphagia, type 2 diabetes. schizoaffective disorder/bipolar type, and depressive disorder. Review of the modification of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment. Review of physician orders revealed on [DATE] Resident #1 was ordered midodrine five milligram (mg) three times a day for hypotension. Midodrine was to be held for systolic blood pressure (SBP) greater than 120 millimeters of mercury (mmHg). Review of medication administration records (MAR) from [DATE] through [DATE] revealed Resident #1 received 47 doses of midodrine with SBP greater than 120 mmHg. The highest blood pressure recorded when midodrine was administered was 169/103 mmHg on [DATE] at 11:00 A.M. Interview on [DATE] at 1:31 P.M., with the Director of Nursing (DON) verified the instructions to hold midodrine for SBP greater than 120 mmHg was on the order but did not show up on the MAR. DON verified Resident #1 received midodrine multiple times with the SBP was greater than 120 mmHg.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, family interview, and staff interview, the faciltiy failed to obtain physician ordered laboratory tests for one resident. This affected one (#17) of three residents reviewed for physician orders. the faciltiy census was 51. Findings include:Review of Resident #17's medical record revealed an admission date of 01/15/25 with diagnoses including Alzheimer's disease, dementia, chronic obstructive pulmonary disease, and chronic heart failure. Review of Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #17's progress note dated 01/20/25 revealed she returned from a nephrology appointment with a follow up appointment to take place on 07/20/25. The physician requested laboratory tests be drawn on 07/14/25 prior to the appointment. Review of Resident #17's physician order dated 01/20/25 revealed on 07/14/25 laboratory test were to be completed. The laboratory test included a complete blood count (CBC), hepatic function panel, magnesium, microalbumin/create ratio, renal function panel, sodium, protein/creatinine ration, and an urinary analysis. Review of Resident #17's medical record from 07/14/25 to 07/21/25 revealed no evidence the laboratory test were completed. Interview on 09/11/25 at 1:20 P.M. and 09/16/25 at 11:44 A.M. with Resident #17's family revealed the facility had not completed ordered test prior to appointments resulting in rescheduled or missing appointments. Interview on 09/15/25 at 11:39 A.M. with the Director of Nursing (DON) verified Resident #17's laboratory test were not completed as ordered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and review of wound care policy, the facility failed to follow the appropriate infection control guidelines when changing dressing for Resident #28's wound. This affected one (#28) of two residents observed for infection control practices. The facility census was 51.Findings include: Review of the medical record revealed Resident #28 was admitted on [DATE] with diagnoses that included Alzheimer's disease, type 2 diabetes, major depressive disorder, and chronic kidney disease. Review of the significant change Minimum Data Set, dated [DATE] revealed Resident #28 had severe cognitive impairment. Review of a wound evaluation note dated 09/08/25 at 2:01 P.M. revealed Resident #28 had a skin tear to the right lower leg. The skin tear measured 2.5 centimeters (cm) long and 0.8 cm wide and was 0. 1 cm deep. Review of the new order, received on 09/11/25 ,to cleanse the skin tear to Resident #28's right lower leg with normal saline or wound cleanser, apply Vitamin A and D ointment and cover with Dermaview II (a moisture-vapor permeable transparent dressing that aids in the prevention of bacterial contamination) island dressing every three days and as needed. Observation on 09/15/25 at 11:07 A.M., revealed the Assistant Director of Nursing (ADON) #260 applied gloves and removed the dressing to Resident #28's right lower leg. ADON #260 placed the soiled dressing on a paper towel on an over the bed table. ADON #260 then cleansed the wound, placed the A and D ointment on the tip of her index finger and applied the ointment to the wound, and then covered the wound with Dermaview II. Interview, at the time of the observation, ADON #260 verified she did not remove her gloves after removing the soiled dressing, perform any hand hygiene, and used her finger, covered with the possibly contaminated glove, to apply the ointment. Review of the policy titled Wound Care dated September 2021, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Steps in the procedure included to wash and dry hands thoroughly and put on exam gloves. The tape to the dressing should be loosen and the dressing removed. Pull the glove over the dressing and discard into appropriate receptacle. Wash and dry hands thoroughly and put on gloves. The wound should be cleaned and treatments applied as ordered by the physician.