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	12/11/2025

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

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	12/11/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative interview, staff interviews, record review, and review of the facility policy, the facility failed to inform a resident's resident representative of a incident involving the resident. This affected one (Resident #37) of three residents reviewed for being informed of health condition. The facility census was 51. Findings include:Record review for Resident #37 revealed an admission date of 11/05/21. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and cognitive communication deficit.Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was severely cognitively impaired. The medical record revealed Resident #37's son was the responsible party and Emergency Contact #1.The progress note dated 12/03/25 (Wednesday) completed by Director of Nursing (DON) revealed a Certified Nursing Assistant (CNA) reported to nurse Resident #37 had a skin tear on top of right foot. Upon assessment, skin tear was red with flap intact 1.0 centimeters (cm) (in length) by four cm (in width) by one cm (in depth) with moderate amount of bleeding noted. The CNA reported Resident #37 was being transferred into chair with mechanical lift and his foot got hit with the bar of the lift causing a skin tear. There was no documentation the resident's representative was notified of the new skin tear.The physician orders for Resident #37 dated 12/08/25 revealed an order for wound care to right foot cleanse with normal saline and pat dry, apply calcium alginate with silver, cover with boarder gauze daily and as needed. There was no documentation the resident's representative was notified of the new order.During a telephone interview on 12/09/25 at 2:26 P.M. with Resident #37's son confirmed he was Resident #37's responsible party/emergency contact #1. Resident #37's son revealed he went to the facility on [DATE] (Saturday) to visit his dad. His dad was going on something about his foot getting hurt. At that time, he was told by a staff member that on Wednesday they used a lift to transfer his dad, he hit his foot causing a wound. Resident #37's son revealed that it was Saturday, 12/06/25 when he was told, the injury occurred the previous Wednesday (12/03/25) and confirmed no one from the facility called to inform him and he was never made aware of the wound until Saturday when he asked. Resident #37's son/Responsible Party revealed he was not aware of any other wounds on Resident #37.During an interview on 12/09/25 at 3:50 P.M., Assistant Director of Nursing (ADON) #231 revealed she never notified Resident #37's family because Resident #37 was alert and oriented. ADON #231 stated sometimes Resident #37 was and sometimes he was not but they have known him three years and he can use his telephone so she notifies him not anyone else.During an interview on 12/09/25 at 3:57 P.M., Regional Director of Clinical Services (RDCS) #271 revealed the resident's responsible party should be notified of a change in condition, new medications, an incident or accident if the resident themselves are not the first contact. During an interview on 12/10/25 at 10:15 A.M., the DON and ADON #231 confirmed Resident #37's responsible party was not notified timely of the new wound to the right foot. The DON revealed she thought Resident #37 was his own responsible party and did not look at the information to see Resident #37's son was the responsible party. The DON confirmed Resident #37's responsible party should have been made aware of the incident at that time. ADON #231 stated she didn't agree the family should be updated because sometimes he was not confused, it comes and goes. Interview on 12/10/25 at 11:25 A.M. with Director of Rehabilitation (DOR) #269 and Physical Therapy Assistant (PTA) #270 stated Resident #37 was alert and oriented to self only, sometimes to place but not always, he had no concept to time, some days he would recognize them, and other days he did not. Review of the facility's undated policy titled Change in a Resident's Condition or Status revealed the facility notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury. Except in medical emergencies, notification will be made within 24 hours of a change occurring in his/her medical care or nursing treatments.This was an incidental finding discovered during the course of the complaint investigation.

