| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365679 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Signature Healthcare of Fayette County | 375 Glenn Avenue<br>Washington Court Hou, OH 43160 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview, and review of facility policy and procedures, the facility failed to ensure the personalized air conditioner (PTAC) in Resident #55's room was maintained in a clean manner and the facility also failed to maintain plumbing in Resident #48's bathroom to prevent leaking. This affected two residents (#48 and #55) of 30 residents in the sample. The facility census was 64.<br><br>Findings include<br><br>1. Review of the medical record for Resident #55 revealed an admission date of 07/30/24. Diagnoses included epilepsy, anxiety, dementia, diabetes, psychotic disorder and heart failure.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 was cognitively impaired with a Brief Interview of Mental Status (BIMS) of 05.<br><br>Interview and observation on 06/16/25 at 10:33 A.M. with Resident #55 confirmed PTAC machine was visibly dirty and had a thick layer of dust on the vent. Resident turned on the PTAC air conditioner and a foul (trash like) smell came from the unit.<br><br>Interview and observation on 06/17/25 at 3:25 P.M. with Resident #55 revealed the PTAC and vent had not been cleaned with large pieces of debris and a thick layer of dust.<br><br>Interview and observation 06/17/25 at 3:31 P.M. with Maintenance Director #110 confirmed PTAC unit was dirty with large pieces of debris and a thick layer of dust. He revealed he was responsible for care and maintenance of the PTAC unit.<br><br>Review of the undated facility policy titled Housekeeping/Environment Services revealed cleaning schedules shall be developed and implemented to assure each area of the facility was maintained.<br><br>2. Review of the medical record for Resident #48 revealed an admission date of 03/04/25. Diagnoses included pulmonary disease, heart disease, and visual loss.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and observation on 06/17/25 at 3:25 P.M. with Resident #48 revealed the bathroom had a leak and when you stepped on the flooring, water beads would seep through the cracks between the floorboards.<br><br>Interview and observation 06/17/25 at 3:31 P.M. with Maintenance Director #110 confirmed the water beads coming up from bathroom flooring in Resident #48's room.<br><br>Review of the undated facility policy titled Housekeeping/Environment Services revealed cleaning schedules shall be developed and implemented to assure each area of the facility was maintained.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165179. |

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| F 0607<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on review of the employee files, staff interview, and review of the facility policy and procedure, the facility failed to complete employee reference checks prior to hire and failed to ensure documented evidence of written policies and procedures pertaining to screening potential new employees with employee reference checks prior to hire. This had the potential to affect all facility residents. The facility census was 64.<br><br>Findings include:<br><br>1. Review of the employee file for Certified Nursing Assistant (CNA) #120 revealed she began employment on 04/09/24. The employee file had no evidence of reference checks being completed prior to hire.<br><br>2. Review of the employee file for Certified Nursing Assistant (CNA) #124 revealed she began employment on on 05/31/25. The employee file had no evidence of reference checks being completed prior to hire.<br><br>3. Review of the employee file for Licensed Practical Nurse (LPN) #78 revealed she began employment on 06/08/25. The employee file had no evidence of reference checks being completed prior to hire.<br><br>4. Review of the employee file for Licensed Practical Nurse (LPN) #79 revealed she began employment around October 2024, the facility was unable to provide an exact start date. The employee file had no evidence of reference checks being completed prior to hire.<br><br>Interview on 06/24/25 at 3:30 P.M. with the Director of Nursing (DON) revealed reference checks were not in the employee files for CNA #120 and #124 and LPN #78 and LPN #79.<br><br>Interview on 06/24/25 at 4:20 P.M. with the Administrator and Director of Nursing (DON) confirmed the facility had no policy related to employee reference checks. The DON stated this company does not do reference checks.<br><br>5. Review of the facility policy titled, Abuse Investigation and Reporting, dated September 2021 revealed no written/documented evidence within the policy related to screening potential staff for a history of abuse, neglect, exploitation or misappropriation, including attempting to obtain information from previous employers and/or current employers.<br><br>Interview on 06/24/25 at 4:20 P.M. with the Administrator and Director of Nursing (DON) confirmed the facility had no policy related to employee reference checks. The DON stated this company does not do reference checks. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff interview, family interviews, review of hospital records, and review of the facility policy, the facility failed to ensure a resident, who was identified at risk of nutritional problems and malnutrition, maintained acceptable parameters of nutritional status, and failed to follow nutritional interventions, complete weekly weights as ordered, provide appropriate assistance with meals, and provide appropriate oversight and monitoring to address significant and severe weight loss for Resident #10. This affected one (#10) of five residents (#10, #21, #26, #34, and #35) reviewed for nutrition. The facility identified a total of eight residents (#10, #11, #21, #27, #33, #35, #46 and #58) as being at nutritional risk. The facility census was 64.<br><br>Findings include:<br><br>Review of the medical record for Resident #10 revealed an admission date of 03/01/24. Diagnoses included respiratory failure, dysphagia, atrial fibrillation, diabetes, muscle weakness, metabolic encephalopathy, and muscle wasting atrophy.<br><br>Review of Resident #10's medical record revealed no documented evidence of an admission nutritional assessment or admission risk assessment.<br><br>Review of Resident #10's weights revealed on 03/01/24 the resident weighed 318 pounds (lbs.) upon admission, on 08/03/24 the resident weighed 269.6 lbs., on 10/04/24 the resident weighed 255.8 lbs., on 11/06/24 the resident weighed 252.0 lbs., and on 12/07/24 the resident weighed 244.0 lbs.