

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on medical record review and staff interview, the facility failed to ensure a resident was provided assistance in obtaining a resident representative to make appropriate decision on behalf of the resident, concerning exercising resident rights and care and treatment at the facility. This affected one (#56) of one resident reviewed for decision making. Facility census was 61.</p> <p>Findings include</p> <p>Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included vascular dementia without behavioral disturbances, unsteadiness on feet, generalized weakness, failure to thrive, and malnutrition.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had significant cognitive impairment.</p> <p>Review progress notes dated 02/08/24, revealed Resident #56 had a significant other at the facility who wanted to take him out of the building. Staff educated Resident#56's girlfriend that Resident #56 was not to be out of the building without family. Progress note dated 04/20/24, revealed Resident #56 was taken outside of the facility to watch the eclipse staff found the wander guard did not alarm. They checked it out and found resident's wander guard was cut off with scissors. Staff believed Resident#56's girlfriend (also a resident) had cut the wander guard off.</p> <p>Interview on 05/21/24 at 2:40 P.M., with Administrator and Corporate Nurse #587 revealed Resident #56's girlfriend was his decision maker, they revealed she was his common law wife and they had been together for [AGE] years. Administrator and Corporate Nurse #587 revealed Resident #56 had a son and confirmed the son was listed in the facility emergency contact list. Administrator and Corporate Nurse #587 stated the facility has been having trouble getting him to respond. Corporate Nurse #587 revealed Resident #56 did not have another family they were aware of and no guardian in place. Corporate Nurse #587 acknowledged Ohio does not recognize common law marriage.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/21/24 at 4:30 P.M. to 5:09 P.M., with Administrator, Director of Nursing, Corporate Nurse (CN) #587 and Corporate Nurse #597, confirmed they had a care conference and discussions with Resident #56's son, who informed the facility, he was done and Resident #56 could do whatever. Staff revealed Resident #56's son had not been reachable since that meeting and did not respond to messages. Staff also revealed they had considered guardianship process but thought it wouldn't be approved due to resident having family. The staff revealed Resident#56's girlfriend (also a resident at the facility) may not be an appropriate decision maker due to showing risky behaviors regarding resident safety.</p> <p>Interview on 05/23/24 at 1:00 P.M., with Administrator confirmed the last time Resident #56's son was involved as a decision maker was before she started at the facility in March 2024. The facility was unable to provide a specific date upon request of when the family was last involved. Administrator verified the facility had not initiated the guardianship process.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on medical record review, review of the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), and staff interview, the facility failed to ensure the resident notice letter was accurately completed. This affected three (#41, #66, and #71) of three residents reviewed for Beneficiary Notification. The facility census was 61.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #41 was admitted on [DATE], with diagnoses of fracture of right femur neck, Parkinson's disease, cognitive communication deficit, dysphagia, neuropathy, anemia, acute embolism and thrombosis of right femoral vein, hypertension, and osteoporosis. The last covered day of Part A service for Resident #41 was 05/03/24 who then transitioned to long-term care.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident#41 was moderately cognitively impaired, was always incontinent of bowel and bladder, and had no range of motion impairment in upper and lower extremities. Resident #41 required set up assistance with eating, moderate assistance with oral and personal hygiene, maximal assistance for bathing, and was dependent for toileting, dressing, bed mobility, and transfers.</p> <p>Review of the SNF Beneficiary Notification Review for Resident #41 revealed a Medicare Part A Skilled Services episode start date of 02/21/24, Last Covered Day of Part A Service of 05/03/24, and the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. A Notice of Medicare Non-Coverage (NOMNC) was signed by Resident #41 on 05/01/24. The facility failed to provide Resident #41 a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN).</p> <p>2. Review of the medical record revealed Resident #66 was admitted on [DATE], with diagnoses of osteomyelitis, acute respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit, metabolic encephalopathy, dysphagia, sepsis, urinary tract infection, chronic kidney disease, stage III, multiple sclerosis, chronic obstructive pulmonary disease, dementia, major depressive disorder, diabetes mellitus type II with foot ulcer, and cognitive communication deficit. The last covered day of Part A service for Resident #66 was 05/11/24 who then discharged home with Hospice services the same day.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #66 was severely cognitively impaired, always incontinent of bowel and bladder, and had no range of motion impairment in upper and lower extremities. Resident #66 was dependent for eating, oral and personal hygiene, bathing, toileting, dressing, bed mobility, and transfers.