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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident, family, and staff interviews, and record review, the facility failed to ensure a pleasant homelike environment free of frequent strong foul odors of urine on the North and South units of the facility and failed to ensure the resident's wheelchairs were clean. This had the potential to affect 38 residents residing on the North and South units and affected three (Residents #25, #40, and #43) of four residents whose wheelchairs were observed for cleanliness. The facility census was 51.Findings include: 1. Observation and interview on 12/08/25 at 2:48 P.M. revealed a strong foul odor of urine upon entering the facility. Tour of the facility confirmed the strong odor was throughout the North and South resident living areas. The Director of Nursing (DON) confirmed the odor. Observations and interviews on 12/08/25 at 3:00 P. M. with Resident #17, at 3:06 P.M. with Resident #24, at 3:24 P.M. with Resident's husband revealed the hallways had a strong foul odor of urine. Observations and interviews on 12/09/25 at 9:21 A.M. with Licensed Practical Nurse (LPN) #248 and at 10:37 A.M. with Certified Nursing Assistant (CNA) #245 confirmed the foul lingering odor of urine on the North and South resident living areas.Observations and interviews on 12/09/25 at 8:30 A.M. with LPN #219, at 8:50 A.M. with Housekeeping #222, at 10:45 A.M. with CNA #217, and at 3:40 P.M. with the DON confirmed the strong foul odor of urine continued to linger throughout the North and South resident areas.2. Record review for Resident #25 revealed an admission date of 08/05/22. Diagnoses included age related cataract and muscle weakness.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was moderately cognitively impaired and used a wheelchair for mobility.Observation on 12/08/25 at 3:09 P.M. revealed Resident #25's frame of his wheelchair and his footrests had a thick coating of grime, dust and dirt. CNA #245 confirmed the dirty wheelchair and revealed the night shift was supposed to clean them, but they do not. Observation on 12/10/25 at 11:45 A.M. with CNA #236 confirmed Resident #25's frame of his wheelchair and his footrests continued to have a thick coating of grime, dust and dirt.3. Record review for Resident #40 revealed an admission date of 09/13/19. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and muscle weakness. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was severely cognitively impaired and used a wheelchair for mobility.Observation and interview on 12/08/25 at 3:24 P.M. revealed Resident #40 was lying in bed and Resident #40's husband was present at the bedside. Resident #40's wheelchair frame had a thick layer of dust and grime. There were dried spills on the foot pedals and seat. Resident #40's husband stated the staff never cleaned the wheelchair, and it was always like that.Observation on 12/10/25 at 11:52 A.M. with Certified Nursing Assistant (CNA) #236 confirmed Resident #40's wheelchair frame and leg rests had a thick layer of dust and grime along with dried unidentified spills on the foot pedals and seat.4. Record review for Resident #43 revealed an admission date of 08/03/23. Diagnosis included Parkinson's disease.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 was cognitively intact. Observation and interview on 12/08/25 at 3:27 P.M. revealed the entire visible area of the frame on Resident #43's electric wheelchair had a thick coating of dust and grime. The seat and foot cushions of the chair both had dried spills, food particles, and unidentified stains throughout both areas. Resident #43 revealed the staff never cleaned her chair.Observation on 12/10/25 at 11:48 A.M. with Certified Nursing Assistant (CNA) #236 confirmed Resident #43's wheelchair continued to have had a thick coating of dust and grime. The seat and foot cushions of the chair both had dried spills, food particles, and unidentified stains throughout both areas. Interview on 12/11/25 at 9:32 A.M. with the Administrator revealed wheelchairs were to be cleaned on resident shower days (twice weekly) and as needed.This deficiency represents non-compliance investigated under Complaint Number 2671070.

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	12/11/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to obtain urine outputs as physician ordered for a resident and failed to ensure a resident's new areas of skin breakdown were timely assessed and treated. This affected one (Resident #37) of three residents reviewed for quality of care. The facility census was 51.Findings include:Record review for Resident #37 revealed an admission date of 11/05/21. Diagnoses included diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cognitive communication deficit, muscle weakness, and lack of coordination.Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was severely cognitively impaired. Resident #37 had impairment on one side to the upper and lower extremities, was dependent on staff for toileting hygiene, bed mobility, frequently incontinent bowel and bladder, and had no skin ulcer/injury treatments. a. Review of the physician order dated 11/23/25 revealed Resident #37 had a indwelling catheter size 16 French and record urine output through the indwelling catheter every shift for urine retention.Review of the Medication Administration Record (MAR), the Treatment Administration Record (TAR) and the complete medical record for Resident #37 revealed no documentation or recordings of urinary output for Resident #37. Interview on 12/11/25 at 2:00 P.M. with Regional Director of Clinical Services (RDCS) #271 confirmed Resident #37 had no documentation in the medical record or anywhere else that had been found. RDCS #271 revealed Resident #37's urine output should have been documented in the medical record per the physician orders.b. Review of the Wound Evaluation Note dated 12/01/25 at 3:45 P. M. completed by Wound Care Nurse #231 revealed