

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Georgetown		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Pocahontas Trail Georgetown, KY 40324	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, clean, comfortable, and homelike environment for 2 out of 4 hallways, 100 Hall and 400 Hall. Observations on 07/07/2025 revealed the drain access covers on the 100 and 400 Hall were loose, creating a possible tripping hazard. The findings include: Observation on 07/07/2025 at 2:05 PM revealed the drain cover at the end of 100 Hall outside room [ROOM NUMBER] was loose and slid side to side. Observation on 07/07/2025 at 3:58 PM revealed plates (covers) on 400 Hall were loose and spun around. In an interview on 07/08/2025 at 9:15 AM, Resident (R) 44 stated it was nice the drain cover was screwed down better now and did not move around when he wheeled over it. He stated it had been loose for a while. In an interview on 07/10/2025 at 10:10 AM, the Maintenance Director stated the process for routine maintenance in the building was to schedule tasks in the maintenance computer program. He further stated he was aware the drain covers periodically came loose and created tripping hazards. Per interview, the Maintenance Director stated he did not schedule checking the drain covers as part of routine maintenance and only addressed the issue if he noticed it during a walk-through. In an interview on 07/10/2025 at 11:10 AM, the Director of Nursing (DON) stated she expected the building to be maintained in a manner to keep residents safe. She stated she had not noticed the plate on 100 Hall that slid around, and she did not know why the plates had been loose. In further interview, the DON stated an uneven area in the floor created a tripping hazard for residents. In an interview on 07/10/2025 at 11:35 AM, the Administrator stated he expected the building to be kept safe for residents. He further stated he believed the machine used to clean the floors had loosened the plates, which were not on the routine maintenance list. In continued interview, the Administrator stated it was important for the plates to remain secure because a loose plate could create a tripping hazard for residents.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Georgetown		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Pocahontas Trail Georgetown, KY 40324	

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 0607</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 to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Georgetown		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Pocahontas Trail Georgetown, KY 40324	
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to follow its Abuse Policy when an employee did not immediately report an allegation of abuse to the Administrator or his designee for 1 of 2 residents reviewed for reporting alleged sexual abuse, Resident (R) 28. On 07/07/2025 at 2:10 PM a housekeeper (HK) 1 reported to the State Survey Agency (SSA) Surveyor that on approximately 07/05/2025, she overheard Certified Nurse Aide (CNA) 2 having a sexually inappropriate conversation with R28. However, that incident was not reported and investigated. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, last revision date 09/15/2023, revealed the definition of abuse was willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain, or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled by technology. Per the policy, Every stakeholder shall immediately report any allegation of abuse, injury of unknown origin or suspicion of a crime, as those terms are defined above, to the Facility Administrator or designee as assigned by the Facility Administrator in his/her absence. Review of R28's Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 06/21/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of eight out of 15, indicating moderate cognitive impairment. During an interview on 07/07/2025 at 2:10 PM with HK1, she approached the SSA Surveyor in the hall and stated, on 07/05/2025, she overheard CNA2 speak to R28 about sex and dead people. HK1 stated she approached CNA2 and told her she felt the conversation was inappropriate. She stated CNA2 told HK1 the resident did not even know what she was talking about, to which HK1 replied, But you do. HK1 stated she immediately reported her concerns to her housekeeping supervisor (HKS). During an interview on 07/08/2025 at 3:08 PM with CNA2, she stated R28 was often confused. CNA2 stated R28 told her, I would like to have [NAME]. CNA2 stated she told R28 she thought the actor was dead. Then CNA2 stated R28 told her that it did not matter to her. CNA2 stated she then told R28, That ain't right! CNA2 was asked to give examples of abuse, and if she saw or heard something that she felt was abuse what would she do about it. CNA2 gave appropriate examples and stated she would make sure the resident was safe, then tell a nurse and/or the Director of Nursing/Administrator immediately. She stated the best way to deal with a difficult resident was to walk away and reapproach or have someone else work with that resident. During an interview on 07/07/2025 at 2:17 PM, the Housekeeping Supervisor (HKS) stated she was aware of the allegation reported by HK1. She stated she recalled some of the verbiage used by HK1, specifically the part where HK1 told CNA2 that R28 did not know what was being talked about, and HK1 said, But you do. The HKS stated she could not hear HK1 very well, and she did not follow up with HK1. During an interview on 07/07/2025 at 4:56 PM with the HKS, she stated she had not told anyone about the incident with R28 because it just happened the previous weekend, and she had not had time to follow up. Regarding HK1, she stated HK1 was new but a good housekeeper. She stated she had no concerns regarding her work. She stated HK1's personal views could have caused her to read into the conversation more than what was said. During an interview on 07/07/2025 at 4:05 PM, the Social Services Director (SSD) stated she knew nothing about the allegation of abuse between CNA2 and R28. During an interview on 07/07/2025 at 2:19 PM, the Administrator stated he was not aware of the incident with R28 and had been on vacation at that time. He stated the incident