</p> <p>(continued on next page)</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SNF Beneficiary Notification Review for Resident #66 revealed a Medicare Part A Skilled Services episode start date of 03/27/24, Last Covered Day of Part A Service of 05/12/24, and the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The facility documented on the SNF Beneficiary Notification Review the Business Office Manager's (BOM), staff #13, failure to issue a Notice of Medicare Non-Coverage (NOMNC) before Resident #66 discharged . The facility did not provide any documentation Resident #66 initiated the discharge.</p> <p>3. Review of the medical record revealed Resident #71 was admitted [DATE] with diagnoses of sepsis, bacteremia, Methicillin Resistant Staphylococcus Aureus infection (MRSA), malignant neoplasm of colon, lymphedema, diabetes mellitus type II, endocarditis, and wedge compression fracture of unspecified thoracic vertebra. The last covered day of Part A service for Resident #71 was 05/04/24 who then transitioned to long-term care.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident#71 was moderately cognitively impaired, occasionally incontinent of bladder and continent of bowel, and had no range of motion impairment in upper and lower extremities. Resident #71 required set up assistance with eating and oral hygiene, moderate assistance with personal hygiene, toileting, bed mobility, and transfers, and maximal assistance for bathing and dressing.</p> <p>Review of the SNF Beneficiary Notification Review for Resident #71 revealed a Medicare Part A Skilled Services episode start date of 04/22/24, Last Covered Day of Part A Service of 05/04/24, and the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. A Notice of Medicare Non-Coverage (NOMNC) was signed by Resident #71 on 05/02/24. The facility to provide Resident #71 a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN). The facility documented on the SNF Beneficiary Notification Review the Business Office Manager's, staff #13, failure to issue a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) to Resident #71.</p> <p>Interview with the Administrator and Business Office staff #10, on 05/22/25 at 12:50 P.M., confirmed the facility failed to issue Resident #41 a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN); failed to issue Resident #66 a Notice of Medicare Non-Coverage (NOMNC); and failed to issue Resident #71 a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN).</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49771</p> <p>Based on medical record review, policy review, and staff interview, the facility failed to ensure the medical record contained documentation reflecting the reason resident was transferred to the hospital. This affected one (#64) of one resident reviewed for hospitalization . The facility census was 61.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #64 revealed an admitted [DATE], with diagnoses of acute metabolic acidosis, sepsis, fatty (change of) liver, post-traumatic stress disorder, personality disorder, ulcerative colitis, attention-deficit hyperactivity disorder, anxiety disorder, alcohol use with intoxication, major depressive disorder, hypertension, fibromyalgia, and alcoholic liver disease. Resident #64 was discharged from the facility on 05/03/24 to a non-specified location.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 was cognitively intact and continent of bowel and bladder. Resident #64 required set up assistance for eating and personal hygiene, touch assistance for oral hygiene, transfers, and ambulation, moderate assistance for toileting, bathing, and dressing, and was independent for bed mobility.</p> <p>Review of physician orders for Resident #64 revealed an order dated 05/01/24 stating Resident #64 is to be discharged home with medications, no controlled substances.</p> <p>Review of a progress note dated 05/01/24 at 3:51 P.M., by Staff #13 stated Resident #64 will be discharging home with a niece on 05/04/24.</p> <p>Review of a progress note dated 05/03/24 at 2:20 P.M., by the Director of Nursing stated Resident #64 is requesting the discharge be moved up to today (05/03/24) due to the niece not being sure of availability on 05/04/24. Resident #64 stated a brother-in-law is available today, if the facility could get everything ready. Staff #13 was alerted, the discharge paperwork was prepared, and Resident #64 was ready to discharge when the brother-in-law arrived.</p> <p>Review of a progress note dated 05/03/24 at 6:57 P.M., by Registered Nurse (RN) #34 stated patient report called to Adena Regional Medical Center (ARMC) emergency room (ER) to Hospital Nurse RN #100.</p> <p>Interview on 05/21/24 at 2:40 P.M., with Staff #13 revealed the staff member failed to provide information as to why Resident #64 was transferred to the hospital when the plan was to be discharged home.</p> <p>Interview on 05/21/24 at 2:56 P.M., with Director of Nursing revealed Resident#64 on 05/03/24 was planned to be discharge home, but then presented with an altered mental status, and was transferred to the hospital. The Director of Nursing confirmed the medical record of Resident #64 does not contain documentation of the change in condition, notification of the physician and resident representative(s), and actual discharge location.