STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365694	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Chillicothe	60 Marietta Road Chillicothe, OH 45601

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview and facility policy review, the facility failed to ensure residents were treated in a dignified manner. This affected three residents (#43, #48, #49) of three residents reviewed for indwelling urinary catheter. The facility census was 67. Findings Include: 1. Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. Review of the resident's admission evaluation dated 01/22/25 revealed the resident was admitted from an acute care hospital for wounds and weakness. The resident had an indwelling urinary catheter on admission. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent for bed mobility and toileting. The assessment indicated the resident had an indwelling urinary catheter and an ostomy. Review of the resident's monthly physician orders for February 2024 identified orders dated 01/22/25 record Foley catheter output every shift, catheter care every shift, Foley catheter 16 FR with 5 milliliter (ml) balloon to gravity drainage every shift, Foley catheter to remain covered every shift for privacy, ostomy site care daily and as needed, empty ostomy bag every shift and as needed, and 02/10/25 change Foley catheter and Foley bag every month every day shift starting on the tenth and ending on the tenth every month, change Foley every 30 days starting on 02/10/25. On 02/11/25 at 11:47 A.M., interview with Resident #43 revealed his indwelling urinary catheter was supposed to be changed on 02/10/25, however it was not changed. Observation of the resident revealed the indwelling urinary catheter collection bag was not in a privacy bag and the clear yellow urine was visible from the hallway. (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: 365694	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE 60 Marietta Road Chillicothe, OH 45601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/12/24 at 2:15 P.M., interview with Licensed Practical Nurse (LPN) #180 confirmed the resident's indwelling urinary catheter collection bag was not in a privacy bag as physician ordered. 2. Review of the medical record for Resident #49 revealed an initial admitted [DATE] with the latest readmission of 02/11/25 with the diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, respiratory failure, asthma, chronic respiratory failure with hypoxia, severe protein calorie malnutrition, systemic lupus, dysphagia, dysphonia, neuromuscular dysfunction of bladder, gastrostomy status, cardiomyopathy, anemia, anxiety disorder, gastro-esophageal reflux disease, hyperlipidemia, hypertension, fibromyalgia and major depressive disorder. Review of the admission evaluation dated 12/27/24 revealed the resident was admitted with an indwelling urinary catheter and was incontinent of bowel. The assessment indicated the resident was a two person assist with toileting and bed mobility. Review of the plan of care dated 12/29/24 revealed the resident had a need for an indwelling urinary catheter. Interventions included monitor for signs and symptoms of urinary tract infection and report to the physician, report signs of peri-area redness, irritation, skin excoriation/breakdown to physician, document output, catheter bag to be emptied every shift, review with resident/family of the risks of catheterization, securement device to be applied to securely anchor catheter tubing, provide peri-care prior to application and after removal of external catheter, change catheter and drainage system as indicated per physician orders, keep tubing free of kinks and twists, maintain drainage bag below the bladder level, privacy cover to drainage bag, provide catheter care every shift and as needed and provide prophylactic interventions per physicians orders. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive impairment. The resident was dependent on staff for toileting. The assessment indicated the resident had an indwelling urinary catheter and was always incontinent of bowel. Review of the resident's monthly physician orders for February 2025 identified orders dated 02/12/25 urinary catheter care every shift, change urinary catheter anchor weekly on Monday, change urinary catheter drainage bag every four weeks on Monday and record urinary catheter output every shift. On 02/12/25 at 8:48 A.M., observation of Resident #49 revealed the indwelling urinary catheter collection bag as not contained in a privacy bag allowing the clear yellow urine to be visible from the hallway. On 02/12/25 at 10:07 A.M., interview with Licensed Practical Nurse (LPN) #130 confirmed the resident's indwelling urinary catheter was not contained in a privacy bag allowing the resident's urine to be visible from the hallway. 3. Review of the medical record for Resident #48 revealed an initial admitted [DATE] with the latest readmission of 01/28/25 with the diagnoses including but not limited to sepsis, obstructive and reflux uropathy, hydronephrosis with renal and urethral calculous obstruction, hypertension and atrial fibrillation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the plan of care dated 02/11/25 revealed the resident had an indwelling urinary catheter related to obstructive uropathy. Interventions included monitor for signs and symptoms of urinary tract infection (UTI) and report to the physician, report signs of peri-area redness, irritation, skin excoriation/breakdown to physician, documents output, catheter bag to be emptied every shift, securement device to be applied to securely anchor catheter tubing, provide peri-care prior to application and after removal of external catheter, change catheter and drainage system as indicated per physician orders, keep tubing free of kinks and twists, maintain drainage bag below the bladder level, privacy cover to drainage bag and provide catheter care every shift and as needed. Review of the resident's February 2025 monthly physician orders identified the only order related to the resident's indwelling urinary catheter dated 02/12/25 record output every shift. On 02/11/25 at 11:45 A.M., observation of Resident #48 revealed the resident's indwelling urinary catheter bag was laying on the floor with clear amber urine visible from the hallway. On 02/11/25 at 2:50 P.M., observation of Resident #48 revealed he was ambulating in the hallway with his walker. Further observation revealed the resident's indwelling urinary catheter collection bag was hanging on the walker with clear amber urine being visible. On 02/11/25 at 10:05 A.M., interview with LPN #130 confirmed the resident's indwelling urinary catheter collection bag was not contained in a privacy bag. Review of the facility policy titled, Dignity, not dated revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. This deficiency represents non-compliance investigated under Complaint Number OH00162558.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and interview, the facility failed to ensure one resident's (#43) bed accommodated his size and had physician ordered enabler bars to enhance bed mobility. This affected one (Resident #43) of three residents reviewed for pressure ulcers. The facility census was 67. Findings Include: Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. Review of the resident's monthly physician orders for February 2024 identified an order dated 01/23/25 enabler bars to enhance bed mobility. On 02/11/25 at 1:34 P.M., observation of resident during wound care revealed the resident's bed was a regular bed with a parameter mattress in place. The resident had no enabler bars in place on the bed to assist with bed mobility. Further observation revealed when the resident was assisted onto his right side his legs fell from the bed due to the bed not being large enough for his size. On 02/11/25 at 2:00 P.M., an interview with Licensed Practical Nurse (LPN) #180 confirmed the resident's bed was too small limiting the resident's ability to turn and reposition to achieve off-loading to the pressure ulcers and would require a bariatric bed. The LPN confirmed the resident was not provided with an air mattress despite the pressure ulcer. The LPN also verified the resident had no enabler bars on the bed as physician ordered. This deficiency represents non-compliance investigated under Complaint Number OH00162365.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review and staff interview, the facility failed to complete a comprehensive admission assessment on admission for two residents (#43, #49). This affected two (Resident #43 and #49) of three residents reviewed for pressure ulcers. The facility census was 67. Findings Include: 1. Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. Review of the progress note dated 02/05/25 at 6:10 P.M. revealed the resident was readmitted to the facility at 6:00 P.M. Review of the medical record revealed a comprehensive readmission assessment was not completed until 02/07/25. Further review revealed the assessment was still in progress. On 02/11/25 at 3:25 P.M., interview with Regional Nurse #210 confirmed the readmission assessment was not completed in a timely manner. 2. Review of the medical record for Resident #49 revealed an initial admitted [DATE] with the latest readmission of 02/11/25 with the diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, respiratory failure, asthma, chronic respiratory failure with hypoxia, severe protein calorie malnutrition, systemic lupus, dysphagia, dysphonia, neuromuscular dysfunction of bladder, gastrostomy status, cardiomyopathy, anemia, anxiety disorder, gastro-esophageal reflux disease, hyperlipidemia, hypertension, fibromyalgia and major depressive disorder. Review of the progress note dated 02/11/25 at 8:27 P.M. revealed the resident was readmitted to the facility. On 02/13/25 at 2:45 P.M., an interview with the Director of Nursing (DON) verified the resident had no readmission assessment, readmission wound assessments were not completed. This deficiency was an incidental finding discovered during the course of this complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and facility policy review, the facility failed to ensure one resident (#72) who was dependent on staff received routine bathing. This affected one (Resident #72) of three residents reviewed for bathing. The facility census was 67. Findings Include: Review of the closed medical record for Resident #72 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), severe protein calorie malnutrition, right bundle branch block, urinary tract infection, pneumonitis due to inhalation of food and vomit, dysphagia, other disorders of lung, history of falling, pain, slow transit constipation, migraine, vitamin D deficiency, intervertebral disc displacement lumbar region, neuromuscular dysfunction of bladder, slurred speech, osteoarthritis, dependence on supplemental oxygen, anxiety disorder and functional quadriplegia. The resident was discharged to another local skilled nursing facility (SNF) on 02/07/25. Review of the resident's admission evaluation dated 01/24/25 revealed the resident preferred bathing at bedtime. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent on staff for personal hygiene, toileting, bathing, bed mobility and substantial/maximal assistance with dressing. Review of the resident's medical record revealed the resident was scheduled for routine showers every Monday and Thursday. Review of the medical record revealed no evidence the resident was provided the scheduled shower on 01/27/25, 01/30/25, 02/03/25 and 02/06/25. On 02/12/25 at 8:30 A.M., an interview with Regional Nurse #210 confirmed the facility had no documented evidence the resident received routine bathing. Review of the facility policy titled, Shower/Tub Bath, dated 09/21 revealed the purpose of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. This deficiency represents non-compliance investigated under Master Complaint Number OH00162558 and Complaint Number OH00162365.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interviews and facility policy review, the facility failed to assess, develop and implement a comprehensive and individualized prevention program to prevent the development of avoidable pressure ulcers, ensure pressure ulcer dressings were provided as ordered and/or prevent the risk of pressure ulcer infection for Resident #43 and #49. Actual harm occurred on 02/05/25 when Resident #43 was readmitted to the facility following an acute care hospital stay, was determined to be at high risk for skin breakdown, dependent on staff for bed mobility and with known pressure ulcers that were found not to have a comprehensive assessment of the known pressure ulcers upon readmission to the facility. Additionally, the resident's physician ordered treatments for pressure ulcers that were not provided as ordered. Furthermore, the resident was sent to the local acute care hospital on 02/13/25 following a physical examination of stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) pressure ulcer to the sacrum for suspected infection in need of surgical intervention, non-staged pressure ulcer to the right outer ankle and a new unidentified wound to the right outer fifth digit to the right foot. Additionally, Actual Harm occurred on 01/10/25 when Resident #49, who was cognitively impaired, was at high risk for pressure ulcer development, dependent on staff for bed mobility and had known pressure ulcers and was found to have a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) pressure ulcer to the left ischium without evidence of adequate and individualized pressure ulcer prevention interventions being in place prior to the development. Furthermore, the resident readmitted to the facility on [DATE] with no readmission assessment and no physician ordered treatments to the unstageable, known but not stageable due to coverage of wound bed by slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed), and/or eschar (Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound), pressure ulcer to the sacrum/coccyx, left ischium and stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also be present as an intact or open/ruptured blister.) pressure ulcer to the left heel. This affected two (Resident #43 and #49) of three residents reviewed for pressure ulcers. The facility census was 67. Findings Include: 1. Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Review of the resident's admission evaluation dated 01/22/25 revealed the resident was admitted from an acute care hospital for wounds and weakness. The assessment indicated the resident had edema to bilateral lower extremities. The resident had an indwelling urinary catheter on admission. The assessment indicated the resident had a skin impairment of a blister. Review of the Braden scale contained within the assessment revealed a score of 15 indicating the resident was at high risk for skin breakdown.