<br><br>Review of Resident #10's dietitian progress notes dated 12/18/24 revealed the resident's weight was trending down from 273 lbs. to 244 lbs. for a 10.6% weight loss in 180 days with 25 to 100% of intakes. Ice cream and pudding supplements were in place and weight loss was beneficial due to the residents' high Body Mass Index (BMI). The physician and nursing staff were notified of the weight loss.<br><br>Review of Resident #10's physician order dated 12/20/24 revealed a diet order for regular diet at regular consistency with double protein portions.<br><br>Review of Resident #10's physician orders revealed an order dated 12/23/24 for the resident to be assisted with meals due to pocketing food.<br><br>Review of Resident #10's weights revealed on 01/07/25 the resident weighed 239 lbs.<br><br>Review of the dietitian progress notes dated 01/08/25 revealed Resident #10's weight was trending down from 275 lbs. to 239 lbs. for a 13.1% loss in 180 days with gradual weight loss. Double protein portions were recommended although the resident voiced displeasure with the quality of the food. Intakes were variable at 25 to 100%. House shakes had also been added and ordered on 12/20/24 for lunch and dinner trays. The order was discontinued on 02/03/25 when the resident was hospitalized . The physician and nursing staff were notified of the weight loss.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of progress note dated 01/28/25 revealed upon assessment, Resident #10 had increased confusion and frequent involuntary movements. Vital signs included blood pressure 143/90 millimeters of mercury (mmHg) [normal ranges around 120/80 mmHg], respirations 19 breaths per minute (normal ranges from around 12 to 18) and pulse 87 beats per minute (bpm) [normal ranges from around 60 to 100]. The resident was maintaining oxygen saturation levels at 94 % on 3 liters of oxygen. After informing the nurse practitioner of findings, an order was received to send Resident #10 to the hospital for evaluation.<br><br>Review of the dietitian's progress notes dated 01/29/25 revealed Resident #10 had a weight loss of 12.9% over 180 days. Intakes were variable at 25 to 75% of meals. Weekly weights were to be added due to the need for close monitoring and follow-up. The most recent weight to this dietitian's note, was on 01/07/25 when the resident weighed 239 lbs.<br><br>Review of the plan of care dated 01/29/25 revealed Resident #10 had a nutritional problem or potential nutrition problem related to significant weight loss, feeding assistance, therapeutic diet, and meal refusals with interventions including to monitor, document and report signs and symptoms of dysphagia including pocketing, choking, coughing, drooling etc., monitor signs and symptoms of malnutrition including weight loss of over three pounds in one week, over five percent in one month, over seven and a half percent in three months, and over 10 percent in six months, to provide and serve diets as ordered, and dietitian to evaluate and make recommendations as needed. There was no documentation of a nutrition care plan prior to 01/29/25 and the care plan was not updated after the resident's weight loss, pureed diet order change or her hospitalization.<br><br>Review of Resident #10's hospital discharge summary revealed the resident was admitted to the hospital on [DATE] and discharged back to the facility on [DATE]. The summary also revealed the resident was evaluated for altered mental status, dysphagia, and aspiration. The hospital discharge diet recommendations were for a carb-controlled diet with pureed texture and thin liquids.<br><br>Review of physician orders dated 02/03/25 revealed Resident #10 had a diet order for a carb-controlled diet with pureed texture.<br><br>Review of Resident #10's weights revealed on 02/03/25 and 02/04/25, the resident weighed 241.3 lbs.<br><br>Review of Resident #10's physician orders dated 02/04/25 through 03/04/25 revealed an order for weekly weights.<br><br>Review of the dietitian's progress notes dated 02/12/25 revealed Resident #10's weight loss was trending down from 270 lbs. to 241.3 lbs. with a weight loss of 10.7% over 180 days. Resident #10 had returned from the hospital with a diet downgrade to pureed texture. Intakes were poor at less than 25 to 75% of meals consumed. It noted that Resident #10 needed assistance for feeding at times and weekly weights were to be continued for close monitoring and follow-up. There was no documented evidence in the medical record of the resident having a weight of exactly 270 lbs. per this dietitian's note.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had significant cognitive impairment with a Brief Interview of Mental Status (BIMS) of 03 indicating impaired cognition. The resident was noted as independent with eating and had previous significant weight loss and was not on a weight loss program.<br><br>Review of the physician note dated 03/03/25 revealed Resident #10 continued to require full assistance with activities of daily living including supervision during meals due to pocketing. She had chronic weight loss with a current weight of 239 lbs. It noted that Resident #10 had a history of poor oral intake due to food dissatisfaction but agreed to house shakes.<br><br>Review of Resident #10's weights revealed on 03/09/25 the resident weighed 217.4 lbs.<br><br>Review of Resident #10's physician orders dated 03/11/25 through 05/21/25 revealed an order for weekly weights.<br><br>Review of the dietitian's progress notes dated 03/12/25 revealed Resident #10 had a weight loss of 241 lbs. to 217.4 lbs. for a weight loss of 10% over 30 days. Resident #10 did not like the pureed texture, and intakes were low at 25 to 75% of meals. Med pass (supplement) was added three times daily as well as an appetite stimulant to improve intakes. The plan was to continue weekly weights for close monitoring and follow up.<br><br>Review of Resident #10's progress notes dated 03/12/25 revealed the physician was notified of the resident's significant weight loss. A new order was received for Mirtazapine (an appetite stimulant).<br><br>Review of Resident #10's physician orders revealed on 03/12/25 the resident was ordered Med Plus 2.0 three times daily for a supplement and Mirtazapine due to increased weight loss.<br><br>Review of Resident #10's Medication Administration Record (MAR) from March 2025 through June 2025 revealed the supplements and appetite stimulant were completed and offered as ordered. The Med Plus supplement was frequently refused or very little was consumed.<br><br>Review of Resident #10's weights revealed on 03/18/25 the resident weighed 216.6 lbs. and on 04/06/25 the resident weighed 217.8 lbs.<br><br>Review of the dietitian's progress notes dated 04/09/25 revealed Resident #10 had a weight loss of 14.8% over 180 days. Resident #10 required assistance at times with meals. The plan was to continue weekly weights for close monitoring and follow up.