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated policy titled Change of Condition policy revealed: 1. the facility must inform the resident, consult with the resident's physician; and notify consistent with his or her authority, the resident's representative(s) when there is: a. an accident involving the resident which results in an injury and has the potential for requiring physician intervention. b. a significant change in the resident's physical, mental, or psychosocial status. c. a need to alter treatment significantly. d. a decision to transfer or discharge a resident from the facility. 2. Documentation of notification or notification attempts should be recorded in the resident electronic medical record. 3. The resident and/or representative (if applicable) and medical provider should be notified of a change in condition. The medical provider will provide guidance related to the change in condition.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on record review and staff interview, the facility failed to complete an accurate comprehensive annual Minimum Data Set (MDS) assessment when they failed to include a diagnosis of post traumatic stress disorder. This affected one (#25) of six residents reviewed for comprehensive assessments. The facility census was 61.</p> <p>Findings include:</p> <p>Review of Resident #25's medical record revealed an admitted [DATE], with diagnoses of: post traumatic stress disorder, iron deficiency anemia, cellulitis of right lower limb, unsteadiness on feet, morbid obesity, chronic obstructive pulmonary disease, anxiety disorder, bipolar disorder, hypertension, and hyperlipidemia.</p> <p>Review of the 09/03/23 and 11/08/23 discharge Minimum Data Set (MDS) assessments revealed section I (active diagnoses section) was coded with a diagnosis of post traumatic stress disorder (PTSD)</p> <p>Review of the 02/15/24 annual comprehensive MDS assessment revealed the resident had no coded diagnosis of post traumatic stress disorder in section I (active diagnoses section).</p> <p>Review of Resident #25's face sheet revealed a diagnoses of post traumatic stress disorder.</p> <p>Interview on 05/22/24 at 3:42 P.M., with Licensed Practical Nurse (LPN) #40, verified Resident #25 has a diagnosis of post traumatic stress disorder and that it should of been coded on the most recent MDS and a care plan should of been developed.</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on record review and staff interview, the facility failed to timely submit Minimum Data Set (MDS) assessments for residents. This affected four (#16, #52, #57, and #61) of six residents reviewed for assessments. The facility census was 61.</p> <p>Findings include:</p> <p>1. Review of Resident #16's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Resident #16 had diagnoses of encephalopathy, schizophrenia, peripheral vascular disease, chronic obstructive pulmonary disease, and retention of urine.</p> <p>Review of Resident #16's MDS assessment on 05/22/24 revealed there was no discharge MDS completed on 12/21/23.</p> <p>Interview on 05/22/24 at 4:23 P.M., with Licensed Practical Nurse (LPN) #40, verified Resident #16 discharged on [DATE] and there was not a discharge MDS completed.</p> <p>2. Review of Resident #52's medical record revealed an admitted [DATE] and a discharge date of [DATE]. The resident had pertinent diagnosis of: diverticulitis of intestine, fibromyalgia, acute myocardial infarction, type two diabetes mellitus.</p> <p>Review of Resident #52's discharge MDS assessment dated [DATE] revealed it was never submitted to Center for Medicare and Medicaid Services (CMS).</p> <p>Interview on 05/22/24 at 4:24 P.M., with Licensed Practical Nurse (LPN) #40 verified Resident #52 discharged on [DATE] and the MDS discharge was not sent to CMS until 05/22/24. LPN #40 stated the MDS should of been submitted within 14 days.</p> <p>3. Review of Resident #57's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Resident #57 had pertinent diagnoses of: anemia, cognitive communication deficit, pleural effusion, and pneumonia.</p> <p>Review of Resident #57's discharge MDS assessment dated [DATE] revealed it was never submitted to Center for Medicare and Medicaid Services (CMS).</p> <p>Interview on 05/22/24 at 4:24 P.M., with Licensed Practical Nurse (LPN) #40, verified Resident #52 discharged on [DATE] and the MDS discharge was not sent to CMS until 05/22/24. LPN #40 stated the MDS should of been submitted within 14 days.</p> <p>4. Review of Resident #61's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Resident #61 had pertinent diagnosis of: elevated white blood, hypertension, atrial fibrillation, heart failure, diffuse large B cell lymphoma, non-Hodgkin lymphoma, and anemia.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #57's discharge MDS assessment dated [DATE] revealed it was never submitted to Center for Medicare and Medicaid Services (CMS).</p> <p>Interview on 05/22/24 at 4:24 P.M., with Licensed Practical Nurse (LPN) #40, verified Resident #61 discharged on [DATE] and the MDS discharge was not sent to CMS until 05/22/24. LPN #40 stated the MDS should of been submitted within 14 days.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on record review and staff interview, the facility failed to develop a comprehensive care plan for a resident identified with the diagnosis of post traumatic stress disorder. This affected one (#25) of 19 residents reviewed for care plans. The facility census was 61.</p> <p>Findings include:</p> <p>Review of Resident #25's medical record revealed an admitted [DATE], with diagnoses of: post traumatic stress disorder, iron deficiency anemia, cellulitis of right lower limb, unsteadiness on feet, morbid obesity, chronic obstructive pulmonary disease, anxiety disorder, bipolar disorder, hypertension, and hyperlipidemia.