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	10/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interviews, review of hospital records, and review of the facility policy, the facility failed to ensure Resident #10 was safely secured while in his electric wheelchair and failed to ensure his wheelchair was properly secured to the floor of the facility's transport van. Actual Harm occurred on 08/25/25 when, during transit, Resident #10's electric wheelchair tipped and moved forward. Resident #10 landed on the right side of his body while still in the wheelchair and hit his head on the transport van's floor. Resident #10 was admitted to the hospital for three days for treatment and monitoring before being discharged back to the facility. This affected one (Resident #10) of three residents reviewed for accidents. The facility census was 54.Findings include:Review of Resident #10's medical record revealed an admission date of 11/5/21. Diagnoses included acute and chronic congestive heart failure, acute and chronic respiratory failure, diabetes mellites, cerebral infarction, and acute pulmonary edema. Resident #10 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of Resident #10's care plan dated 12/03/24 revealed the resident was at risk for falls due to decreased strength and endurance and a history of falls. Listed interventions included encouraging the resident to keep his self-releasing seat belt buckled when in chair and to provide resident education on safety interventions. Resident #10 had an activities of daily living (ADL) self-care performance deficit. Listed interventions included assisting residents with ADLs as needed, providing two-person assistance for bed mobility, transfers and toileting, utilizing a Hoyer (mechanical) lift for transfers and motorized wheelchair use for ambulation, and reporting changes in ADL abilities to the nurse, physician, and therapy. Review of Resident #10's quarterly Minimum Data Set (MDS) assessment, dated 08/22/25, revealed Resident #10 was cognitively intact. He required extensive assistance from two staff members for bed mobility and required the use of a mechanical lift to move to and from bed to chair. Resident #10 utilized an electric wheelchair for mobility. Review of an incident report dated 08/25/25, at 9:30 A.M., revealed Transportation Specialist (TS) #101 called and reported, during transport with Resident #10, a car in front of her slammed on their brakes causing her to slam on her brakes and Resident #10 flipped forward in his wheelchair. She reported that she did secure Resident #10's wheelchair locks to the floor of the van. Review of an Emergency Medical Services (EMS) incident report dated 08/25/26 revealed EMS arrived on the scene at 9:38 A.M. and documented the patient (Resident #10) was secured in a power chair while being transported via a transport van. The van made a sudden stop and caused the secured wheelchair to break free. The patient flipped forward while secured to the wheelchair and landed on his right side with the wheelchair attached. The patient complained of right arm pain. The patient was paraplegic and denied loss of consciousness, head or neck pain at time of the initial assessment. The patient had a small laceration and swelling to his right eye and bleeding that subsided prior to arrival at the hospital. Review of the Emergency Doctor's Provider Notes dated 08/25/25 at 10:17 A.M. revealed Resident #10 had a history of a cardiovascular accident (stroke) presented to a local emergency department (ED) as a level 2 trauma after falling out of his wheelchair and striking his head when in transport as the vehicle came to a sudden stop. He denied loss of consciousness. Resident #10 was on blood thinners. He had an abrasion and slight swelling along his right eye. Resident #10 endorsed low back pain and right arm pain. All imaging tests were negative for acute fractures, however, Resident #10 was having significant lower back pain. He was admitted for pain control and ongoing monitoring. Review of the hospital Trauma Physician's progress notes, dated 08/25/25 at 8:34 P.M. revealed Resident #10 was in a wheelchair strapped to a van when it came to a sudden stop. The strap broke and he fell out of his chair and hit his head. Resident #10 complained of significant back pain and had an abrasion and slight swelling to the right side of his face. Computed tomography (CT) scan and x-ray imaging were negative but Resident #10 was being admitted to observation for pain control and physical and occupational therapy. The note referenced the resident was admitted with risk variables including coagulation defect, chronic fatigue and reduced mobility. Review of the nursing progress notes dated 08/25/25 revealed Resident #10 was out to a doctor's appointment. The notes revealed no indication of an accident or that Resident #10 was admitted to the hospital until 08/26/25 at 12:00 A.M. when the hospital called the floor nurse to verify the resident's information and the equipment he routinely used. Review of a summary of the incident dated 08/25/25, authored by the Administrator, revealed TS #101 had reported and described the incident to her. TS #101 stated the resident was utilizing his own wheelchair seatbelt, so the vehicle's seatbelt was not needed. The summary referenced following the