<br><br>Review of the dietitian's progress notes dated 04/29/25 revealed Resident #10 had a weight loss of 14.9% over 180 days. Resident #10 required assistance at times with meals. The plan was to continue weekly weights for close monitoring and follow up. The most recent weight to this dietitian's note, was on 04/06/25 when the resident weighed 217.8 lbs.<br><br>Review of Resident #10's weights revealed on 05/04/25 the resident weighed 216.6 lbs.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the quarterly Minimum Data Set (MDS) assessment, with a target date of 05/16/25, revealed Resident #10 had significant cognitive impairment with a BIMS of 04. The activities of daily living section of the assessment, dated 05/29/25 within the MDS, noted that Resident #10 was independent for eating.<br><br>Review of facility tasks from 05/01/25 to 05/31/25 revealed Resident #10 was independent with eating seven meals out of 93. The remaining days the resident required supervision assistance for 42 meals, limited assistance for five meals, extensive assistance for three meals, and total dependence for three meals. Thirty-three meals were either not documented or marked as refused and NA for not applicable.<br><br>Review of facility tasks from 06/01/25 to 06/15/25 revealed Resident #10 was independent with eating two meals out of 45. The remaining days the resident required supervision assistance for 26 meals, limited assistance for zero meals, extensive assistance for one meal, and total dependence for three meals. Thirteen meals were either not documented or marked as refused and NA for not applicable.<br><br>Review of the dietitian's progress notes dated 05/21/25 revealed Resident #10's weekly weights were discontinued due to stabilization of weights over 90 days.<br><br>Review of Resident #10's Treatment Administration Record (TAR) from February 2025 to May 2025 revealed Licensed Practical Nurse (LPN) #138 had signed off the weekly weight for all of the residents ordered weekly weights, but there was no documentation on the TAR for what the weights actually were.<br><br>Review of Resident #10's medical record related to the weekly weights order for February 2025 through May 2025 revealed weekly weights were not completed as ordered. The resident had monthly weights completed with only two additional weights completed on 03/09/25 and 03/18/25.<br><br>Review of Resident #10's weights revealed on 06/04/25 the resident weighed 212.4 lbs.<br><br>Review of the dietitian's progress notes dated 06/04/25 revealed Resident #10 triggered for significant weight loss for a weight loss of 13.1% over 180 days. It noted that her intake improved from 25 to 100% and the resident required assistance at times with meals.<br><br>Review of a speech therapy note dated 06/07/25 revealed an assessment occurred of Resident #10 eating a cookie. She required excessive time for chewing and moderate pocketing and food left in the cheek. Resident #10 was unable to fully clear food and was given maximum verbal cues.<br><br>Review of speech therapy notes dated 06/11/25 revealed Resident #10 was trialed on a more liberalized (mechanical) diet and had a choking episode during the trial.<br><br>Review of the menu ticket dated 06/16/25 revealed Resident #10 had a pureed diet order and was to receive pureed honey glazed turkey, pureed sweet potatoes, pureed green beans, and pureed strawberries. A note at the bottom stated vanilla house shake and ice cream with lunch and dinner trays only [indicating the shake and ice cream were to be given in addition to the meal].<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 06/16/25 at 11:50 A.M. revealed Resident #10 was served a lunch tray. Resident #10 was not assisted to a sitting position in her bed and was not supervised or assisted while eating. Resident #10 told Certified Nurse Aide (CNA) #80 she did not want her food as it looked gross. CNA left the tray at the bedside and did not offer any alternatives.<br><br>Observation and interview on 06/16/25 at 12:20 P.M. revealed Resident #10 had eaten less than 25% of the meal. CNA #80 confirmed Resident #10 had eaten less than 25% of the meal tray and confirmed no assistance was provided.<br><br>Review of facility tasks for meal assistance revealed on 06/16/25 it indicated Resident #10 received supervision assistance for the lunch meal.<br><br>Interview on 06/16/25 at 3:19 P.M. with Resident #10's family revealed the resident had not been eating the pureed food and confirmed she had lost weight. He was concerned and wanted her moved back to a mechanical soft diet so she wouldn't refuse her meals as often. He also reported concerns about quality of life versus quantity of life, especially if she was just starving herself due to not liking the food.<br><br>Observation on 06/17/25 at 12:08 P.M. revealed Resident #10 had a lunch tray at bedside. Resident #10 was not assisted to a sitting position in her bed and was not supervised or assisted while eating.<br><br>Review of facility tasks for meal assistance revealed on 06/17/25 it stated Resident #10 required total dependance upon staff assistance for the lunch meal.<br><br>Interview on 06/17/25 at 12:13 P.M. with CNA #118 revealed they picked up Resident #10's food tray and the resident had eaten about 10% of her food. CNA #118 confirmed she did not offer an alternative and did not assist the resident with eating. CNA #118 was unable to answer if Resident #10 required assistance with eating and was unable to answer when asked how staff should find out/determine if a resident required assistance with eating. CNA #118 was shown the orders in Resident #10's record and she then confirmed Resident #10 had an order to assist with eating due to pocketing food and confirmed staff should be observing and offering assistance per the physician order.<br><br>Interview on 06/17/25 at 12:13 P.M. with the Director of Nursing (DON) confirmed Resident #10 had an order to assist with meals due to pocketing and was unable to state what the order meant for the resident or what her expectations were related to staff responding to or following the order. She further stated she would need to review the facility policy regarding what the order meant.<br><br>Interview on 06/17/25 at 1:51 P.M. with Regional Nurse #160 confirmed Resident #10 had an order for assistance with meals due to pocketing and the facility had no policy specific to and could not explain what the order of assistance due to pocketing meant.