Review of the wound evaluation dated 01/22/25 revealed the resident had an unstageable pressure ulcer to his left gluteal fold measuring 4.0 centimeters (cm) by 8.0 cm by 0.1 cm. The wound was described as 20% granulation tissue with scant sanguineous exudate and 80% slough. The peri-wound was described as pink.

Review of the wound evaluation dated 01/22/25 revealed the resident had an unstageable pressure ulcer to his right gluteal fold measuring 7.0 cm by 6.25 cm by 0.1 cm. The wound was described as 20% granulation tissue with scant sanguineous exudate and 80% slough. The peri-wound was pink.

Review of the wound evaluation dated 01/23/25 revealed the resident had an unstageable pressure ulcer to his coccyx measuring 13/5 cm by 9.5 cm by 0.1 cm and the wound was described as 90% slough with a scant amount of serosanguineous exudate. The peri-wound was pink.

Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent for bed mobility and toileting. The assessment indicated the resident had an indwelling urinary catheter and an ostomy. The assessment indicated the resident was at risk for skin breakdown and was admitted with one stage II and three stage III pressure ulcers. The assessment indicated the resident had an infection to his foot, other lesion to his foot and open lesions. The facility implemented a pressure reducing device to bed, pressure ulcer/injury care, application of ointments/medications other than to feet and application of dressings to feet.

Review of the progress note dated 01/25/25 at 9:33 A.M. revealed the resident was shaking all over stating that he was freezing. The resident requested to be sent to the emergency room (ER) for an evaluation.