incontinence associated wound to the buttocks was resolved.Record review for Resident #37 revealed no documentation of current wounds or treatment to the buttocks.Observation on 12/09/25 at 10:53 A.M. of incontinence care for Resident #37 provided by Certified Nursing Assistants (CNAs) #217 and #246 revealed multiple small, scabbed areas to the right scrotum. The entire peri area between both thighs had a large amount of crusty white residue; CNA #246 attempted to clean the white crusty residue but was unable to get it all. The tissue in the peri area including the scrotum and buttocks was deep red. Resident #37 also had an open area to the posterior right upper thigh, the right buttocks, and the coccyx. Resident #37 groaned during peri care and confirmed the wounds were painful to touch. CNA #246 applied A&D ointment to the open wounds on the buttocks and applied antifungal powder to the peri area over the dried remaining crusty areas. CNA #246 revealed the open wounds to Resident #37 buttocks, thigh and coccyx were there for over a week. Interview on 12/10/25 at 9:17 A.M. with Licensed Practical Nurse (LPN) #233 confirmed she was Resident #37's primary care nurse. LPN #233 revealed Resident #37 had a wound to the right foot and left leg but no other wounds. LPN #233 reviewed Resident #233's orders and progress notes and confirmed there were no other wounds.Observation on 12/10/25 at 9:35 A.M. of incontinence care for Resident #37 with CNA #225 and #246 verified Resident #37 continued to have three open wounds, an open area to the posterior right upper thigh, the right buttocks and the coccyx. The buttocks and peri area remained red. CNA #246 applied zinc oxide to the open areas. CNA #246 revealed the wounds had been there over a week and revealed they just take care of the wounds, they report what was new, and they know what was new and what was not.Interview on 12/10/25 at 9:45 A.M. with Wound Care Nurse #231 revealed Resident #37's wound to his sacrum resolved 12/01/25 and stated if Resident #37 has something new, she did not know about it. Wound Care Nurse #231 stated she would expect staff to let her or the floor nurse know. Wound Care Nurse #231 confirmed Resident #37 had no treatment orders or documentation of wounds to the thigh, buttocks, coccyx or scrotal areas. This was an incidental finding discovered during the complaint investigation.

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	12/11/2025

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 - Minimal harm or potential for 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)

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	12/11/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure a resident was safely transferred using a mechanical lift (Hoyer). This affected one (Resident #37) of two residents reviewed for transfers. The facility census was 51.Findings include:Record review for Resident #37 revealed an admission date of 11/05/21. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, morbid, severe obesity, cognitive communication deficit, muscle weakness, lack of coordination, and need for assistance with personal care.Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was severely cognitively impaired, had impairment on one side to the upper and lower extremities, and was dependent on staff for bed mobility. Review of the care plan dated 12/03/24 revealed Resident #37 had an activity of daily living self-care performance deficit related to impaired mobility, shortness of breath, hemiplegia, hemiparesis and weakness. Interventions included Resident #37 required two-person assistance for transfers.Review of Resident #37's progress note dated 12/03/25 at 1:07 P.M. completed by the Director of Nursing (DON) revealed Certified Nursing Assistant (CNA) reported to the nurse that Resident #37 had (new) skin tear on top of right foot. Upon assessment, skin tear was red with a flap intact measuring 1.0 centimeters (cm) (in length) by four cm (in width) by one cm (in depth) with moderate amount of bleeding noted. The CNA reported Resident #37 was being transferred into chair with mechanical lift and his foot got hit with the bar of the lift causing a skin tear.Review of the physician orders for Resident #37 revealed on 12/08/25, an order for wound care to right foot cleanse with normal saline and pat dry, apply calcium alginate with silver, cover with boarder gauze daily and as needed. Interview on 12/09/25 at 3:50 P.M. with Assistant Director of Nursing (ADON) #231 confirmed on 12/03/25 Resident #37 obtained an injury during a transfer with the mechanical lift. LPN #231 revealed CNA #225 was one of the CNAs present during the transfer. Telephone interview on 12/09/25 at 4:11 P.M. with CNA #225 revealed on 12/03/25, CNA #246 and herself were transferring Resident #37 from his chair to bed, and they were using the Hoyer lift. They went to transfer Resident #37 and his foot got caught under the foot pedal of his chair. CNA #225 was distracted, Resident #37 was going up with him in the sling, his foot was caught under his foot rest, he was saying something, I was distracted and did not pay attention. CNA #225 looked down and there was blood on the floor. CNA #225 stated she was distracted because CNA #236 won't assist South unit, which CNA #225 worked South unit. CNA #236 stated South unit had a heavy work load and CNA #236 won't help her out. CNA #236 reported she was distracted and upset, felt rushed, and didn't pay attention.Interview and observation on 12/10/25 at 8:45 A.M. with CNA #246 revealed on 12/03/25. therapy requested requested staff to lay Resident #37 back down in bed. CNA #246 stated she was at the top of the chair holding Resident #37's head up, because the chair did not have a headrest and he was having a hard time holding his head up. CNAs #225 and #246 got him hooked up to the mechanical lift. CNA #225 hooked the bottom half, CNA #225 started lifting Resident #37 up in mechanical lift, and Resident #37 started screaming 