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/18/25 at 9:35 A.M. with Dietitian #162 revealed Resident #10 had been steadily losing weight since her admission in March 2024. She confirmed Resident #10 was obese and some weight loss was not concerning to her, but she did not want the resident to have significant drops in weight or be listed as excessive weight loss. Dietitian #162 confirmed the resident was hospitalized for an aspiration event and returned on a pureed diet. Resident #10 was accepting of the shakes and ice cream and ate very little of her meals. Dietitian #162 confirmed she recommended weekly weights to try and catch any big drops or changes in her weights and staff informed her they were assisting residents [including Resident #10] with eating. Dietitian #162 confirmed facility staff were not completing weekly weights as recommended and it was a struggle to get staff to obtain weights. She stated she spoke to the floor staff and management staff about getting the weights completed. She also reported corporate staff told her to discontinue weekly weights so they would not get a citation for not obtaining weights. She stated she would expect staff to offer assistance with eating when required and alternatives should have been offered if residents declined the meal or ate very little of it.<br><br>Interview on 06/18/25 at 10:29 A.M. with Speech Therapist (ST) #155 revealed Resident #10 had not passed the food trial for the mechanical soft food texture due to coughing during the trial. She revealed Resident #10 did pocket pureed food, especially pureed eggs, but that she continued to recommend pureed texture and continued to work with the resident. She acknowledged while many days Resident #10 could feed herself, pocketing food was not safe and monitoring/assisting during meals was appropriate.<br><br>Interview on 06/18/25 at 11:00 A.M. with the DON confirmed weekly weights were not obtained as ordered for Resident #10 and she also confirmed the resident was not being assisted during meals as ordered/required.<br><br>Interviews on 06/16/25 around 11:00 A.M. and on 06/18/25 around 4:00 P.M. with Regional Nurse #160 revealed the facility had been purchased by a new entity with a change over in December 2024. Regional Nurse #160 stated the previous company had walked in and took many boxes of records without current staff's knowledge of exactly what was taken. He also revealed the previous company had Matrix electronic charting system and now this new company had Point Click Care (PCC) charting system, and not everything had been transferred over to PCC. He revealed they only had access to a limited version of the old Matrix charting system, leading to missing medical record documentation including information pertaining to Resident #10's nutrition.<br><br>Interview on 06/26/25 at 10:54 A.M. with LPN #138 revealed that weekly weights and other vital signs were to be completed over the weekends, so when she worked on Tuesday's she would just sign off it got completed. LPN #138 verified she did not obtain any weights for Resident #10 but signed them off. She reported all weights would be documented in the weights and vital signs section of the medical record.<br><br>Review of the facility policy titled, Weights, dated 09/01/21 revealed weights must be obtained routinely in order to monitor parameters of nutrition over time. Weekly weight should be obtained by the same day each week when possible. The dietitian or physician may order specific nutritional interventions as indicated.<br><br>Review of the facility policy titled Assistance with meals dated September 2021 revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff shall serve resident trays and help residents who require assistance with eating.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the undated facility policy titled Activities of Daily Living revealed residents shall be provided with care, treatment and services to maintain or improve abilities. The types of assistance included: Independent, where the resident shall complete the activity with no help or staff oversight at any time in the last seven days; Supervision, where the resident required oversite, encouragement or cueing to complete the activity three or more times in the previous seven days; Limited assistance, where the resident was highly involved in the activity and received physical help in guided maneuvering of limbs(s) or other non-weight bearing assistance three or more times in the previous seven days; Extensive assistance, where the resident preformed part of the activity over the past seven days or staff provided weight bearing support; And total dependance, where staff performed an activity with no participation by resident for any aspect of the ADL activity during the entire seven day look back.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165179. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365679 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Signature Healthcare of Fayette County | 375 Glenn Avenue<br>Washington Court Hou, OH 43160 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, review of dietary production spreadsheets, review of resident meal tickets, and review of the facility's always available menu, the facility failed to ensure portion sizes were served as planned, which had the potential to affect all residents. The facility also failed to ensure items on the always available menu were available for Resident #17 and Resident #37. This affected two residents (#17 and #37) out of 64 residents observed during dining. The facility also failed to ensure the meal served matched the meal ticket. This affected two Residents (#10 and #21) of three observed for meal tickets. The facility census was 64.<br><br>Findings include:<br><br>1. Observations on 06/17/25 from 11:05 A.M. to 11:35 A.M. revealed four ounce scoops were utilized for the pureed and regular broccoli. When [NAME] #125 was serving the meal and scooped the pureed and regular broccoli, she was not filling the entire scoop.<br><br>Interview on 06/17/25 at 11:35 A.M., [NAME] #125 verified she was not consistently filling the entire scoop with the pureed and regular broccoli when serving. When queried as to how much broccoli was actually being served, [NAME] #125 replied, that's a good question.<br><br>2. Observations on 06/17/25 from 11:05 A.M. to 12:09 P.M. revealed three ounce scoops were utilized for the pureed and ground pork loin.<br><br>Review of the Production Sheet, dated 2025, revealed the serving size for the ground pork and pureed pork was a #8 scoop (4 ounces).<br><br>Interview on 06/17/25 at 12:09 P.M., Dietary Director (DD) #101 verified three ounce scoops were utilized for the pureed and ground pork and the serving size on the production sheet was four ounces. DD # 101 stated the cook was responsible for ensuring the appropriate scoop size was used.