</p> <p>Review of the 09/03/23 and 11/08/23 discharge Minimum Data Set (MDS) assessments revealed section I (active diagnoses section) was coded with a diagnosis of post traumatic stress disorder (PTSD)</p> <p>Review of Resident #25's face sheet revealed a diagnoses of post traumatic stress disorder.</p> <p>Review of Resident #25 medical record on 05/22/24 at 3:30 P.M., revealed she did not have a care plan for PTSD.</p> <p>Interview on 05/22/24 at 3:42 P.M., with Licensed Practical Nurse (LPN) #40, verified Resident #25 has a diagnosis of post traumatic stress disorder and a care plan should of been developed.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on record review and staff interview, the facility failed to ensure resident care plans were updated and to include appropriate interventions for elopement for Resident #56 and for nutrition and weight loss prevention for Residents #23 and #51. This affected three (#23, #51, and #56) of 16 residents care plans reviewed. The facility census was 61.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included vascular dementia without behavioral disturbances, unsteadiness on feet, generalized weakness, failure to thrive, and malnutrition.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 had significant cognitive impairment and required assistance for transfers.</p> <p>Review of the plan of care dated 02/08/24 revealed the resident was at risk for elopement due to exit seeking behavior with interventions to monitor battery of wander guard, check wander guard placement, each shift and functionality daily, monitor resident for triggers of wandering, redirect from doors, ensure resident was at the correct level of care, alarm systems as appropriate, complete elopement observation as indicated and observe behaviors. The care plan had no interventions added after the 02/08/24 creation, including after the wander guard was cut off on 04/20/24 or when Resident #56 eloped the facility on 05/11/24.</p> <p>Review progress notes dated 02/08/24 revealed Resident #56 had a significant other at the facility who wanted to take him out of the building. Staff educated resident's girlfriend; Resident #56 was not to be out of the building without family. A progress note dated 04/20/24 revealed Resident #56 was taken outside of the facility to watch the eclipse staff found the wander guard did not alarm. They checked it out and found the resident's wander guard was cut off with scissors. Staff believed the resident's girlfriend had cut the wonder guard off. Progress note dated 05/11/24 revealed an aide informed nursing staff that resident was not at the building, facility initiated a search and looked at the restaurant next door. Staff at the restaurant stated Resident #56 and his girlfriend had eaten there and had left already. Facility staff returned and found Resident #56 and his girlfriend had returned to the facility.</p> <p>Interview on 05/21/24 at 4:30 P.M. to 5:09 P.M., with Administrator, Director of Nursing (DON), Corporate Nurse (CN) #587 and Corporate Nurse #597 revealed the DON stated when Resident #56 had eloped, staff contacted her at 2:03 P.M., and she was on the phone while they searched for resident. She knew Resident #56 had been talking about going to the nearby restaurant and asked staff to check the restaurant and see if they were there. When they found Resident #56 and his girlfriend had returned, staff found she knew the door code to let Resident #56 through without the wander guard alarming. They changed the code and provided education to Resident #56's girlfriend and to staff about ensuring only staff have access to the door codes. Administrator, DON, and CN #587 and CN#597 confirmed Resident #56's care plan was not updated during either incident of resident's wander guard being cut off on 04/20/24 or during the elopement on 05/11/24.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, muscle weakness, diabetes, and spinal stenosis.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 was cognitively intact.</p> <p>Review of Resident #27's weights revealed from 01/19/24 to 03/01/24 revealed the resident's weight ranged from 225.8 to 229.2 pounds (lbs.). On 04/01/24, Resident #27's weighed 208.8 lbs. with no evidence of a reweigh for weight loss percentage of 8.34% in 30 days. On 04/08/24, the resident weighed 193.2 lbs. for a weight loss percentage of 15.19% in about five weeks.</p> <p>Review of the plan of care dated 01/19/24 revealed resident had potential for nutritional risk as evidenced by Parkinson's diagnosis, depression and therapeutic diet with interventions entered on 01/19/24 included provide diet as ordered, observe for vomiting diarrhea, cramping and fatigue, observe for signs of aspiration, observe for acceptance of for palatability, supervise and assist with meals as needed, Speech therapy consult as ordered, encourage good intake and assist with tray/meal set-up, offer snack, encourage resident to eat in dining room, Dietician to evaluate nutritional status and provide updated recommendations, weight routinely and monitor weight changes, encourage fluid intake and approach for changes in nutritional status. The care plan had no newly identified interventions after 01/19/24 including none after weight loss had occurred.</p> <p>Review of physician orders dated 04/29/24 to 05/21/24 revealed an order for fortified shakes with meals three times daily. The physician order dated 05/21/24 revealed an order for House Shakes twice daily.