Review of the progress note dated 01/25/25 at 5:50 P.M. revealed the resident was admitted to the hospital for the diagnoses of influenza A, dehydration and cough.

Review of the progress note dated 02/05/25 at 6:10 P.M. revealed the resident was readmitted to the facility at 6:00 P.M.

Review of the medical record revealed a comprehensive readmission assessment was not completed until 02/07/25. Further review revealed the assessment was still in progress. The resident was admitted from the hospital for wound care. The resident had an ostomy as well as an indwelling urinary catheter. The assessment indicated the resident was admitted with pressure ulcer and blisters. The Braden scale contained within the evaluation revealed a score of 14 indicating the resident was at risk moderate for skin breakdown.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Review of the medical record revealed no documented comprehensive assessment of the resident's pressure ulcers to the sacrum, left gluteus, right gluteus, right out ankle and surgical wound to left shin.

Review of the resident's monthly physician orders for February 2024 identified orders dated 01/22/25 encourage and assist with frequent offloading, heel medic boots bilaterally to assist with offloading, cleanse wound to sacrococcygeal region with wound cleanser, pat dry, apply barrier cream daily and as needed, 01/23/25 enabler bars to enhance bed mobility, bilateral ischial tuberosities-cleanse wounds with wound cleanser, pat dry, apply calcium alginate to wound bed and cover with comfort foam border dressing daily and 01/24/25 cleanse wounds to bilateral lower legs and feet with wound cleanser, pat dry, apply Xeroform to wounds wrap with Kerlix starting at base of toes working up the knee and secure with tape, change daily and as needed.

On 02/11/25 at 1:34 P.M., observation of Licensed Practical Nurse (LPN) #180 provide the physician ordered treatment to the resident's wounds revealed the LPN donned a gown and gloves for enhanced barrier precautions (EBP). The LPN placed a barrier on the bedside table consisting of a clear trash bag. She then set up the required supplies on the barrier. The dressings to the bilateral lower extremities (BLE) were dated 02/09/25. LPN #180 verified the dressing changes were physician ordered as daily and had not been changed since 02/09/25. The LPN removed the soiled dressing to the resident's left lower extremity (LLE) then removed the soiled dressing to the right outer ankle using the same gloves. The LPN placed the soiled dressings on the clear trash bag used as a barrier on the bedside table next to the clean treatment supplies. The LPN then cleansed the wounds to his LLE and right outer ankle. The LPN then washed her hands and donned a pair of gloves. The LPN then removed a piece of gauze used to cleanse the wound to the left lower extremity and placed a piece of Xeroform to the wound. She then placed multiple 4 X 4 on the Xeroform and wrapped the resident's left lower extremity with Kerlix. Using the same gloves the LPN placed a piece of Xeroform to the pressure ulcer on the right outer ankle, covered with a 4 X 4 and wrapped with Kerlix. The LPN removed the barrier from the bedside table and EBP to obtain the supplies to provide treatment to the left and right ischium wounds and the sacral wound. The LPN set-up the required supplies on the bedside table with no barrier. The resident was assisted onto his right side by a Certified Nursing Assistant (CAN) with difficulty due to the parameter mattress being too small for the resident's size. The dressing to the resident's sacrum was dated 02/08/25. The dressing was saturated with blood-tinged drainage and a foul odor was noted. LPN #180 verified the dressing changes were daily and had not been changed since 02/08/25. The LPN removed the soiled dressings to the left ischium, right ischium and sacrum using the same gloves. The LPN then cleansed all three wounds using wound cleanser and 4 X 4. The LPN then washed her hands, donned a pair of gloves and placed calcium alginate to all wound beds and covered with multiple 4 x 4. The LPN then covered all three wounds with two ABD pads and secured with tape.

On 02/11/25 at 2:00 P.M., an interview with LPN #180 confirmed the resident's bed was too small limiting the resident's ability to turn and reposition to achieve off-loading to the pressure ulcers and would require a bariatric bed. The LPN confirmed the resident was not provided with an air mattress despite the stage IV pressure ulcer to the sacrum.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/11/15 at 3:25 P.M., interview with the Licensed Nursing Home Administrator (LNHA) and the Regional Nurse revealed the contracted wound company was supposed to start in March 2025. The LNHA and Regional Nurse was made aware of no admission assessment, no comprehensive assessment of the resident's wounds, the resident's left and right ischium wounds and sacral/coccyx wound treatments had not been completed since 02/08/25 and 02/09/25. The LNHA and Regional Nurse was made aware of the resident's bed was not large enough to accommodate his size to off-load pressure to the wounds. On 02/13/25 at 9:05 A.M., an interview with the resident's primary care physician (PCP) #200 revealed he was scheduled to see Resident #43. The resident's PCP was unaware the facility had no contracted wound company, and the resident was not referred to a wound clinic, the physician ordered treatments were not being rendered as ordered and the resident was not on a specialized mattress. Review PCP #200's progress note dated 02/13/25 revealed the resident was being seen for evaluation of multiple wound and recent hospitalization for influenza A. On 01/30/25 the resident underwent surgical incision and drainage of a left calf abscess a right ankle wound, a sacral wound and ischial wounds. An examination revealed a deep stage IV pressure wound to the coccyx with significant slough and some odor indicative of an underlying infection. The wounds needed immediate debridement which could not be delayed for the wound physician's visit in the next six days. The physician's plan was to send to the hospital for further evaluation, management and treatment. The physician documented the risk of osteomyelitis was high and required surgical intervention. Review of the progress note dated 02/13/25 at 4:12 P.M. revealed the resident was admitted to the local acute care hospital for the evaluation and treatment of wounds. The facility failed to provide any documented evidence that the readmission assessment, comprehensive wound assessment and the physician ordered treatments were completed. 2. Review of the medical record for Resident #49 revealed an initial admitted [DATE] with the latest readmission of 02/11/25 with the diagnoses including but not limited to cerebrovascular accident with right sided hemiplegia, respiratory failure, asthma, chronic respiratory failure with hypoxia, severe protein calorie malnutrition, systemic lupus, dysphagia, dysphonia, neuromuscular dysfunction of bladder, gastrostomy status, cardiomyopathy, anemia, anxiety disorder, gastro-esophageal reflux disease, hyperlipidemia, hypertension, fibromyalgia and major depressive disorder. Review of the admission evaluation dated 12/27/24 revealed the resident was admitted with an indwelling urinary catheter and was incontinent of bowel. The assessment indicated the resident was a two person assist with toileting and bed mobility. The assessment indicated the resident was admitted to the facility with pressure to the sacrum/coccyx being described as a large open deep wound with tunneling, measuring 6.0 centimeters (cm) by 7.2 cm by undefinable depth. The resident also had a wound to her right ischium measuring 1.3 cm x 1.5 cm by 0.3 cm. The assessment had no description of the tissue of the wounds. Review of the wound evaluation dated 12/27/24 revealed the resident had an open wound to the sacrum/coccyx measuring 8.0 cm by 12.0 cm by undefinable depth. The wound had tunneling at 12 o'clock, 3 o'clock and 9 o'clock. The wound was described as 60% slough with a heavy purulent exudate. The peri-wound was described as pink. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365694	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Chillicothe	60 Marietta Road Chillicothe, OH 45601