'ouch'. CNA #225 looked said oh no. Observation with CNA #246 revealed Resident #37 had a bariatric manual wheelchair and the wheelchair did not have a head rest. CNA #246 revealed Resident #37's previous chair had a head rest which he used while he was up in the chair and the new chair was a facility chair given to him by therapy. CNA #246 revealed normally she would have been able to walk around the chair to ensure everything was clear but that time she couldn't because she had to hold Resident #37's head during the entire transfer. Observation on 12/10/25 at 9:40 A.M. of wound care to Resident #37's right foot provided by ADON #231 revealed the right foot had a large skin tear surrounded by dark bruising. The flap of the skin tear on top the right foot was not intact, the wound bed was exposed and actively bleeding after removal of the dressing. Resident #37 moaned throughout the wound care and confirmed the wound was painful.Interview on 12/10/25 at 11:25 A.M. with Director of Rehab (DOR) #269 and Physical Therapy Assistant (PTA) #270 confirmed Resident #37 had a different wheelchair, and it was not his personal chair. DOR #269 revealed Resident #37's personal wheelchair was electric and had a headrest. Resident #37 had a decline, so the therapist placed him in a manual wheelchair that was available. DOR #269 confirmed Resident #37's personal wheelchair had a headrest, the one provided did not have one available. DOR #269 revealed the day the CNAs got him up, they were trialing the new chair, when they started the trial, Resident #37 could hold his head up, he got tired and couldn't hold it up anymore, so they asked the CNAs to put him to bed, and the CNA had to hold his head for him. This deficiency represents

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	12/11/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, review of the facility policy, and review of the insulin pen guidance, the facility failed to ensure their medication error rate did not exceed five percent (%). Two errors occurred within 27 opportunities for an error rate of 7.4%. This affected one (Resident #40) of five residents observed for medication administration. The facility census was 51.Findings include:Record review for Resident #40 revealed an admission date of 09/13/19. Diagnoses included type II diabetes mellitus (DM). Review of the care plan dated 04/27/25 revealed Resident #40 had an impaired metabolic status related to DM. Interventions included to administer medications as indicated by physician orders.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was severely cognitively impaired, had a diagnosis of DM and received daily injections.Review of the physician orders for December 2025 for Resident #40 included orders for Basaglar Kwikpen subcutaneous (sq) solution pen injector 100 units per milliliter (ml) inject six units sq two times a day related to DM and was to be administered at 7:00 A. M. and 7:00 P.M. An additional order included admelog solostar sq solution pen injector 100 units per ml inject as per sliding scale sq before meals for DM. The sliding scale indicated for a blood sugar of 251 to 300 administer six units. The insulin was to be administered at 8:00 A.M., 11:00 A.M., and 4:00 P.M.Observation of medication administration on 12/09/25 at 10:28 A.M. with Registered Nurse (RN) #221 revealed Resident #40's blood sugar was checked at 6:20 A.M. and the blood sugar result was 251. RN #221 revealed Resident #40 ate her breakfast at 7:30 A.M. and ate 100% of intake. RN #221 took the insulin pen admelog solostar kwikpen out of the medication cart, placed a new needle on the end of the pen and dialed in six units. RN #221 never primed the insulin pen. RN #221 then took the basaglar kwikpen out of the medication cart, placed a new needle on the end of the insulin pen and dialed in six units. RN #221 never primed the insulin pen. RN #221 then administered both insulin pens to Resident #40 sq.Interview on 12/09/25 at 10:35 A.M. with RN #221 verified he never primed either insulin pen prior to administering them to Resident #40 and revealed he only primed insulin pens if they were brand new and never used prior. RN #221 revealed he would prime them with four units of insulin if they were brand new.Interview on 12/09/25 at 11:56 A.M. with the Director of Nursing (DON) revealed an insulin pen should be primed before each use. Interview on 12/09/25 at 2:11 P.M. with DON and RN #221 together confirmed the insulin administered to Resident #40 at 10:28 A.M. was the ordered morning dose. RN #221 confirmed the Basaglar insulin was to be administered at 7:00 A.M. and the admelog solostar insulin was to be administered at 8:00 A.M., 11:00 A.M., and 4:00 P.M. ; RN #221 revealed he did not administer the admelog solostar 11:00 A.M. dose yet because he gave the morning dose so late he decided to wait to administer the 11:00 A.M. dose. The DON confirmed medications should be administered per physicians orders. Review of the facility's undated policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. Review of the undated insulin pen instruction manual titled, Instruction for Use for both admelog solostar and Basaglar insulin pens for use guidance revealed to attach a new needle to the pen. Always do a safety test (Priming) before each injection to check your pen and the needle to make sure they are working properly and to make sure you get the correct insulin dose. Select two units by turning the dose selector until the dose pointer is at the two mark, press the injection button all the way in, when insulin is coming out of the needle tip, your pen is working correctly. If no insulin appears, you may need to repeat this step up to three times before seeing insulin. If no insulin comes out after the third time the needle may be blocked. If this happens change the needle and repeat the safety check. After the safety check is complete, select the dose to administer.This was an incidental finding discovered during the complaint investigation.