</p> <p>Review of the Quarterly Nutrition assessment dated [DATE] revealed the resident had a current weight of 193 and a usual weight in the 220's lbs. The assessment revealed significant weight loss over 38 days of 15.2%. The dietician recommended house shake twice daily and revealed the care plan was updated.</p> <p>Interview on 05/22/24 at 4:15 P.M., with Corporate MDS Coordinator #577 confirmed no new interventions were on the care plan. She revealed she would need to review the older care plans to see if interventions were present and removed. She provided updated care plans with no new interventions added from weight loss incidents.</p> <p>3. Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included iron deficiency, endocarditis, sepsis, and muscle wasting.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 was cognitively intact with a BIMS of 15 and was dependent with eating.</p> <p>Review of Resident #51's weights revealed from 11/13/23 to 01/08/24, Resident #51's weight ranged from 158 to 158.4 pounds (lbs.). On 01/08/24, Resident #51 weighed 125 lbs. with a reweigh on 02/07/24 of 125.4 lbs. for weight loss percentage of 20.89%. On 03/03/24, Resident #51 weighted 123.6 lbs. for a weight loss percentage of 21.77% in three months. The following weekly weights included: on 03/04/24 at 146.6 lbs. on 03/12/24 at 130 lbs., on- 04/01/24 at 129.5 lbs., on 04/22/24 at 134.5 lbs., on 05/06/24 at 130 lbs., and on 05/13/24 at 123.5 lbs. In 6 months, Resident #51 had a weight loss of 21.84%. The record contained no information on how each weight was obtained by chair or bed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the plan of care dated 05/22/23 revealed resident was at nutritional risk as evidenced by total feed, chronic conditions of quadriplegia, and refusing weights at times with interventions entered on 05/22/23 included provide diet as ordered, Juven and Prostat supplements twice daily. Interventions entered on 01/05/24 included double portions with meals. interventions entered on 04/13/24 included fortified oatmeal with trays and peanut butter sandwich with meals. No new interventions were updated on the care plan from weight boss on 02/05/24 until 04/13/24, and again no new interventions were added after weight loss of over 8% from 04/22/24 to 05/13/24.</p> <p>Review of physician orders from 12/29/23 to 01/02/24 revealed an order for Juven one pack twice daily, Prostat 30 ml daily, fortified shakes with meals and nutritional juice daily at lunch. A physician order dated 01/02/24 to 01/05/24 revealed an order for Juven 1 pack twice daily. A physician order dated 01/05/24 to 04/13/24 revealed an order for Juven one packet twice daily, Prostat 30 ml twice daily, and double portion proteins. Physician order dated 04/13/24 to 04/13/24 revealed an order for Juven one packet twice daily, Prostat twice daily, double portion proteins, fortified oatmeal with trays and peanut butter sandwiches with meals. Physician order dated 05/08/24 revealed an order for Juven powder in packet 7-7-1.5-gram amt 1 packet with instructions to administer one packet in eight ounces of water to promote wound healing. Physician order dated 05/21/24 revealed an order for prostate 30 ml to be given twice daily.</p> <p>Review progress notes dated 02/06/24 from Dietician revealed resident had recent significant weight loss. Resident was on double protein, Juven shake twice daily and Prostat 30 ml twice daily. New recommendations included adding fortified shake twice daily 6g pro, and weekly weights. The next note was on 03/04/24 stating resident was on fortified oatmeal and peanut butter and jelly with dinner with supplements of Juven and Prostat 30 ml twice daily and plan for dietician to monitor weekly weights.</p> <p>Review of the Quarterly Nutrition assessment dated [DATE] revealed resident had a current weight of 129.5 and a usual weight in the 150's lbs. It stated the resident was on regular diet with double portions. The assessment stated the resident had Juven twice daily, fortified milkshake three times daily and nutritional juice daily and Prostat twice daily. The assessment revealed significant weight loss over 74 days of 17.7% and over 180 days of 17% weight loss. The assessment revealed the care plan was updated.</p> <p>Interview 05/22/24 at 4:15 P.M., with Corporate MDS Coordinator #577 confirmed no new interventions were on the care plan. She revealed she would need to review the older care plans to see if interventions were present and removed. She provided updated care plans with no new interventions added from weight loss incidents.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on medical record review, staff interviews, and policy review, the facility failed to recognize and timely address severe resident weight loss. This affected one (#27) of three residents reviewed for nutrition. The facility census was 61.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included Parkinson's disease, muscle weakness, depression, diabetes, and spinal stenosis.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], Resident #27 was cognitively intact, was 66 inches tall and weight was 229 pounds (lbs.). Review of the quarterly MDS assessment dated [DATE] revealed Resident #27 was cognitively intact and weighed 193 pounds. The MDS indicated there was no weight loss or gain.</p> <p>Review of the monthly physician orders for January 2024 to May 2024 revealed the resident was to receive a carb-controlled diet with regular texture.