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Review of the plan of care dated 12/29/24 revealed the resident had impaired skin integrity. Interventions included assisting resident with turning and repositioning as needed, complete skin inspection every seven to 10 days and as needed, complete wound evaluation to monitor the progress of the resident's skin condition and treatments per physician orders.

Review of the resident's readmission assessment dated [DATE] revealed the resident was admitted to the facility with an indwelling urinary catheter and was incontinent of bowel. The assessment indicated the resident was a two person assist with toileting and bed mobility. The assessment indicated the resident was readmitted to the facility with pressure ulcers. The assessment contained no location, staging or description of the pressure ulcers.

Review of the skin inspection dated 01/10/25 revealed the resident had skin issues as follows and were present on admission:

Sacrum/coccyx wound measured 0.8 centimeters (cm) by 12.0 cm by undefinable depth with bone involvement. The wound was described as 60% tan slough with 40% granulation tissue, bone was visible at the center of the wound. The wound also had tunneling/undermining present at 3 o'clock, 6 o'clock and 9 o'clock with heavy malodorous brown wound drainage. The wound edges were uneven, and the peri-wound was pink.

Right Ischium open wound measured 0.3 cm with a 0.1 cm depth. The wound bed was not described and had no drainage. The peri-wound was described as dark purple-maroonish.

The left ischium open area was from shearing measuring 0.3 cm by 0.8 cm by 0.1 cm with no description of the wound bed. The wound edges were uneven, and the peri-wound was pink.

Left heel open wound measured 1.5 cm by 3.0 cm by 0.1 cm with no description of the wound bed. The wound edges were uneven, and the peri-wound was dark purple maroonish in color.

Review of the wound evaluation dated 01/11/25 revealed the resident was readmitted to the facility with an unstageable pressure ulcer to her sacrum/coccyx measuring 8.0 cm by 12.0 cm by undefinable. The wound had tunneling and/or undermining at 3 o'clock, 6 o'clock and 9 o'clock. The wound was described as 30% epithelial tissue, 10% granulation and 60% slough with a heavy serous exudate. The peri-wound was described as pink.

Review of the wound evaluation dated 01/16/25 revealed the resident stage IV pressure ulcer to the coccyx measured 12 cm by 7.0 cm by 1.3 cm. The wound was described as 70% granulation tissue and 30% slough with a moderate amount of serosanguineous exudate. The peri-wound was described as pink, and the facility determined the wound had remained unchanged.