had not been reported to anyone, and it had not gone any further than the HKS. During an attempted second interview with HK1 on 07/09/2025, it was reported she was not scheduled to work. However, the HK District Manager (HKDM) stated HK1 was in the building, but HK1 then exhibited strange behaviors and abruptly left. HK1 never returned to work and did not answer her phone for the remainder of the survey. During an interview on 07/10/2025 at 10:50 AM with the Director of Nursing (DON), she stated she expected staff to report allegations of abuse immediately to the supervisor or abuse coordinator. She stated the reporting process was to immediately report to the supervisor, and the supervisor would call the Administrator. She stated the supervisor, clinical manager, or DON would be notified. She stated, if the manager felt it was egregious or substantiated, they called the Administrator immediately. She stated all concerns were always taken seriously. During an interview on</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Georgetown		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Pocahontas Trail Georgetown, KY 40324	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of Georgetown		STREET ADDRESS, CITY, STATE, ZIP CODE 102 Pocahontas Trail Georgetown, KY 40324	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, record review, and review of guidelines from the Centers for Disease Control and Prevention (CDC), the facility failed to follow infection control precautions for 1 of 9 sampled residents under Enhanced Barrier Precautions (EBP), Resident (R) 58. Observation on 07/08/2025 revealed Certified Nurse Aide (CNA) 1 changing linens and removing garbage for a resident under EBP precautions (R58) without wearing appropriate personal protective equipment (PPE). The findings include: Review of the facility provided signage for Enhanced Barrier Precautions (EBP) revealed the signage followed the guidelines from the United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). The EBP signage, posted on R58's door, directed that everyone must clean their hands before entering and before leaving the room; providers and staff were directed to wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy) and wound care (any skin opening requiring a dressing). Review of R58's admission Record revealed the facility admitted the resident on 06/18/2025 with diagnoses of sepsis, chronic prostatitis, meningitis, lung cancer, pressure ulcer of the sacrum, and gastrostomy status (feeding tube). Review of R58's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 06/26/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, indicating moderate cognitive impairment. Review of R58's Clinical Orders, dated 06/18/2025 revealed an order for Enhanced Barrier Precaution (EBP) for his gastrostomy tube and wounds. Further review revealed an order for an enteral feeding tube, dated 06/18/2025, and an order for a suprapubic urinary catheter, dated 06/19/2025. Review of R58's Comprehensive Care Plan [CCP], dated 06/19/2025, revealed an active care plan for requiring EBP related to a gastrostomy tube, wounds, and a catheter. The documented goal of the care plan was the resident would not experience any adverse outcomes related to EBP. The documented approaches were to disinfect high touch surfaces as able as needed, attempt to maintain environmental cleanliness, staff to wear personal protective equipment (PPE) as indicated, and report to physician signs and symptoms of infection as needed. On 07/08/25 at 8:17 AM (CNA)1 was observed in R58's room, which had a sign on the door indicating R58 was on EBP, with Occupational Therapist (OT)1, changing linens and removing garbage. CNA1 was observed with gloves on but did not have a gown on. Upon interview, CNA1 stated she had been working at the facility for two weeks and had received some training on hire, but no one had explained EBP to her and she had not seen the signage on the door. CNA1 further stated she was not sure of the importance of EBP. During an interview on 07/08/2025 at 8:40 AM with the Regional Clinical Consultant (RCC), she stated CNA1 had just received an on the spot training session for EBP. The RCC further stated CNA1 had been scheduled for additional in person education that morning when she arrived, and as CNA1 was a very helpful person and wanted to do everything for everyone, she began resident care immediately and before the IP could meet with her and provide the training. During an interview on 07/09/2025 at 3:28 PM with the IP, she stated all staff received training upon hire via an hour-long infection control (IC) video, and then periodic education, quarterly and as needed, was provided to staff as a refresher. The IP stated the IC education included a return demonstration portion in which staff would show her how to wash hands and put on and remove PPE. The IP also stated new staff orientation included walking staff through handwashing, the donning (put on) and doffing (remove) of PPE, and a checklist was completed. The IP further stated CNA1 was not out of her orientation period yet, and her orientation checklist was not complete. The IP stated her expectation was that all staff used PPE appropriately and every time. The IP stated when CNA1 arrived yesterday morning she began her work before she met with her to complete her education. The IP stated it was her expectation that all staff looked at infection control signage on a resident's door and followed the directions provided every time. During an interview on 07/10/2025 at 11:02 AM with the Director of Nursing (DON), she stated she had been at the facility for two years. The DON stated for new referrals, if a resident had tubes or wounds, the room was set up for EBP immediately, and the facility process was to put EBP in as an order for all residents that needed it. The DON stated if a resident had an event that made EBP necessary after admission, an order would be written, and staff would be made aware and instructed by nursing leadership to post signage and put the three drawer PPE bin near the door of the resident's room. The DON stated nursing leadership then rounded and made sure the signs were posted, and PPE was available. The DON also stated Infection Control (IC)</p>		