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	12/11/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, review of the facility policy, and review of the insulin pen guidance, the facility failed to ensure a resident was free from significant medication errors when nursing failed to prime insulin pens prior to insulin administration. This affected one (Resident #40) of five residents observed for medication administration. The facility census was 51.Findings include: Record review for Resident #40 revealed an admission date of 09/13/19. Diagnoses included type II diabetes mellitus (DM). Review of the care plan dated 04/27/25 revealed Resident #40 had an impaired metabolic status related to DM. Interventions included to administer medications as indicated by physician orders.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was severely cognitively impaired, had a diagnosis of DM and received daily injections.Review of the physician orders for December 2025 for Resident #40 included orders for Basaglar Kwikpen subcutaneous (sq) solution pen injector 100 units per milliliter (ml) inject six units sq two times a day related to DM and was to be administered at 7:00 A. M. and 7:00 P.M. An additional order included admelog solostar sq solution pen injector 100 units per ml inject as per sliding scale sq before meals for DM. The sliding scale indicated for a blood sugar of 251 to 300 administer six units. The insulin was to be administered at 8:00 A.M., 11:00 A.M., and 4:00 P.M.Observation of medication administration on 12/09/25 at 10:28 A.M. with Registered Nurse (RN) #221 revealed Resident #40's blood sugar was checked at 6:20 A.M. and the blood sugar result was 251. RN #221 revealed Resident #40 ate her breakfast at 7:30 A.M. and ate 100% of intake. RN #221 took the insulin pen admelog solostar kwikpen out of the medication cart, placed a new needle on the end of the pen and dialed in six units. RN #221 never primed the insulin pen. RN #221 then took the basaglar kwikpen out of the medication cart, placed a new needle on the end of the insulin pen and dialed in six units. RN #221 never primed the insulin pen. RN #221 then administered both insulin pens to Resident #40 sq.Interview on 12/09/25 at 10:35 A.M. with RN #221 verified he never primed either insulin pen prior to administering them to Resident #40 and revealed he only primed insulin pens if they were brand new and never used prior. RN #221 revealed he would prime them with four units of insulin if they were brand new.Interview on 12/09/25 at 11:56 A.M. with the Director of Nursing (DON) revealed an insulin pen should be primed before each use. Interview on 12/09/25 at 2:11 P.M. with DON and RN #221 together confirmed the insulin administered to Resident #40 at 10:28 A.M. was the ordered morning dose. RN #221 confirmed the Basaglar insulin was to be administered at 7:00 A.M. and the admelog solostar insulin was to be administered at 8:00 A.M., 11:00 A.M., and 4:00 P.M. ; RN #221 revealed he did not administer the admelog solostar 11:00 A.M. dose yet because he gave the morning dose so late he decided to wait to administer the 11:00 A.M. dose. The DON confirmed medications should be administered per physicians orders. Review of the facility's undated policy titled Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. Review of the undated insulin pen instruction manual titled, Instruction for Use for both admelog solostar and Basaglar insulin pens for use guidance revealed to attach a new needle to the pen. Always do a safety test (Priming) before each injection to check your pen and the needle to make sure they are working properly and to make sure you get the correct insulin dose. Select two units by turning the dose selector until the dose pointer is at the two mark, press the injection button all the way in, when insulin is coming out of the needle tip, your pen is working correctly. If no insulin appears, you may need to repeat this step up to three times before seeing insulin. If no insulin comes out after the third time the needle may be blocked. If this happens change the needle and repeat the safety check. After the safety check is complete, select the dose to administer.This was an incidental finding discovered during the coure of the complaint investigation.