<br><br>3. Observation on 06/17/25 at 11:52 A.M. revealed an unidentified staff member opened the door to the kitchen and asked the dietary staff for a grilled cheese for Resident #17. [NAME] #135 stated there were no grilled cheese's available. The unidentified staff member then exited the kitchen without any food.<br><br>Review of the undated facility document titled, Always Available at Mealtimes, revealed grilled cheese, hot dogs, peanut butter and jelly sandwiches, deli sandwiches, and salads were available.<br><br>Observation on 06/17/25 at 12:50 P.M. revealed the always available menu was posted throughout the building.<br><br>Interview on 06/17/25 at 12:50 P.M., Dietary Director (DD) #101 confirmed grilled cheese was on the always available menu, posted throughout the building and was not available for the lunch meal. DD #101 stated she had ran out of cheese. DD #101 stated she was going to go to a local grocery store earlier in the day, however the Administrator told her not to go. DD #101 confirmed items on the always available menu should always be available.<br><br>(continued on next page) |

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| Signature Healthcare of Fayette County | 375 Glenn Avenue<br>Washington Court Hou, OH 43160 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 06/18/25 at 2:56 P.M., Resident #17 stated she did not like what she was served for lunch on 06/17/25 and stated she did not recall receiving a grilled cheese at lunch instead of the original menu items.<br><br>4. Review of Resident #37's lunch meal ticket, dated 06/17/25, revealed a note to add a grilled cheese to the meal.<br><br>Review of the undated facility document titled, Always Available at Mealtimes, revealed grilled cheese, hot dogs, peanut butter and jelly sandwiches, deli sandwiches, and salads were available.<br><br>Observation on 06/17/25 at approximately 12:15 P.M. revealed Resident #37's meal tray contained pork loin, a baked potato, broccoli, and a lemon bar. There was no grilled cheese provided on the lunch tray.<br><br>Interview on 06/17/25 at approximately 12:15 P.M., Dietary Director (DD) #101 verified Resident #37 was not provided with a grilled cheese because the kitchen was out of cheese.<br><br>Interview on 06/18/25 at 2:54 P.M., Resident #37 verified she did not receive the grilled cheese at lunch on 06/17/25 as was printed on her meal ticket. Resident #37 stated what was served on her tray did not match what was printed on her meal ticket and that happened all the time.<br><br>5. Review of the medical record for Resident #10 revealed an admission date of 03/01/24. Diagnoses included respiratory failure, dysphasia, atrial fibrillation, diabetes, muscle weakness, metabolic encephalopathy, and muscle wasting atrophy.<br><br>Review of Resident #10's dietician progress notes dated 12/18/24, 01/08/25, and 01/29/25 revealed the resident did not like the quality of the food provided.<br><br>Review of Resident #10's hospital discharge summary revealed the resident was admitted to the hospital on [DATE] and discharged back to the facility on [DATE]. The summary also revealed the resident was evaluated for altered mental status, dysphagia, and aspiration. The hospital discharge diet recommendations were for a carb-controlled diet with puree texture and thin liquids.<br><br>Review of physician orders dated 02/03/25 revealed Resident #10 had a diet order for a carb-controlled diet with puree texture.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had significant cognitive impairment with a Brief Interview of Mental Status (BIMS) of 03 indicating impaired cognition. The resident was noted as independent with eating and had previous significant weight loss and was not on a weight loss program.<br><br>Review of the menu ticket dated 06/16/25 revealed Resident #10 had a puree diet order and was to receive pureed honey glazed turkey, pureed sweet potatoes, pureed green beans, and pureed strawberries.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 06/16/25 at 11:50 A.M. revealed Resident #10 was served a lunch tray which included mashed potatoes and gravy, with no mashed sweet potatoes provided. Resident #10 told Certified Nurse Aide (CNA) #80 she did not want her food as it looked gross and also stated, those don't look like sweet potatoes. The CNA left the tray at bedside and did not offer any alternatives.<br><br>Observation and interview on 06/16/25 at 12:20 P.M. revealed Resident #10 had eaten less than 25% of the meal. CNA #80 confirmed Resident #10 had eaten less than 25% of the meal tray. The CNA also confirmed the resident was not provided the meal that was on the menu, as she was given mashed potatoes and not pureed sweet potatoes.<br><br>Interview on 06/18/25 at 9:35 A.M. with Dietician #162 revealed the facility should be following the meal tickets and menu.<br><br>6. Review of the medical record for Resident #21 revealed an admission date of 05/24/23. Diagnoses included Parkinson's disease, dysphasia, muscle wasting, diabetes and malnutrition.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 had cognitive impairment with a Brief Interview of Mental Status (BIMS) of 09.<br><br>Review of Resident #21's physician order dated 02/11/25 revealed a diet order for a no added salt diet with mechanical soft texture.<br><br>Review of the meal ticket dated 06/16/25 revealed Resident #21 was to receive ground honey glazed turkey, soft roasted sweet potatoes, green beans, and bananas.<br><br>Review of the substitution log dated June 2025 revealed no evidence of the facility being out an any items on 06/16/25.<br><br>Observation and interview on 06/16/25 at 12:03 P.M. with Resident #21 and Licensed Practical Nurse (LPN) #122 revealed the LPN brought in the food tray for the lunch meal which did not include green beans. LPN #122 confirmed the meal ticket stated green beans yet no green beans were provided. Resident #21 reported that the kitchen rarely served the menu as posted and items frequently did not match the tickets.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165179. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and record review, the facility failed to place Resident #26 on the appropriate diet. This affected one resident (#26) out of 30 residents reviewed for the sample. The facility had a census of 64.<br><br>Findings include:<br><br>Review of the medical record for Resident #26 revealed an original admission date of 01/30/25 and the most recent re-entry on 05/28/25. Diagnoses included acute osteomyelitis of the left tibia and fibula, extended-spectrum beta-lactamase (ESBL)-producing Escherichia coli infection, metabolic encephalopathy, and acute kidney failure with tubular necrosis.