

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/27/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Galion		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to timely complete nutritional assessments and requests to obtain resident weights to monitor and provide intervention for continued weight increases. This affected one (#28) of three residents reviewed for nutrition and weights. The census was 48. Findings Include: Review of the medical record for Resident #28 revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic kidney disease, unspecified convulsions, hypothyroidism, morbid obesity, type II diabetes, chronic obstructive pulmonary disease, dysphagia, muscle weakness, anxiety disorder, and major depressive disorder. Review of Resident #28's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. Review of Resident #28's weights, dated April 2025 to October 2025, revealed on 04/01/25 the resident weighed 286.6 pounds and on 05/01/25 the resident weighed 302.6 pounds, which represented a 5.6 percent (%) weight increase in one month. Review of Resident #28's nutritional note dated 05/06/25 revealed a request from Dietitian #200 to obtain a re-weight for Resident #28 due to a significant increase. The next weight was not taken until 06/01/25. Review of Resident #28's weights revealed on 06/01/25 the resident weighed 310.8, which represented an additional 2.7% weight increase over the month. On 08/01/25, Resident #28 weighed 317.0 pounds and on 09/01/25 she weighed 338.4 pounds, which represented a 6.8% weight increase over one month. Review of Resident #28's nutritional note dated 09/16/25 revealed Dietitian #200 requested a re-weight to be taken due to the significant weight gain. Also, Dietitian #200 indicated she would complete a full nutritional assessment once the re-weight was obtained. The re-weight was not obtained until 10/01/25, which reflected another significant increase. Review of Resident #28's weight obtained on 10/01/25, revealed the resident weighed 370.0 pounds, for an additional 9.3% weight gain over one month. Review of Resident #28's full nutritional assessments dated between February 2025 to October 2025 revealed an annual nutritional assessment was completed, which reflected her weight as 286.6 pounds. There was not another full nutritional assessment completed after any of the significant weight increases were identified. Interview with Certified Nurse Aide (CNA) #213 on 10/27/25 at 1:25 P.M. stated the nurse aides obtain resident weights on a monthly or as needed/requested basis. The nurse aides receive directions from the nurses if the nurse aides need to get a re-weight for a particular resident. CNA #213 stated if a re-weight was completed, it was documented as a separate entry in the resident's medical record. CNA #213 confirmed the nurse aides or nurses can put the weights in the electronic medical record (EMR) and she does not factor or determine if a resident has a significant weight change as the dietitian will determine that. Interview with Dietitian #200 on 10/27/25 at 2:35 P.M. confirmed the re-weights from her requests on 05/06/25 and 09/16/25 were not completed in a timely manner for Resident #28. Dietitian #200 stated he preferred any re-weight be completed within a week of her request, and she confirmed the re-weights requests for Resident #28 were not timely. She also had a preference if there was a significant weight change noted in the medical record at the time nursing staff entered it into the electronic medical record, that she was notified about it. Dietitian #200 confirmed she would do a full nutritional assessment every six months, annually, and when there was a significant change. She confirmed there had not been a full nutritional assessment completed since February 2025 for Resident #28. Review of the facility weight assessment and intervention policy, dated September 2021, revealed the nursing staff will measure resident weights on admission, and at least monthly unless otherwise ordered by the physician. The dietitian will review the weights to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change have been met. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the resident's target weight range, approximate calorie, protein, and other nutrient needs compared with the resident's current intake, the relationship between current medical condition or clinical situation and recent fluctuations in weight, and whether and to what extent weight stabilization or improvement can be anticipated. Care planning for weight loss or impairment will be a multidisciplinary effort and will include the interdisciplinary team (IDT). The dietitian will discuss undesired weight gain with the resident and/or family. Interventions for undesired weight gain should consider resident preferences and rights. If a resident declines to participate in a weight loss goal, the dietitian will document the resident's wishes, and those wishes will be respected. This deficiency represents non-compliance investigated under Complaint Number 2643992</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and resident and staff interview, the facility failed to obtain ordered medications to administer to residents. This affected one (#28) of three residents reviewed for medication administration. The facility census was 48. Findings include: Review of the medical record revealed Resident #28 was admitted on [DATE] with diagnoses that included chronic kidney disease, unspecified convulsions, morbid obesity, type II diabetes mellitus, anxiety disorder, major depressive disorder, and lymphedema. Review of a plan of care dated 03/24/25 revealed Resident #28 had the potential for pain. Interventions included to administer medications per physician orders, encourage the resident to request pain medication before the pain becomes too intense, and to monitor for changes in usual activities. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact and did not receive opioid medication. Review of a nursing progress note dated 10/09/25 at 4:40 P.M. revealed Resident #28 was admitted to the hospital for hyperkalemia. Review of an admission progress note dated 10/13/25 at 4:45 P.M. revealed Resident #28 returned to the facility on [DATE] at 4:45 P.M. Review of a physician order dated 10/13/25 at 4:20 P.M., created by Regional Director of Nursing #300, revealed Resident #28 was ordered pregabalin (an anticonvulsant medication commonly used to treat nerve pain and certain types of seizures) 75 milligrams (mg) twice a day for neuropathy. Review of the medication administration record (MAR) revealed Resident #28 did not receive pregabalin 75 mg on 10/13/25 at 8:00 P.M. through 10/20/25 at 8:00 A.M. Resident #28 received pregabalin 75 mg on 10/20/25 at 8:00 P.M. through 10/22/25 at 8:00 A.M. Resident #28 did not receive pregabalin 75 from 10/22/25 at 8:00 P.M. through 10/27/25 at 8:00 A.M. Review of the resident's progress notes revealed pregabalin was not available on 10/13/25 through 10/20/25 and 10/22/25 through 10/27/25. Review of a nursing progress note dated 10/19/25 at 4:16 P.M. revealed the pharmacy requested a new prescription for pregabalin 75 mg twice a day. The pharmacy indicated pregabalin could not be filled without a new prescription. The on-call certified nurse practitioner (CNP) was contacted, and a three-day supply prescription was sent to pharmacy. Nursing staff were to follow up with the primary care physician or CNP for the need of a new prescription. Review of a triage note dated 10/20/25 at 12:59 A.M. revealed Resident #28 was readmitted to the facility. The resident's pregabalin was changed from 100 mg twice a day to 75 mg twice a day. The pharmacy had not filled this particular script yet. The pharmacy indicated they have not received a new prescription to indicate the change in dosage. The CNP was notified about the dosage change and the need for the new prescription. An interview on 10/27/25 at 1:30 P.M. with Resident #28 stated she did not know why her pain medication was stopped. Resident #28 stated the medication was stopped when she returned from the hospital. An interview on 10/27/25 at 3:16 P.M. with Regional Director of Nursing #300 stated the pharmacy would not send Resident #28's pregabalin without a prescription. Regional Director of Nursing #300 stated the facility CNP indicated the prescription had been sent but the pharmacy responded they never received the prescription. Regional Director of Nursing #300 verified Resident #28 received pregabalin on 10/20/25 through 10/22/25 because an on-call CNP ordered the pregabalin. The on-call doctors/CNPs would only order medications for three days so the facility doctor/CNP could make the decision whether to continue the medication. Regional Director of Nursing #300 verified Resident #28 did not receive pregabalin 75 mg from 10/13/25 at 8:00 P.M. through 10/20/25 at 8:00 A.M. and from 10/22/25 at 8:00 P.M. through 10/27/25 at 8:00 A.M. as ordered. This deficiency represents non-compliance investigated under Complaint Number 2643992.</p>		