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	12/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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	12/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, review of manufacturer instructions, review of Centers for Disease Control and Prevention (CDC) guidance, and review of the facility policies, the facility failed to maintain infection control practices while administering medications to the residents, completing hand hygiene when providing care to the residents, donning proper personal protective equipment (PPE) and completing proper hand hygiene for residents on Enhanced Barrier Precautions (EBP) for indwelling devices, and disinfecting a glucometer between use for Residents #4 and #5. This affected six residents (#4, #5, #34, #37, #40, and #47) observed for infection control. The facility census was 51.Findings include:1. Observation of medication administration and staff interview on 12/09/25 at 10:28 A.M. revealed after Registered Nurse (RN) #221 exited Resident #34's room, RN #221 did not wash his hands or use hand sanitizer. RN #221 returned to the medication cart and prepared Resident #40's insulin injections, Basaglar kwikpen and admelog solostar for administration. RN #221 re-entered Resident #40's room, placed gloves on (did not wash hands or use hand sanitizer prior to glove use) then administered the insulin injections to Resident #40. RN #221 then exited the room with the same gloves and returned to the medication cart, placed the used insulin syringes on top the cart, removed his gloves then put insulin pens back in the medication drawer without washing his hands or using hand sanitizer. RN #221 confirmed all the above findings. 2. Record review for Resident #47 revealed an admission date of 10/23/25. Diagnoses included retention of urine. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was severely cognitively impaired and had an indwelling catheter. Review of the care plan for Resident #47 revealed Resident had a need for indwelling catheter related to urinary retention. Interventions included catheter bag to be emptied every shift.Observation on 12/09/25 at 10:46 A.M. revealed Certified Nursing Assistant (CNA) #217 entered Resident #47's room. There was signage on Resident #47's door for EBP. CNA #217 did not don an isolation gown, placed gloves on and did not wash or sanitize her hands prior to glove use. CNA #217 proceeded to empty Resident #47's indwelling catheter bag of urine. CNA #217 then exited Resident $47's room without washing or sanitizing her hands. CNA #217 then entered Resident #37's room. Interview on 12/09/25 at 11:12 A.M. with CNA #217 confirmed she did not wash her hands or use hand sanitizer before or after providing care for Resident #47 and confirmed she never donned an isolation gown before providing catheter care for Resident #47.3. Record review for Resident #37 revealed an admission date of 11/05/21. Diagnoses included acute and chronic respiratory failure and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was severely cognitively impaired. Review of the physician orders for Resident #37 revealed an order dated 11/23/25 for indwelling catheter care every shift and as needed. Review of the care plan dated 12/03/25 revealed Resident #37 had a need for a indwelling catheter. Interventions included EBP.Observation on 12/09/25 at 10:53 A.M. revealed Certified Nursing Assistant (CNA) #217 entered Resident #37's room. There was signage on Resident #37's door for EBP. CNA #217 did not don an isolation gown, placed gloves on and did not wash or sanitize her hands prior to glove use. CNA #217 removed Resident #37's brief and initiated catheter care. Licensed Practical Nurse (LPN) #219 entered the room, placed gloves on, no gown, then assessed Resident #37's peri area for skin breakdown. LPN #219 touched several areas of Resident #37's peri area while assessing skin breakdown. CNA #217 completed catheter care. LPN #219 then used hand sanitizer and exited the room. CNA #246 entered the room to assist to turn Resident #37 for incontinence care and instructed CNA #217 to place an isolation gown on.Interview on 12/09/25 at 11:12 A.M. with CNA #217 confirmed she did not wash her hands or use hand sanitizer before or after providing care for Resident #37 and confirmed she never donned an isolation gown before providing catheter care for Resident #37.4. Observation and interview on 12/09/25 at 11:15 A.M. revealed Medication Technician (MT) #223 was going to complete blood sugar assessment via fingerstick glucometer for two residents, Residents #4 and #5. MT #223 removed the glucometer from the top drawer of the medication cart and there was one glucometer and MT #223 confirmed she utilized the same glucometer for Residents #4 and #5. MT #223 obtained the glucometer, two glucometer strips several alcohol wipes and two lancets. MT #223 never cleaned the glucometer prior to use. MT #223 gathered the supplies and entered Resident #4's room, applied gloves and assessed Resident #4's blood sugar via fingerstick. MT #223 then exited the room without removing her gloves, cleansing her hands