<br><br>Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #26 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Additionally, Section K of the MDS stated Resident #26 had no swallowing disorders, was on a therapeutic diet, but it did not state that the resident was receiving a mechanically altered diet.<br><br>Review of Resident #26's hospital Discharge summary dated [DATE] revealed the resident was to continue a regular diet.<br><br>Review of Resident #26's physician orders revealed the facility initiated a mechanically soft texture diet on 06/03/25. The order was changed to a regular texture diet on 06/17/25 following surveyor intervention.<br><br>Review of the amount eaten task for the past 30 days revealed Resident #26 consumed less than 50% of meals on multiple dates, including 05/31/25, 06/06/25, 06/07/25, 06/08/25, 06/10/25, 06/12/25, 06/14/25, and 06/15/25.<br><br>Interview on 06/16/25 at 4:00 P.M. with Resident #26 revealed he was placed on a mechanically soft diet upon admission on [DATE] and did not know why. He stated he did not like the mechanically soft diet and most of the time would not eat the meals provided, so his family would bring in food. On 06/18/25 at 10:08 A. M., Resident #26 further stated he was not eating the food because of the mechanical soft texture.<br><br>Interview on 06/17/25 at 12:57 P.M. with Rehabilitation Director #144 revealed the speech therapist mistakenly placed Resident #26 on a mechanically altered diet based on his previous admission. The Rehabilitation Director stated there were no speech therapy progress notes from the current admission, and the therapist based the order on Section K of the MDS, which incorrectly reflected that the resident was on a mechanically altered diet.<br><br>Interview on 06/18/25 at 11:49 A.M. with the Registered Dietitian (RD) #162 revealed that placing Resident #26 on a mechanical soft diet was an error. The RD stated that during the initial screening, the resident did not demonstrate any issues with chewing or swallowing and had not failed any feeding or pocketing tests. She confirmed the diet was mistakenly continued from the prior stay, during which the resident had been on a mechanical soft renal diet due to broken teeth. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. a. Review of the record for Resident #59 revealed an admission date 10/05/23. Diagnoses included type two diabetes and developmental disorder of scholastic skills.<br><br>Review of Resident #59's physician order dated 12/09/24 revealed that Resident #59 had an order for Insulin Lispro injection solution 100 unit per milliliter subcutaneously before meals and at bedtime for diabetes.<br><br>Review of the plan of care dated 04/03/25 revealed that Resident #59 had impaired metabolic status related to diabetes. Interventions included administering medication as ordered, monitoring laboratory results, monitoring vital signs, and reporting adverse side effects to the physician.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #59 had Brief Interview for Mental Status (BIMS) of 15 that indicated she was cognitively intact.<br><br>b. Review of the record for Resident #30 revealed an admission date 01/05/24. Diagnoses included type two diabetes mellitus and chronic systolic heart failure.<br><br>Review of the physicians order dated 04/04/25 revealed that Resident #30 had an order for insulin Glargine-yfgn subcutaneous solution 100 units per milliliter one time a day with blood glucose check in the morning.<br><br>Observation on 06/17/25 at 8:00 A.M. with Licensed Practical Nurse (LPN) #135 revealed she came out of Resident #30's room with a glucometer in her hand. LPN #135 took a Sani disinfectant wipe disinfectant (a germicidal, tuberculocidal, and viricidal disinfectant) and wrapped it around the glucometer and sat it on top of the medication cart where it stayed wrapped in the Sani wipe for six minutes. LPN #135 prepared medication for Resident #59 and after the medications were prepared, LPN #135 took the wrapped glucometer with the Sani wipe to Resident #59 room to perform a blood glucose check. LPN #135 laid a brown paper towel on top of a bedside table then placed the wrapped glucometer on top of it. LPN #135 washed her hands, then placed gloves on her hands, then unwrapped the Sani wipe from the glucometer, then picked it up to obtain Resident #59's blood glucose check. LPN #135 took the blood glucose from Resident #59's finger, then disposed of her gloves in the trash can. LPN #135 washed her hands, then wrapped the Sani wipe back around the glucometer (the same wipe that was used to disinfect the glucometer after Resident #30's blood glucose check), then exited Resident #59 room. LPN #135 laid the glucometer with the Sani wipe on top of her medication cart.<br><br>Interview on 06/17/25 at 8:05 A.M. with LPN #135 verified that she did not maintain infection control by utilizing the same Sani disinfectant wipe from Resident #30's room after her blood glucose was taken and took it into Resident #59's room for her blood glucose check.<br><br>Interview on 06/17/25 at 5:00 P.M. with LPN #135 stated that she also did not follow the Sani wipe directions that stated to clean, and then leave the item to dry for two minutes after the cleaning to work properly.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility document titled Safety Data Sheet dated 02/18/19 revealed that product Super Sani-Cloth Germicidal wipes directions were to use it as a disinfectant on hard, non-porous surfaces. It stated to not reuse the towelette and to pick up the wipe and place it in appropriate container for infectious waste disposal.<br><br>Review of the facility document titled Super Sani-Cloth dated unknown revealed that the bactericidal, tuberculocidal and viricidal had a dwell time to dry in two minutes.<br><br>4. Review of the medical record revealed that Resident #19 had admission date 05/17/25. Diagnoses included paraplegia, neuromuscular dysfunction of bladder, depression disorder, and dependence on wheelchair.<br><br>Review of the physician order dated 12/20/24 revealed Resident #19 had an order for enhanced barrier precautions every day and night.<br><br>Review of the physician order dated 12/22/24 revealed Resident #19 had a suprapubic catheter, 24 french with a 10 milliliter (ml) bulb. The orders also revealed an order for suprapubic catheter care every shift.<br><br>Review of physician order dated 03/21/25 revealed that Resident #19 had wound care for right hip and left ischial with instructions to apply Dakins solution to moisten gauze, squeezing out excess moisture to lightly pack gauze inside the wound, ensuring it did not pass the edge of the wound, cover with abdominal dressing, then apply a thin layer of thick barrier paste to satellite macerated ulcerations twice a day or as needed every shift for wounds.