Review of the wound evaluation dated 01/16/25 revealed the shearing wound was now a stage III pressure ulcer to the left ischium measuring 6.0 cm by 3.0 cm by 0.1 cm and described as 70% granulation and 30% slough with a small amount of serosanguineous exudate. The assessment indicated the resident was admitted with stage III pressure ulcer.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive impairment. The resident was dependent on staff for toileting. The assessment indicated the resident had an indwelling urinary catheter and was always incontinent of bowel. The assessment indicated the resident was at risk for skin breakdown and was admitted with one stage II pressure ulcer, one stage III pressure ulcer and one stage IV pressure ulcer. The facility implemented pressure reducing devices to bed/chair, turning/repositioning program, nutrition or hydration intervention to manage skin problems and pressure ulcer/injury care. Review of the wound evaluation dated 01/22/25 revealed the resident stage IV pressure ulcer to the coccyx measured 10 cm by 6.5 cm by 1.3 cm. The wound was described as 70% granulation tissue and 30% slough with a moderate amount of sanguineous exudate. The peri-wound was described as pink, and the facility determined the wound had remained unchanged. Review of the wound evaluation dated 01/22/25 revealed the resident had a stage III pressure ulcer to the left ischium measuring 6.0 cm by 3.0 cm by 0.1 cm and described as 70% granulation and 30% slough with a small amount of sanguineous exudate. The assessment indicated the resident was admitted with stage III pressure ulcer. Review of the medical record revealed no documented evidence the wounds to the right ischium and the left heel were assessed every seven days as required. Review of the residents' January 2025 Treatment Administration Record (TAR) revealed a treatment was not implemented for the wound to the resident's left heel, left ischium until 01/17/25. The physician ordered treatment was not provided for the left ischium wound on 01/19/25 and 01/30/25. Further review revealed the physician ordered treatment to the sacral/coccyx wound was not provided as ordered on 01/16/25, 01/19/25 and 01/30/25. Additionally, the air mattress was not implemented until 01/28/25. Review of the progress note dated 02/01/25 at 9:05 A.M. revealed the resident was displaying an altered mental status. The resident was sent to the local emergency room (ER) for an evaluation. Review of the progress note dated 02/01/25 at 11:01 P.M. revealed the resident was admitted to the acute care hospital for altered mental status, possible urinary tract infection (UTI) and acute metabolic encephalopathy. Review of the progress note dated 02/11/25 at 8:27 P.M. revealed the resident was readmitted to the facility. Review of the medical record revealed no documented evidence a readmission assessment or wound assessment was completed. Review of the resident's monthly physician orders for February 2025 identified orders dated 02/12/25 enhanced barrier precautions (EBP) related to wound, tube feeding and tracheostomy. Further review revealed no orders for the treatment of the sacral/coccyx wound, left ischium wound, the right ischium wound and the left heel wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the first documented wound evaluation following survey request revealed on 02/13/25 the unstageable pressure ulcer to the sacral/coccyx measured 10.0 cm by 6.5 cm by 1.3 cm and described as 30% slough and 70% granulation tissue. The wound had a heavy amount of serosanguineous exudate. The peri-wound was described as pink. Review of the first documented wound evaluation following survey request revealed on 02/13/25 the unstageable pressure ulcer to the left ischium measured 6.0 cm by 1.3 cm by 0.1 cm and described as 30% slough and 70% granulation tissue with a small amount of serosanguineous exudate. The peri-wound was described as pink. Review of the first documented wound evaluation following survey request revealed on 02/13/25 the stage III pressure ulcer measuring 6.0 cm by 1.3 cm by 0.1 cm with the wound being described as 30% slough and 70% granulation tissue with a small amount of serosanguineous exudate. The peri-wound was described as pink. Review of the resident's February 2024 Treatment Administration Record (TAR) revealed a treatment to the unstageable pressure ulcer to the sacrum/coccyx and left ischium and the stage II pressure ulcer to the left heel was not implemented until 02/13/24. On 02/13/25 at 9:05 A.M., an interview with the resident's PCP #200 revealed he was scheduled to see Resident #49 and revealed he was unaware the resident had no treatment in place for the multiple pressure ulcers. On 02/13/25 at 2:45 P.M., an interview with the Director of Nursing (DON) verified the resident had no readmission assessment, readmission wound assessments and treatments for the multiple pressure ulcers. Review of the facility policy titled, Wound Care, dated 09/21 revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Verify there is a physician's order for the procedure. Review of the facility policy titled, Pressure Reducing and Relieving Devices, not dated revealed the purpose of the procedure was to provide guidelines for the assessment of the appropriate reducing and relieving devices for residents at risk of skin breakdown. Redistributing support surfaces are to promote for bed or chairbound residents to prevent skin breakdown, promote circulation and provide pressure relief or reduction. Mattresses are chosen for the residents based on Braden scale pressure ulcer risk. Residents at risk for developing pressure ulcers should be placed on a redistribution support surface such as foam, gel, static, air, alternating air or air loss or gel when lying in bed. This deficiency represents noncompliance investigated under Complaint Number OH00162365.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and interview, the facility failed to ensure an indwelling urinary catheter was changed as physician ordered for Resident #43. Additionally, the facility failed to ensure one resident (#73) received routine indwelling catheter care. This affected two (Resident #43 and #73) of three residents reviewed for indwelling urinary catheter. The facility census was 67. Findings Include: 1. Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. Review of the resident's admission evaluation dated 01/22/25 revealed the resident was admitted from an acute care hospital for wounds and weakness. The resident had an indwelling urinary catheter on admission. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent for bed mobility and toileting. The assessment indicated the resident had an indwelling urinary catheter and an ostomy. Review of the resident's monthly physician orders for February 2024 identified orders dated 02/10/25 change Foley catheter and Foley bag every month every day shift starting on the tenth and ending on the tenth every month, change Foley every 30 days starting in 2/10/25. Review of the medical record revealed no evidence the resident's indwelling urinary catheter was changed as physician ordered on 02/10/25. On 02/11/25 at 11:47 A.M., interview with Resident #43 revealed his indwelling urinary catheter was supposed to be changed on 02/10/25, however it was not changed. Observation of the resident revealed the indwelling urinary catheter collection bag was not in a privacy bag and the clear yellow urine was visible from the hallway. On 02/11/25 at 2:15 P.M., interview with Licensed Practical Nurse (LPN) #180 confirmed the resident's indwelling urinary catheter was not changed as physician ordered on 02/10/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the closed medical record for Resident #73 revealed an initial admitted [DATE] with the latest readmission of 11/21/24 with the diagnoses including but not limited to sepsis, severe sepsis with shock, urinary tract infection (UTI), adult failure to thrive, retention of urine, chronic atrial fibrillation, cystitis with hematuria, hypertension, osteoarthritis, pain, anemia, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, edema, malignant neoplasm of prostate, presence of urogenital implants, bladder neck obstruction, cerebral ischemia and hyperlipidemia. Review of the resident's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. The resident was dependent on staff for toileting and transfers. The assessment indicated the resident had an indwelling urinary catheter and was always incontinent of bowel. Review of the resident's Foley catheter justification dated 12/17/24 revealed the assessment was blank. Review of the resident's discharged physician orders identified an order dated 12/19/24 record Foley catheter output every shift. Review of the medical record revealed no physician orders or documented evidence the resident's indwelling urinary catheter was provided care. On 02/13/25 at 3:45 P.M., interview with the Director of Nursing (DON) confirmed the the resident had no physician orders or documented evidence the resident's indwelling urinary catheter was provided care. This deficiency represents non-compliance investigated under Complaint Number OH00162180.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and interview, the facility failed to maintain two residents (#50, #72) enteral feeding tube in proper working order. This affected two (Resident #50 and #72) of three residents reviewed for enteral feedings. The facility census was 67. Findings Include: 1. Review of the closed medical record for Resident #72 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), severe protein calorie malnutrition, right bundle branch block, urinary tract infection, pneumonitis due to inhalation of food and vomit, dysphagia, other disorders of lung, history of falling, pain, slow transit constipation, migraine, vitamin D deficiency, intervertebral disc displacement lumbar region, neuromuscular dysfunction of bladder, slurred speech, osteoarthritis, dependence on supplemental oxygen, anxiety disorder and functional quadriplegia. The resident was discharged to another local skilled nursing facility (SNF) on 02/07/25. Review of the resident's plan of care dated 02/03/25 last revised on 02/11/25 revealed the resident had nutritional problem or potential nutritional problem related to peg-tube placement 12/23/24, enteral feedings, skin impairment, body mass index (BMI) low end of normal, dysphagia, MS, aspiration pneumonia, chewing/swallowing difficulties, broken/missing teeth, appetite stimulant and abnormal labs. Interventions included monitor/document/report as needed any signs/symptoms of dysphagia, monitor/record/report to physician as needed signs/symptoms of malnutrition, provide and serve diet as ordered, Registered Dietician (RD) to evaluate and make diet change recommendations as needed and speech therapy to screen and provide recommendations for feeding as needed. Review of the resident's discharged physician ordered identified orders dated 01/25/25 nothing by mouth (NPO), enteral feeding of Pivot 1.5 at 45 milliliters (ml) per hour with 100 ml water flush every four hours via peg-tube, check residuals every eight hours, if greater than 100 ml, hold feeding and recheck in one hour, if not resolved call the physician, check peg-tube placement before feeding, flush and medications, flush peg-tube with minimum of 30 ml of water before giving medications, flush with at least 5 ml between medications and flush with minimum of 30 ml after all medications given, monitor for tube feeding complications and 01/28/25 change feeding administration set with each new bottle, label the formula container, syringe and administration set with resident's name, date, time and the nurse's initials. On 02/11/25 at 11:30 A.M., interview with Licensed Practical Nurse (LPN) #168 verified she worked with Resident #72 and his peg-tube leaked due to the connector had a crack. The LPN revealed the facility did not have a replacement connector so they wrapped the connection in a towel to soak up the enteral feeding leaking out. On 02/12/25 at 12:27 P.M., interview with Certified Nursing Assistant (CNA) #149 verified she cared for Resident #72 and his peg-tube leaked the entire time he was a the facility. She revealed she wrapped his peg-tube in a towel to catch the leaking formula and changed the towel frequently. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #50 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, diabetes mellitus, cardiac arrest due to other underlying condition, moderate protein calorie malnutrition, intracranial injury with loss of consciousness, dysphagia, atrial fibrillation, obstructive sleep apnea, hyperlipidemia, hypertension, gastro-esophageal reflux disease, insomnia, obesity, major depressive disorder, anemia, hearing loss, mood disorder, osteoarthritis, polyneuropathy and atypical atrial flutter. Review of the plan of care dated 01/31/25 revealed the resident was at risk for altered nutritional status related to diabetes mellitus, protein calorie malnutrition, dysphagia, hyperlipidemia, hypertension, peg-tube placement 11/06/24, abnormal labs, diarrhea, swallowing difficulties, significant weight loss and appetite stimulant. Interventions included administer medication and/or vitamin/mineral supplement per physician order, encourage/provide intake of fluids throughout the day, if not contraindicated, notify RD, family, and physician of any signs / symptoms of dehydration, obtain labs per physicians orders associated with nutritional status and report results to the physician and ensure dietician is aware, therapy referral/evaluation/treatment as needed, periodically obtain resident's weight, evaluate, and report to RD, physician, and family of significant weight changes, Provide feeding/dining assistance as needed, Provide meals/snacks/fluids based on resident food preferences and physician orders, provide nutritional supplements as ordered by physician, administer enteral nutrition per physician orders, notify physician of complications observed with enteral nutrition, review with resident and/or family any issues or concerns about the enteral nutrition, flush feeding tube per physician orders, treatment to tube site per physician orders, Monitor and report to physician any abdominal pain, distension, tenderness at tube site, nausea/vomiting and check for tube placement and residual as indicated. Review of the resident's physician orders for February 2025 identified orders dated 01/31/25 flush peg tube every shift with 100 ml of water every 4 hours via peg-tube, Peptide 1.5-55 ml/hour continuously, change syringe daily daily on night shift, check and record residuals every shift, contact physician if residual exceeds 100 ml, check tube placement before initiation of formula, medication administration, and flushing tube or at least every eight hours, continuous feed, check every four to six hours, prior to irrigation and as needed, closed system container, change feeding administration set with each new bottle/bag; label the formula container, syringe and administration set with resident's name, date, time, and nurse's initials, elevate head of bed 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped, 02/01/25 cleanse peg-tube site with normal saline and pat dry, apply split sponge and secure with tape daily, and 02/03/25 NPO diet, Enhanced Barrier Precautions related to g-tube every shift. On 02/11/25 at 11:15 A.M., observation of Licensed Practical Nurse (LPN) #168 administer Resident #50 morning medication via his peg-tube revealed the crushed all of the resident's medications and opened the capsules and placed in a clear plastic medication cup together. The LPN checked placement of the peg-tube with 10 ml of air and aspiration for residual enteral formula. The LPN then placed a syringe onto the peg-tube and filled the syringe with approximately 30 ml of water. The peg-tube was clogged so the LPN pushed the water resulting in the water spraying onto the resident's clothing. The LPN obtained another syringe and attempted to administer the resident's morning medication with the syringe with the part of the medication leaking out onto the resident. Interview with LPN #168 at the time of the observation revealed the facility did not have any piston type syringes in stock for the resident's peg-tube. The LPN donned no enhanced barrier precaution (EBP) equipment (gown and gloves) during the procedure. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Administering Medications Through an Enteral Tube, dated 09/21 revealed the purpose of the procedure was to provide guidelines for the safe administration of medications through an enteral tube. Do not mix medications together prior to administering through an enteral tube. Administer each medication separately. This deficiency represents non-compliance investigated under Complaint Number OH00162365.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, interview and facility policy review, the facility failed to ensure one resident (#72) was provided the physician ordered chest vest (help clear patients ' airways. It dislodges mucus from the bronchial walls, and helps move secretions and mucus from smaller to larger airways, where it can be coughed or suctioned out.) for chest physiotherapy. This affected one (Resident #72) of one resident reviewed for chest vest use. The facility census was 67. Findings Include: Review of the closed medical record for Resident #72 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), severe protein calorie malnutrition, right bundle branch block, urinary tract infection, pneumonitis due to inhalation of food and vomit, dysphagia, other disorders of lung, history of falling, pain, slow transit constipation, migraine, vitamin D deficiency, intervertebral disc displacement lumbar region, neuromuscular dysfunction of bladder, slurred speech, osteoarthritis, dependence on supplemental oxygen, anxiety disorder and functional quadriplegia. The resident was discharged to another local skilled nursing facility (SNF) on 02/07/25. Review of the resident's admission evaluation dated 01/24/25 revealed the resident was admitted to the facility from an acute care hospital stay for MS, increased weakness and post-op debridement of pressure ulcers. The assessment did not address the use of the chest vest for chest physiotherapy. Review of the medical record revealed no baseline plan of care addressing the resident's respiratory status and the use of the chest vest for chest physiotherapy. Review of the resident's discharge physician orders identified an order dated 01/25/25 chest physiotherapy via chest vest three times a day. Review of the progress note dated 01/25/25 at 7:21 P.M. revealed the resident arrived at the facility without the chest vest for chest physiotherapy. Review of the progress note dated 01/30/25 at 12:42 P.M. revealed the percussion wrap arrived to the facility and placed in resident room for percussion therapy. On 02/12/25 at 8:50 A.M., interview with the Regional Nurse #210 verified the chest vest for chest physiotherapy had not arrived in a timely manner. This deficiency represents non-compliance investigated under Complaint Number OH00162365.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, interview and facility policy review, the facility failed to ensure staffing to meet residents needs. This affected two (Resident #50 and #72) residents and had the potential to affect all 67 residents residing in the facility. The census was 67. Finding Include: 1. On 02/11/25 at 11:15 A.M., observation of Licensed Practical Nurse (LPN) #168 administer Resident #50 morning medication due at 6:00 A.M. via his peg-tube revealed the resident's medication was being administered late. On 02/11/25 at 11:30 A.M., interview with LPN #168 confirmed Resident #50's morning medication was administered outside of the allotted timeframe. LPN #168 revealed the the facility only had three nurses on duty so she had half of another hallway and had three residents who she had to administer morning medications yet. 2. Review of the closed medical record for Resident #72 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD), severe protein calorie malnutrition, right bundle branch block, urinary tract infection, pneumonitis due to inhalation of food and vomit, dysphagia, other disorders of lung, history of falling, pain, slow transit constipation, migraine, vitamin D deficiency, intervertebral disc displacement lumbar region, neuromuscular dysfunction of bladder, slurred speech, osteoarthritis, dependence on supplemental oxygen, anxiety disorder and functional quadriplegia. The resident was discharged to another local skilled nursing facility (SNF) on 02/07/25. Review of the resident's admission evaluation dated 01/24/25 revealed the resident preferred bathing at bedtime. Review of the resident's comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive deficit. The resident was dependent on staff for personal hygiene, toileting, bathing, bed mobility and substantial/maximal assistance with dressing. Review of the resident's medical record revealed the resident was scheduled for routine showers every Monday and Thursday. Review of the medical record revealed no evidence the resident was provided the scheduled shower on 01/27/25, 01/30/25, 02/03/25 and 02/06/25. On 02/12/25 at 12:27 P.M., interview with Certified Nursing Assistant (CNA) #149 revealed facility staff had been an issue and showers are not done when staffing is not adequate. Review of the facility policy titled, Staffing, dated 09/21 revealed the facility provides staffing to needed care and services for the resident population. (continued on next page)