</p> <p>Review of Resident #27's weights revealed from 01/19/24 to 03/01/24, Resident #27's weight ranged from 225.8 to 229.2 pounds (lbs.). On 03/01/24, Resident #27 weighed 227.8. On 04/01/24, Resident #27 weighed 208.8 lbs., with no evidence of a reweigh for weight loss percentage of 8.34% in 30 days. On 04/08/24, Resident #27 weighed 193.2 lbs. for a weight loss percentage of 15.19% in about five weeks. On 05/01/24, Resident #27 had a weight of 210 lbs. for a weight gain. The record contained no information on how each weight was obtained, i.e. chair, bed or standing weight.</p> <p>Review of the plan of care dated 01/19/24 revealed resident had potential for nutritional risk as evidenced by Parkinson's diagnosis, depression and therapeutic diet with interventions entered on 01/19/24 included provide diet as ordered, observe for vomiting diarrhea, cramping and fatigue, observe for signs of aspiration, observe for acceptance of for palatability, supervise and assist with meals as needed, speech therapy consult as ordered, encourage good intake and assist with tray/meal set-up, offer snack, encourage resident to eat in dining room, Dietician to evaluate nutritional status and provide updated recommendations, weight routinely and monitor weight changes, encourage fluid intake and approach for changes in nutritional status. The care plan had no interventions after 01/19/24.</p> <p>Review of medical nutrition screening evaluation dated 01/22/24 revealed Resident #27 was assessed as having moderate decreased food intake, scored at risk for malnutrition, medical doctor (MD) gave order for a diagnosis for risk of malnutrition and referral to registered dietitian.</p> <p>Review of the Quarterly Nutrition assessment dated [DATE] revealed resident had a current weight of 193 and a usual weight in the 220's lbs. The assessment indicated the resident was on carb-controlled diet with regular texture. The assessment revealed a significant weight loss over 38 days of 15.2%. Dietician #550 questioned the validity of the weight and a reweigh was requested. Recommendation also included house shake twice daily. The assessment revealed the care plan was updated.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician orders revealed no physician orders for any nutritional supplements from 04/01/24 until 04/29/24. A physician order dated 04/29/24 to 05/21/24 revealed an order for fortified shakes with meals three times daily. On 05/21/24, a new physician order for House Shakes twice daily was written in place of the fortified shakes. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for April and May 2024 revealed the supplements were documented as being provided as ordered.</p> <p>Interview on 05/22/24 at 11:40 A.M. and again at 12:13 P.M., with Dietician #550 revealed he started end of March 2024. He revealed he was unaware of the weight loss and was currently following Resident #27. Dietician #550 revealed he first assessed Resident #27 on 04/26/24 and revealed he recommended the fortified shakes which were ordered on 04/29/24. He confirmed Resident #27 was not seen or assessed and no interventions were put in place from 04/01/24 (when significant weight was identified) until 04/26/24 when the assessment was completed and 04/29/24, when the first interventions were put in place. Dietician #550 revealed he had no knowledge of the nutritional supplements being changed from fortified shake three times daily to house shake twice daily. Dietician #550 revealed facility did not have any diet techs who would have made the change and revealed his expectation would be for the facility to speak with the dietician regarding slowing or removing a supplement for a resident especially after they had significant weight loss.</p> <p>Interview on 05/22/24 at 5:00 P.M., with Director of Nursing (DON) confirmed residents should have timely intervention after weight loss including weight monitoring and supplements and assessment by the Dietician. DON confirmed no evidence of timely follow up for Resident #27 and the facility was unable to provide any additional evidence or documentation.</p> <p>Review of the policy titled, Nutrition, Hydration, Weighing and Measuring Height - Resident Policy, dated 09/15/23, revealed the facility would strive to maintain residents' usual body weight or desirable weight. Facility shall monitor weights and identify residents at nutritional risk and establish a schedule for weights. Facility shall provide nutritional and hydration care and services consistent with the care plan, Physician orders and resident condition. It stated significant weight loss was measured at: one-month significant loss was 5% and severe loss was greater than 5%; three months significant loss was 7.5% and severe loss was greater than 7.5%; and six months significant loss</p>		