<br><br>Review of plan of care dated 04/21/25 Resident #19 had a suprapubic catheter related to having neurogenic bladder. Interventions included monitor and document intake and output as per facility policy, monitor for pain and discomfort, and report to the physician for signs and symptoms of urinary tract infection.<br><br>Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #19 had a Brief Interview for Mental Status (BIMS) of 15 that indicated he was cognitively intact. Resident #19 was independent with all care though he did have a wound and a suprapubic catheter.<br><br>Observation and interview on 06/16/25 at 4:51 P.M. with Certified Nurse Aid (CNA) #501 verified there was no enhanced barrier precaution sign for Resident #19's room even though the resident had an indwelling urinary catheter.<br><br>Interview on 06/17/25 at 11:40 A.M. with Wound Nurse Practitioner #600 confirmed Resident #19 had a wound and it was being debrided in an outpatient clinic because it was too deep to treat at the facility.<br><br>Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated January 2024 revealed that enhanced barrier precautions are an infection control method used in the facility to reduce transmission of drug-resistant organisms.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility policy titled Infection Prevention and Control Program dated September 2022 revealed the infection prevention and control program was a facility-wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program. Prevention of infection was to implement appropriate isolation precautions when necessary and educating staff and ensuring that they adhere to the proper techniques and procedures.<br><br>5. Review of the medical record revealed that Resident #38 was admitted on [DATE]. Diagnoses included myotonic muscular dystrophy, aural vertigo, and ataxic gait.<br><br>Review of the physician order dated 03/03/25 revealed that Resident #38 was to be on enhanced barrier precautions every shift.<br><br>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #38 had a Brief Interview for Mental Status (BIMS) of 02 that indicated severely cognitively impaired. Resident #38 was independent for eating, oral care, and personal hygiene. Resident #38 required partial to moderate assistance for toileting and required substantial maximum assistance for dressing the lower body and baths. The assessment indicated the resident had an indwelling suprapubic catheter.<br><br>Review of the plan of care dated 05/20/25 revealed that Resident #38 had suprapubic catheter related to obstructive uropathy. Interventions included monitor of signs and symptoms of urinary tract infection, document output, securement device to be applied to securely anchor catheter tubing, change catheter and drainage system as ordered, keep tubing free of kinks, and privacy cover to the drainage bag.<br><br>Review of the physician order dated 05/22/25 revealed that Resident #38 had an order for a suprapubic catheter and an order to re-insert Foley catheter as needed for malfunction or dislodgement.<br><br>Observation on 06/16/25 at 4:51 P.M. with Resident #38 revealed an enhanced barrier precaution sign was not posted outside or in the room.<br><br>Interview on 06/16/25 at 4:51 P.M. with Certified Nurse Aid (CNA) #501 verified there was no enhanced barrier precaution sign for Resident #38's room even though the resident had an indwelling urinary catheter.<br><br>Review of the facility policy titled Enhanced Barrier Precautions (EBP) dated January 2024 revealed that enhanced barrier precautions are an infection control method used in the facility to reduce transmission of drug-resistant organisms.<br><br>Review of the facility policy titled Infection Prevention and Control Program dated September 2022 revealed the infection prevention and control program was a facility-wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program. Prevention of infection was to implement appropriate isolation precautions when necessary and educating staff and ensuring that they adhere to the proper techniques and procedures.<br><br>6. Review of record revealed that Resident #60 had admission date 01/09/25. Diagnoses included injury at C4 level of cervical spinal cord, quadriplegia, acute and chronic respiratory failure with hypoxia, disorder of autonomic nervous system, and morbid (severe) obesity.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the plan of care dated 03/21/25 revealed that Resident #60 had episodes of bladder and bowel incontinence. Interventions included administering medications, assisting residents with toileting needs, monitoring rectal area for redness, irritation, and skin excoriation or breakdown, provide peri care after each incontinent episode, then apply house barrier after incontinence care.<br><br>Review of plan of care dated 03/21/25 revealed that Resident #60 had impaired skin integrity as evidenced by a pressure ulcer related to the resident being confined to a bed at all times, or most of the times with intervention to assist the resident with turning and repositioning, encourage the resident to reposition, laboratory services as ordered, medication per physicians ordered, complete Braden scale as needed, if resident refuses interventions and treatments encourage compliance to minimize further skin impairment, and complete wound evaluation to monitor the progress of the resident's skin condition.<br><br>Review of the physician order dated 05/04/25 revealed that Resident #60 had an order to cleanse the coccyx wound with 0.125% Dakins solution, then rinse with saline, apply zinc oxide topically to the peri wound and apply silver alginate rope to wound bed, leaving a one-inch tail and cover with abdominal daily and may change as needed if it becomes soiled or displaced.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #60 had a Brief Interview of Mental Status (BIMS) of 15 that indicated he was cognitively intact. Resident #60 was dependent on staff for assistance with meals, oral care, incontinence care, dressing lower and upper body, personal hygiene, and bathing.<br><br>Review of the skin evaluation dated 06/11/25 revealed that Resident #60's coccyx pressure wound was a stage four and measured 2.5 centimeters (cm) by 2.5 cm by 5.5 cm depth.<br><br>Observation on 06/18/25 from 10:39 A.M. through 10:55 A.M. with Resident #60 who was provided incontinence care before wound care. CNA #90 provided the incontinence care. She used a washcloth to wipe away feces, but instead pushed a large amount of feces into the wound bed. LPN #94 then performed the wound treatment by using Dakins to the wound bed that was 0.0125 strength (quarter strength) then utilized four normal saline syringes to cleanse the wound bed. Then calcium alginate rope was applied with a sterile Q-Tip, then an abdominal dressing with tape was applied.