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	365694	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Chillicothe	60 Marietta Road Chillicothe, OH 45601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents non-compliance investigated under Master Complaint Number OH00162558 and Complaint Number OH00162365.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review and interviews, the facility failed to maintain a complete and accurate record for one resident (#43) in the area of physician ordered treatments. This affected one (Resident #43) of three residents reviewed for pressure ulcers. The facility census was 67. Findings Include: Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. Review of the medical record revealed a comprehensive readmission assessment was not completed until 02/07/25. Further review revealed the assessment was still in progress. The resident was admitted from the hospital for wound care. The resident had an ostomy as well as an indwelling urinary catheter. The assessment indicated the resident was admitted with pressure ulcer and blisters. The Braden scale contained within the evaluation revealed a score of 14 indicating the resident was at risk moderate for skin breakdown. Review of the medical record revealed no documented comprehensive assessment of the resident's pressure ulcers to the sacrum, left gluteus, right gluteus, right out ankle and surgical wound to left shin. Review of the resident's monthly physician orders for February 2024 identified orders dated 01/22/25 encourage and assist with frequent offloading, heel medic boots bilaterally to assist with offloading, cleanse wound to sacrococcygeal region with wound cleanser, pat dry, apply barrier cream daily and as needed, 01/23/25 enabler bars to enhance bed mobility, bilateral ischial tuberosities-cleanse wounds with wound cleanser, pat dry, apply calcium alginate to wound bed and cover with comfort foam border dressing daily and 01/24/25 cleanse wounds to bilateral lower legs and feet with wound cleanser, pat dry, apply Xeroform to wounds wrap with Kerlix starting at base of toes working up the knee and secure with tape, change daily and as needed. Review of the resident's monthly Treatment Administration Record (TAR) for February 2025 revealed the physician ordered treatments to the residents' sacrum/coccyx pressure ulcer was initialed by a staff nurse indicating the treatment was completed on 02/09/25 and 02/10/25. Further review revealed the treatment to the resident's bilateral lower extremities was initialed by a staff nurse indicating the treatment was completed on 02/10/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE 60 Marietta Road Chillicothe, OH 45601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/25 at 1:34 P.M., observation of Licensed Practical Nurse (LPN) #180 provide the physician ordered treatment to the resident's wounds revealed the LPN donned a gown and gloves for enhanced barrier precautions (EBP). The LPN placed a barrier on the bedside table consisting of a clear trash bag. She then set up the required supplies on the barrier. The dressings to the bilateral lower extremities (BLE) were dated 02/09/25. LPN #180 verified the dressing changes were physician ordered as daily and had not been changed since 02/09/25. The resident was assisted onto his right side by a certified nursing assistant with difficulty due to the parameter mattress being too small for the resident's size. The dressing to the resident's sacrum was dated 02/08/25. The dressing was saturated with blood-tinged drainage and a foul odor was noted. LPN #180 verified the dressing changes were daily and had not been changed since 02/08/25. This deficiency was an incidental finding discovered during the course of this complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observation, record review, interview, and facility policy review, the facility failed to maintain infection control practices to prevent the potential spread of infection during pressure ulcer dressing change for one resident (#43). Additionally, the facility failed to implement enhance barrier precautions for one resident (#50) with an indwelling medical device. This affected one resident (#43) of three residents reviewed for pressure ulcers and one resident (#50) of three residents reviewed for enteral feeding tubes. The facility census was 67. Findings include: 1. Review of the medical record for Resident #43 revealed an initial admitted [DATE] with the latest readmission of 02/05/25 with the diagnoses including but not limited to cellulitis of right lower limb, pressure induced deep tissue damage of sacral region sacral region, hypertension, neurogenic bowel, benign prostatic hyperplasia neuromuscular dysfunction of bladder, anemia, bipolar disorder, anxiety disorder, post-traumatic stress disorder, osteoarthritis, gastro-esophageal reflux disease, retention of urine, edema, pain, Rhabdomyolysis, insomnia, spondylosis lumbar region, obesity, colostomy status and polyneuropathy. Review of the medical record revealed a comprehensive readmission assessment was not completed until 02/07/25. Further review revealed the assessment was still in progress. The resident was admitted from the hospital for wound care. The resident had an ostomy as well as an indwelling urinary catheter. The assessment indicated the resident was admitted with pressure ulcer and blisters. The Braden scale contained within the evaluation revealed a score of 14 indicating the resident was at risk moderate for skin breakdown. Review of the medical record revealed no documented comprehensive assessment of the resident's pressure ulcers to the sacrum, left gluteus, right gluteus, right out ankle and surgical wound to left shin. Review of the resident's monthly physician orders for February 2024 identified orders dated 01/22/25 encourage and assist with frequent offloading, heel medic boots bilaterally to assist with offloading, cleanse wound to sacrococcygeal region with wound cleanser, pat dry, apply barrier cream daily and as needed, 01/23/25 enabler bars to enhance bed mobility, bilateral ischial tuberosities-cleanse wounds with wound cleanser, pat dry, apply calcium alginate to wound bed and cover with comfort foam border dressing daily and 01/24/25 cleanse wounds to bilateral lower legs and feet with wound cleanser, pat dry, apply Xeroform to wounds wrap with Kerlix starting at base of toes working up the knee and secure with tape, change daily and as needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/25 at 1:34 P.M., observation of Licensed Practical Nurse (LPN) #180 provide the physician ordered treatment to the resident's wounds revealed the LPN donned a gown and gloves for enhanced barrier precautions (EBP). The LPN placed a barrier on the bedside table consisting of a clear trash bag. She then set up the required supplies on the barrier. The dressings to the bilateral lower extremities (BLE) were dated 02/09/25. LPN #180 verified the dressing changes were physician ordered as daily and had not been changed since 02/09/25. The LPN removed the soiled dressing to the resident's left lower extremity (LLE) then removed the soiled dressing to the right outer ankle using the same gloves. The LPN placed the soiled dressings on the clear trash bag used as a barrier on the bedside table next to the clean treatment supplies. The LPN then cleansed the wounds to his LLE and right outer ankle. The LPN then washed her hands and donned a pair of gloves. The LPN then removed a piece of gauze used to cleanse the wound to the left lower extremity and placed a piece of Xeroform to the wound. She then placed multiple 4 X 4 on the Xeroform and wrapped the resident's left lower extremity with Kerlix. Using the same gloves the LPN placed a piece of Xeroform to the pressure ulcer on the right outer ankle, covered with a 4 X 4 and wrapped with Kerlix. The LPN removed the barrier from the bedside table and EBP to obtain the supplies to provide treatment to the left and right ischium wounds and the sacral wound. The LPN set-up the required supplies on the bedside table with no barrier. The resident was assisted onto his right side by a certified nursing assistant with difficulty due to the parameter mattress being too small for the resident's size. The dressing to the resident's sacrum was dated 02/08/25. The dressing was saturated with blood-tinged drainage and a foul odor was noted. LPN #180 verified the dressing changes were daily and had not been changed since 02/08/25. The LPN removed the soiled dressings to the left ischium, right ischium and sacrum using the same gloves. The LPN then cleansed all three wounds using wound cleanser and 4 X 4. The LPN then washed her hands, donned a pair of gloves and placed calcium alginate to all wound beds and covered with multiple 4 X 4. The LPN then covered all three wounds with two ABD pads and secured with tape. On 02/11/25 at 2:15 P.M., an interview with LPN #180 confirmed she completed the wounds to the resident's bilateral lower legs together and the wounds to the sacrum/coccyx, left ischium and right ischium together instead of separately introducing potential infection to the wounds. 2. Review of the medical record for Resident #50 revealed an initial admitted [DATE] with the diagnoses including but not limited to acute respiratory failure with hypoxia, diabetes mellitus, cardiac arrest due to other underlying condition, moderate protein calorie malnutrition, intracranial injury with loss of consciousness, dysphagia, atrial fibrillation, obstructive sleep apnea, hyperlipidemia, hypertension, gastro-esophageal reflux disease, insomnia, obesity, major depressive disorder, anemia, hearing loss, mood disorder, osteoarthritis, polyneuropathy and atypical atrial flutter. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the plan of care dated 01/31/25 revealed the resident was at risk for altered nutritional status related to diabetes mellitus, protein calorie malnutrition, dysphagia, hyperlipidemia, hypertension, peg-tube placement 11/06/24, abnormal labs, diarrhea, swallowing difficulties, significant weight loss and appetite stimulant. Interventions included administer medication and/or vitamin/mineral supplement per physician order, encourage/provide intake of fluids throughout the day, if not contraindicated, notify registered dietician (RD), family, and physician of any signs / symptoms of dehydration, obtain labs per physicians orders associated with nutritional status and report results to the physician and ensure dietician is aware, therapy referral/evaluation/treatment as needed, periodically obtain resident's weight, evaluate, and report to RD, physician, and family of significant weight changes, Provide feeding/dining assistance as needed, Provide meals/snacks/fluids based on resident food preferences and physician orders, provide nutritional supplements as ordered by physician, administer enteral nutrition per physician orders, notify physician of complications observed with enteral nutrition, review with resident and/or family any issues or concerns about the enteral nutrition, flush feeding tube per physician orders, treatment to tube site per physician orders, Monitor and report to physician any abdominal pain, distension, tenderness at tube site, nausea/vomiting and check for tube placement and residual as indicated.