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<p>F 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>33023</p> <p>Based on review of personnel files and staff interview, the facility failed to ensure nurse aides received a performance review at least every 12 months. This affected three State tested Nurse Aide (STNA) (#90, #503, and #514) of four nurse aide personnel records reviewed, with the potential to affect all 61 residents in the facility. The facility census was 61.</p> <p>Findings include:</p> <p>Review of the personnel file for STNA #90 revealed a hire date of 07/25/23 and works on the skilled nursing rehabilitation unit. No annual or 90-day evaluations could be provided according to facility documentation.</p> <p>Review of the personnel file for STNA #503 revealed a hire date of 07/29/14 and works on the skilled nursing rehabilitation unit. No annual evaluations could be provided according to facility documentation.</p> <p>Review of the personnel file for STNA #514 revealed a hire date of 02/27/24 and works on the skilled nursing rehabilitation unit. No annual or 90-day evaluations could be provided according to facility documentation.</p> <p>Interview on 05/23/24 at 1:59 P.M., with the Administrator verified the 90-day and annual evaluations can not be provided as the facility does not have any record of them being completed.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31404</p> <p>Based on record review and staff interview, the facility failed to ensure resident drug regimen were free from unnecessary medications when there was not a valid diagnosis for the use of antibiotics. This affected one (#325) of six residents reviewed for unnecessary medications. The facility census was 61.</p> <p>Findings include:</p> <p>Review of Resident #325's medical record revealed an admitted [DATE] with pertinent diagnoses of: cerebral infarction and unsteadiness on feet.</p> <p>Review of a physician order dated 05/16/24 revealed take by mouth amoxicillin-potassium clavulanate (an antibiotic) tablet; 875 milligrams (mg)-125 mg; amount: one tablet; oral Administer one tablet by mouth twice daily x 11 days for infection.</p> <p>Review of a physician order dated 05/16/24 revealed take by mouth doxycycline monohydrate (an antibiotic) capsule; 100 mg; amount: one capsule; oral Special Instructions: Administer one capsule by mouth twice daily x 11 days for infection.</p> <p>Review of the medical record on 05/21/24 revealed no documented supporting diagnosis for the antibiotic orders for amoxicillin-potassium clavulanate or doxycycline monohydrate.</p> <p>Interview on 05/22/24 at 4:37 P.M., with the Director of Nursing revealed she is unable to determine why Resident #325 was on the two antibiotics.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on observations, medical record review, staff interview and policy review, the facility failed to ensure resident were placed in enhanced barrier precautions appropriately and failed to ensure staff were wearing appropriate personal protective equipment (PPE) when interacting with residents in enhanced barrier precautions. This affected six (#10, #14, #47, #51, #55, and #376) of six residents the facility identified to be in enhanced barrier precautions. The facility census was 61.</p> <p>Findings include:</p> <p>Observations on 05/20/24 between 8:00 A.M. and 8:30 A.M., revealed no residents were identified as requiring enhanced barrier precautions (EBP) when care was provided.</p> <p>1. Observation and interview on 05/20/24 at 8:35 A.M., with Restorative Aide #403 revealed she was doing range of motion exercise with Resident #51 including exercising the upper and lower body and placing hand splints on and off for bilateral upper extremities. Restorative Aide #403 revealed she was not aware of Resident #51's isolation status and if he were in enhanced barrier precautions it was only for staff providing care such as incontinence care and bathing assistance. Restorative Aide #403 was observed to be doing range of motion for several minutes in close proximity to Resident #51.</p> <p>Review of the medical record for Resident #51 revealed an admitted [DATE]. Diagnoses included endocarditis, sepsis, and urinary tract infection.</p> <p>Review of the medical record found Resident #51 had a wound identified 01/09/24 that required dressing changes and catheter present upon admission.</p> <p>Review of physician orders revealed enhanced barrier precautions from 04/02/24 to 04/10/24, 05/08/24 with no stop date, and 05/20/24 with no stop date revealed resident was placed in enhanced barrier precautions.</p> <p>2. Observation on 05/20/24 at 10:00 A.M., revealed Resident #10 had no isolation signs on the door and no Personal Protective Equipment (PPE) was observed available at the resident's door.</p> <p>Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included traumatic brain injury, diabetes, bipolar disorder, and cardiomyopathy.</p> <p>Review of the medical record found Resident #10 had a wound identified 05/09/24 that required dressing changes.</p> <p>Review of physician orders for 05/20/24 revealed resident was placed in enhanced barrier precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Observation and interview on 05/22/24 at 4:40 P.M., with Licensed Practical Nurse (LPN) #405 revealed LPN #405 did not wear any PPE besides gloves when performing wound care. Observations of a sign on Resident #376's door stated to wear gloves and a gown for high contact resident care activities and specifically stated wound care: any skin opening requiring a dressing. LPN #376 revealed the enhanced precautions were more for aides that were providing care for a longer time period such as incontinence care or bathing. LPN #376 revealed the facility education was provided and they were instructed nursing staff did not need to use PPE for medication administrator or wound treatments.</p> <p>Review of the medical record for Resident #376 revealed an admitted [DATE]. Diagnoses included respiratory failure and heart failure.</p> <p>Review of the medical record found Resident #376 had a tracheostomy present at admission.</p> <p>Review of physician orders for 05/20/24 revealed resident was placed in enhanced barrier precautions.</p> <p>4. Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included artificial knee joint, and chronic obstructive pulmonary disease.</p> <p>Review of the medical record found Resident #14 had a wound identified 05/01/24 that required dressing changes.</p> <p>Review of physician orders for 05/20/24 revealed resident was placed in enhanced barrier precautions.</p> <p>5. Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included sepsis, encephalopathy, parkinson's, heart failure, and diabetes.</p> <p>Review of the medical record found Resident #47 had a wound identified 02/20/24 that required dressing changes.</p> <p>Review of physician orders for 05/20/24 revealed resident was placed in enhanced barrier precautions.</p> <p>6. Review of the medical record for Resident #55 revealed an admitted [DATE]. Diagnoses included cerebral palsy, scabies, and urine retention.</p> <p>Review of the medical record found Resident #55 had a Foley catheter upon admission.</p> <p>Review of physician orders for 05/20/24 revealed resident was placed in enhanced barrier precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 05/22/24 at 5:00 P.M., with the Director of Nursing (DON) revealed the facility had completed training with staff on the enhanced barrier precautions but when corporate staff had come to the facility they found out the training included inaccurate information. DON confirmed any staff providing hands on care should be wearing PPE, but it was not required if you just talk with resident or you bring food or medications. DON confirmed restorative aides providing care and nursing staff performing wound care should be wearing PPE. The DON verified six residents (#10, #14, #47, #51, #55, and #376) required EBP and they were not in place on 05/20/24.</p> <p>Review of the policy titled, Enhanced Barrier Precautions Policy, dated 03/25/24, revealed the facility policy and practices were intended to facilitate maintaining a safe and sanitary environment to help prevent transmission of disease and infections. Enhanced Barrier Precautions are additional measures to attempt to decrease transmissions of drug resistant organisms. When a resident was placed on enhanced barrier precautions, signage shall be posted at the room entrance and shall include instructions for use of PPE. Enhanced Precautions were indicated for residents who have chronic wounds or indwelling medical devices.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</p> <p>Based on record review and staff interview, the facility failed to ensure influenza and pneumonia vaccinations were offered and provided to residents. This affected two (#47 and #56) of five residents reviewed for influenza and pneumonia vaccination. The facility census was 61.</p> <p>Findings include.</p> <p>1. Review of the medical record for Resident #47 revealed an admitted [DATE]. Diagnoses included sepsis, vascular disease, heart failure, diabetes, and Parkinson's.</p> <p>Review of the vaccination consent form dated 09/25/23 revealed he consented for flu but not for pneumonia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was cognitively intact.</p> <p>Review of vaccination preventative health listing revealed Resident #47 had received pneumococcal vaccine on 02/04/21 in an outside setting.</p> <p>Review of the undated vaccination record revealed Resident #47 had received the pneumococcal PPV23 on 02/04/21.</p> <p>Review of the Centers for Disease Control Pneumococcal Vaccine Recommendations revealed Resident #47 should receive PCV 15 or PCV20 at least one year after the last dose of PPSV23 before vaccinations would be complete.</p> <p>2. Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included vascular dementia, aphagia, muscle weakness and malnutrition.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #56 was cognitively impaired.</p> <p>Review progress notes dated 01/25/24 at 12:46 P.M., revealed a call was made to Resident #56's family to get consent for influenza and pneumonia. On 01/25/24 at 12:52 P.M., the facility received a call from resident's son who gave consent for both flu and pneumonia vaccine. On 01/28/24, the pneumonia vaccine was administered into right deltoid. Review of progress notes from 01/25/24 to 05/21/22 found no evidence of influenza vaccine being administered as consented.</p> <p>Review of vaccination administration record revealed no evidence of influenza vaccination being administered.</p> <p>Interview on 05/23/24 at 3:30 P.M., with Administrator confirmed the facility had not obtained consent for Resident #47 to receive the pneumonia due to having previously receiving a pneumonia vaccine. She was not aware of the pneumonia vaccine requiring multiple doses. Administrator also confirmed Resident's #56's family had been consented for the influenza vaccination and this was not provided.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/23/24 at 5:00 P.M., with the Director of Nursing (DON) revealed the facility had no evidence of pneumonia vaccination being offered for Resident #47 and no evidence of flu vaccine being administrator for Resident #56.</p> <p>Review of the policy titled, Influenza and Pneumococcal Immunizations, dated 02/04/24, revealed facility would minimize risk of residents acquiring, transmitting or experiencing complications from influenza and pneumonia vaccinations. Facility shall offer the flu vaccination from October 01 st. through March 31 st. annually unless it was contraindicated. Each resident shall be offered a pneumonia vaccination unless contraindicated or course had been completed.</p>