<br><br>Interview on 06/18/25 at 10:49 A.M. with CNA #90 confirmed that during incontinence care for Resident #60, she had wiped the feces into the wound bed when providing incontinence care. CNA #90 stated that was not normal practice and stated it could cause an infection in the wound.<br><br>Interview on 06/18/25 at 10:52 A.M. with LPN #94 revealed that it looked like a problem having feces in the wound bed. LPN #94 stated it had happened before and that she would have to wash the wound out some more to cleanse the feces out of the wound bed.<br><br>Review of the facility policy titled Wound Care dated September 2021 revealed part of the procedure was to wash and dry hands thoroughly, put on gloves, cleanse the wound and then apply treatments as ordered by the physician.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165179.<br><br>(continued on next page) |

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| Signature Healthcare of Fayette County | 375 Glenn Avenue<br>Washington Court Hou, OH 43160 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, record review, interview, and review of facility policy and procedure, the facility failed to ensure implementation of the appropriate isolation status for Resident #19, #26, and #38. This affected three residents (#19, #26, and #38) out of five residents reviewed for infections. The facility failed to ensure proper hand hygiene was followed during a tube feed administration for Resident #162. This affected one resident (#162) out of one residents reviewed for tube feeding. The faciltiy failed to ensure appropriate glucometer sanitation for Resident #59. This affected one resident (#59) out of three residents observed for medication administration. And the facility failed to maintain infection control during wound care for Resident #60. This affected one resident (#60) out of one resident reviewed for pressure ulcers. The facility census was 64.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #26 revealed an original admission date of 01/30/25 and the most recent re-entry was on 05/28/25. Diagnoses included acute osteomyelitis of the left tibia and fibula, extended-spectrum beta-lactamase (ESBL)-producing Escherichia coli infection, metabolic encephalopathy, and acute kidney failure with tubular necrosis.<br><br>Review of the 5-day minimum data set (MDS) 3.0 assessment dated [DATE] for Resident #26 revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating moderately impaired cognition.<br><br>Review of Resident #26's physician orders revealed ongoing enhanced barrier precautions (EBP) starting on 05/29/25 related to an indwelling urinary catheter and an order for contact precautions specifically for Clostridioides difficile (C. diff) from 06/16/25 to 06/17/25.<br><br>Review of the laboratory results confirmed a positive test for C. diff on 06/06/25. No subsequent testing was completed to determine a resolution; however, on 06/18/25, the Assistant Director of Nursing stated that the resident had completed antibiotic treatment and had formed stool for 48 hours, so retesting was not performed.<br><br>Observation on 06/16/25 at 11:45 A.M. revealed only the enhanced barrier precaution sign posted on the resident's door, but no contact precaution signage was present.<br><br>Further observation and interview on 06/17/25 at 11:30 A.M. revealed multiple family members present in the resident's room without the use of any personal protective equipment (PPE). The resident's son reported that staff had not educated the family on the risks of entering the room without PPE.<br><br>Interview on 06/16/25 at 11:45 A.M. with Licensed Nurse Practitioner (LPN) #93 confirmed the resident had an active C. diff infection, but contact precautions were not implemented in practice, despite new orders for contact precautions being placed on the same date.<br><br>Review of the facility policy titled, Infection prevention and control program dated September 2022 revealed to prevent infection the facility will implement appropriate isolation precautions when necessary.<br><br>2. Review of the medical record for Resident #162 revealed an admission date of 11/14/24. Diagnoses included type one diabetes mellitus without complications, chronic obstructive pulmonary disease, muscle wasting and atrophy, and presence of a gastrostomy feeding tube.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365679 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Signature Healthcare of Fayette County | 375 Glenn Avenue<br>Washington Court Hou, OH 43160 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] for Resident #162 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident required moderate assistance with most transfers and lower body dressing, used a wheelchair, and was occasionally incontinent of bladder and bowel.<br><br>Review of physician orders revealed Resident #162 received TwoCal 240 milliliters via gastrostomy tube five times per day as bolus feeds, with water flushes of 150 milliliters every six hours and 60 milliliters every four hours. The resident also had orders to flush the tube before and after medications, maintain the head of bed at 30 to 45 degrees during and after feedings, and monitor the site for signs of infection or complications. The care plan identified maintaining adequate nutritional and hydration status as a goal, with interventions including infection monitoring, respiratory assessment, and monitoring for gastrointestinal symptoms.<br><br>Observation on 06/23/25 at 9:59 A.M. revealed Licensed Practical Nurse (LPN) #138 performed hand hygiene and donned personal protective equipment (PPE) prior to administering the resident's tube feeding. During the process, the nurse dropped an item on the floor and touched the floor while wearing gloves. The nurse did not change gloves or perform hand hygiene before proceeding with the procedure. The nurse then attempted to pull residual fluid, then flushed the tube with 30 milliliters of water, administered the full TwoCal bolus feeding via syringe, and flushed again with 30 milliliters of water.<br><br>Interview on 06/23/25 at 9:59 A.M. confirmed that she had touched the ground with her gloved hands and did not remove or change gloves or wash her hands prior to completing the resident's tube feeding.<br><br>Review of the facility policy titled, Infection prevention and control program dated 09/22 revealed to prevent infection the facility will educate staff and ensure that they adhere to proper techniques and procedures. |