Review of the resident's physician orders for February 2025 identified orders dated 01/31/25 flush peg tube every shift with 10 milliliters (ml) of water every 4 hours via peg-tube, Peptide 1.5-55 ml/hour continuously, change syringe daily daily on night shift, check and record residuals every shift, contact physician if residual exceeds 100 ml, check tube placement before initiation of formula, medication administration, and flushing tube or at least every eight hours, continuous feed, check every four to six hours, prior to irrigation and as needed, closed system container, change feeding administration set with each new bottle/bag; label the formula container, syringe and administration set with resident's name, date, time, and nurse's initials, elevate head of bed 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped, 02/01/25 cleanse peg-tube site with normal saline and pat dry, apply split sponge and secure with tape daily, and 02/03/25 NPO diet, Enhanced Barrier Precautions related to g-tube every shift.

On 02/11/25 at 11:15 A.M., observation of Licensed Practical Nurse (LPN) #168 administer Resident #50 morning medication via his peg-tube revealed the LPN checked placement of the peg-tube with 10 ml of air and aspiration for residual enteral formula. The LPN then placed a syringe onto the peg-tube and filled the syringe with approximately 30 ml of water. The peg-tube was clogged so the LPN pushed the water resulting in the water spraying onto the resident's clothing. The LPN obtained another syringe and attempted to administer the resident's morning medication with the syringe with the part of the medication leaking out onto the resident. Interview with LPN #168 at the time of the observation revealed the facility did not have any piston type syringes in stock for the resident's peg-tube. The LPN donned no enhanced barrier precaution (EBP) equipment (gown and gloves) during the procedure and no EBP equipment was available at bedside.

On 02/11/25 at 11:25 A.M., interview with LPN #168 confirmed EBP equipment was not worn during the procedure as physician ordered and the EBP was not available at bedside.

Review of the facility policy titled, Enhanced Barrier Precautions (EBP), dated 01/24 revealed EBP are an infection control method used in the facility to reduce transmission of drug-resistant organisms (MDROs). EBP refers to the use of gown and gloves during high- contact care activities for residents with any of the following, known infection or colonization with a resistant organism when contact precautions do not otherwise apply, chronic wounds and indwelling medical devices.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency was an incidental finding discovered during the course of this complaint investigation.