STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, and interview, the facility failed to maintain resident dignity when urinary drainage bags were uncovered for 2 residents (Residents #14 and #2) of 6 residents reviewed with indwelling urinary catheters.The findings include: Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Wedge Compression Fracture of Spine, Respiratory Failure, and Heart Failure. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #14 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of a comprehensive care plan for Resident #14 revealed a problem dated 12/9/2025, .indwelling .catheter .urogenital implant .urinary retention . During observations on 1/20/2026 at 11:30 AM and 1/20/2026 at 4:15 PM, Resident #14 was lying in bed with a urinary drainage bag hanging from the bed frame, uncovered, with the contents in view. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Quadriplegia, Neuromuscular Dysfunction of Bladder, and Liver Cirrhosis. Review of a quarterly MDS assessment dated [DATE], revealed Resident #2 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Review of a comprehensive care plan for Resident #2 revealed a problem dated 9/2/2019, .suprapubic catheter . During observations on 1/20/2026 at 11:35 AM and 1/20/2026 at 4:20 PM, revealed Resident #2 was lying in bed with a urinary drainage bag hanging from the bed frame, uncovered, with the contents in view. During an observation on 1/22/2026 at 9:45 AM, revealed Resident #2 lying in bed, with the urinary drainage bag hanging from the bed frame, uncovered, and the drainage outlet for emptying the contents was hanging out instead of being placed back into the outlet's holding pocket. During an observation and interview on 1/22/2026 at 2:30 PM, the 2nd floor Registered Nurse Manager (NM) confirmed Resident #2's urinary drainage bag was uncovered, with the contents visible, and the drainage port hanging outside of the bag. The NM stated all catheter bags were expected to be covered with a privacy bag, and the drainage outlet should be cleaned and replaced in the outlet's holding pocket. During an interview on 1/22/2026 at 3:30 PM, the Assistant Director of Nursing confirmed all urinary drainage bags were expected to be covered so the contents are not visible to maintain resident dignity.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to provide a clean and sanitary environment to ensure cleanliness of personal fans for 2 residents (Residents #92 and #40) of 134 residents reviewed for a clean and sanitary environment.The findings include: Review of the facility's undated policy titled, General Environmental Cleaning Techniques revealed, .conduct visual preliminary site assessment .clean from cleaner to dirtier .clean from high to low . Review of the medical record revealed Resident #92 was admitted to the facility on [DATE] with diagnoses including History of a Stroke, Dysphagia (Difficulty Swallowing), and Diabetes. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Diabetes, Pulmonary Disease, and Epilepsy (Seizure Disorder). During observations on 1/20/2026 at 11:45 AM, 1/21/2026 at 9:30 AM, and 1/22/2026 at 9:00 AM, Resident #92's room revealed a portable personal fan at bedside. The fan blades had a large amount of gray dust and thick debris resembling clumped gray fibers which had accumulated on the protective grille. During observations on 1/20/2026 at 11:55 AM, 1/21/2026 at 9:40 AM, and 1/22/2026 at 9:10 AM, Resident #40's room revealed a portable personal fan at bedside. The fan blades had a large amount of gray dust and thick debris resembling clumped gray fibers which had accumulated on the protective grille and the inside walls of the fan. During an observation and interview on 1/22/2026 at 10:45 AM, the 2nd floor Registered Nurse Manager (NM) confirmed both portable fans for Resident #92 and Resident #40 had a large amount of gray dust on the blades and thick debris resembling clumped gray fibers accumulated on the protective grilles and confirmed the debris should not be present with routine cleaning. During an interview on 1/22/2026 at 3:00 PM, the Environmental Services Director confirmed housekeeping was responsible for ensuring the rooms and contents were cleaned routinely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to resubmit a Pre-admission Screening and Resident Review (PASRR) for Level II Evaluation after new mental health diagnoses were identified for 1 resident (Resident #6) of 5 residents reviewed for accurate PASRR.The findings include: Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Incomplete Quadriplegia, and Insomnia. Continued review revealed the following diagnoses added for Resident #6 after admission: [DATE] added Adjustment Disorder with Depressed Mood, 7/15/2024 added Post-Traumatic Stress Disorder (PTSD), 9/25/2024 added Nightmare Disorder, 12/4/2024 added Major Depressive Disorder, 12/4/2024 added Generalized Anxiety Disorder, 1/15/2026 added Personal History of Other Mental and Behavioral Disorders. Review of the PASRR Level I screen dated 1/11/2024, revealed Resident #6 had a diagnosis of .Anxiety Disorder .Adjustment Disorder . The PASRR outcome was .Level I no status change .Level II Evaluation is not required . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #6 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact. Review of a comprehensive care plan for Resident #6 revealed a problem revised on 1/21/2026, .Psychiatric/Psychotropic Medications .related to .Adjustment Disorder with Depressed Mood, Insomnia, Anxiety .Nightmare Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder . Review of the medical record for Resident #6 revealed no documentation a PASRR was submitted for Level II Evaluation after identification of new mental health diagnoses including PTSD, Nightmare Disorder, Major Depressive Disorder, and Personal History of Other Mental and Behavioral Disorders. During an interview on 1/22/2026 at 2:30 PM, the MDS Nurse confirmed a new PASRR had not been submitted to the state-designated authority for Resident #6 after new mental health diagnoses were identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

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 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** Based on review of medical records, observations, and interviews, the facility failed to provide nail care to 1 resident (Resident #26) of 134 residents reviewed.The findings include:Review of the medical record revealed Resident #26 was admitted to the facility on [DATE], with diagnoses including Cerebral Ischemia, Dementia, and Restlessness and Agitation. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #26 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident was dependent on staff for personal hygiene and bathing. Review of a comprehensive care plan for Resident #26 revealed, .Keep nails clean and trimmed .During an observation on 1/20/2026 at 11:30 AM, revealed Resident #26's nails unclean with a brown substance underneath the nails and around the cuticles of both hands. During an observation on 1/21/2026 at 8:30 AM, revealed Resident #26 eating a piece of bacon with her right hand. Resident #26 still had the same brown substance underneath the nails and around the cuticles of both hands.During an observation on 1/22/2026 at 9:15 AM, revealed Resident #26 sitting in bed. Resident #26 still had the same brown substance underneath the nails and around the cuticles of both hands. During an interview on 1/22/2026 at 9:17 AM, Certified Nursing Assistant (CNA) A stated she cared for the resident regularly and had not provided nail care for Resident #26.During an interview on 1/22/2026 at 9:20 AM, Registered Nurse Nurse Manager (NM) entered Resident #26's room with surveyor. NM inspected the resident's hands and confirmed Resident #26's nails had a brown substance underneath the nails and around the cuticles of both hands and nails had not been cleaned or trimmed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, observations, and interviews, the facility failed to follow Physician Orders for 2 residents (Residents #3 and #77) of 134 residents reviewed. The facility was cited at F-684 as Past Non-Compliance (PNC). Non-compliance began on 11/14/2025 and ended on 12/15/2025. The findings include:Review of the facilities policy titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, 2/22/2025 revealed .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Residents are identified before the medication is administered by using a methos of identification .photograph .to medical record .verifying resident identification with other facility personnel .the person who prepares the dose for administration is the person administers the dose .Review of the facilities policy titled, PREVENTING AND DETECTING ADVERSE CONSEQUENCES AND MEDICATION ERRORS, 2/22/2025 revealed .The facility employs a system to assure that medication usage is evaluated .Significant medication related problems are assessed, documented, and reported as appropriate .Facility staff observe the resident for possible medication-related adverse consequences .when the following conditions occur .Medication error .wrong medication .Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Dementia, Cerebral Infarct, and Hypertensive Chronic Kidney Disease.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the Physician Orders for Resident #3 dated 11/5/2025, revealed, .Clonidine [blood pressure medication] 0.1mg [milligram]/24 hr [hour] weekly one time a day on Tue [Tuesday], Diltiazem HCL [blood pressure medication] tablet 120 mg 1 tablet hold for systolic BP [blood pressure] < [less than] than 110 or HR [heart rate] < [less than] than 60 twice a day, Cholecalciferol (vitamin D3) tab 50mcg [microgram] daily .Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Epilepsy, and Hypertensive Chronic Kidney Disease.Review of the Physician Recapitulation Orders dated 1/20/2026, for Resident #77, revealed Aspirin [used to prevent blood clots] 81mg, Cholecalciferol (vitamin D3) 10 mcg, Levetiracetam [used to treat seizures or epilepsy] 500 mg, Lisinopril [blood pressure medicine] 20 mg, Metoprolol tartrate [blood pressure medicine] 37.5 mg, Potassium Chloride [used to treat low Potassium levels] extended release 20 mEq, and Rivastigmine tartrate [used to treat mild to moderate Dementia]1.5mg. Review of the Medication Administration Record (MAR) dated 11/1/2025-11/30/2025, for Resident #3, revealed Diltiazem HCL 120 mg and Cholecalciferol 50mcg were held. Review of a Physician Order dated 11/14/2025, for Resident #3 revealed, check vital signs every 4 hours x 4 hours. Every hour (x4) 11:00 AM, 12:00 PM, 01:00 PM, 02:00 PM. This was an intervention placed to monitor Resident #3 following a medication administration error. Review of a Basic Metabolic Panel (BMP) dated 11/14/2025, for Resident #3 revealed the Potassium level was 4.2, in normal range (3.4-5.1). Review of a Comprehensive Metabolic Panel (CMP) dated 11/18/2025, for Resident #3 revealed the Potassium level was 4.0, in normal range (3.4-5.1).Review of a Nursing note for Resident #3 dated 11/14/2025, revealed, .Medication Nurse prepared meds with students [a person enrolled in an educational institution] and gave the med cup of medications to the students. Medication nurse was entrance of room turned head back towards hallway and medications were given to wrong patient. Medication nurse immediately reported incident to nurse manager, ADON [Assistant Director of Nursing], DON [Director of Nursing]. NP [Nurse Practitioner] was notified with new orders received. Attempted to call Sister to inform of the incident, call not answered, called twice. Vital signs taken. Will monitor resident's condition and will notify provider for any changes .Review of Nursing notes dated 11/14/2025-11/17/2025, revealed Resident #3 remained on alert charting with no adverse side effects, change of condition, or change in vital (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs. Review of a facility documentation/Event Report for Resident #3 dated 11/14/2025, revealed, .Medications involved in the event .Aspirin [used to prevent blood clots] 81mg, Vitamin D3 [vitamin deficiency]10 mcg, Levetiracetam 500 mg [used to treat seizures or epilepsy], Lisinopril [high blood pressure medication] 20mg, Metoprolol 37.5mg [used to treat high blood pressure and chest pain], Potassium 20 meq [milliequivalents] [a mineral used to treat low potassium], and Rivastigmine Tartrate 1.5mg [used to treat mild to moderate Dementia] further review revealed .Medication Nurse prepared meds with students and gave the med cup of medications to the students. Medication nurse was entrance of room turned head back towards hallway and medications given to the wrong patient .Medication nurse immediately reported to nurse manager, ADON, DON. NP was notified with new orders received.Review of facility documentation for Resident #3 dated 11/14/2025, Revealed the following: .Patient identifiers in use at time of event: name on door pictures on chart .ADON made sure identifiers [name on door, pictures on chart] were in place at time of event .at 9:51 am [Nurse managers name] RN was with TCAT [Tennessee College of Applied Technology] students preparing medications for [Resident #3's] roommate [Resident #77]. [Nurse managers name] and the student entered the room, but the student administered medications to [Resident #3] when [Nurse manager] turned back towards the door .NP notified .new orders .monitor blood pressure every hour for four hours .BMP .hold diltiazem and vitamin d for one dose .Review of facility documentation for Resident #3 revealed, .Medication error .received roommates [Resident #77] morning medications that were administered by a Licensed Practical Nurse (LPN) student, who being supervised by Licensed Nurse preceptor .During an interview on 1/22/2026 at 12:40 PM, the NM stated the following: I had two students .we scan the medication. If they are comfortable, they administer the medication with me there they are on clinicals .We were in the hallway in front of the resident's room (back was to the door). I scanned [Resident #77 Name] medicine and hand it to the student and said this is [Resident #77 Name] medicine and handed it to the student. I turned to get [Resident #3 Name] medicine to scan and prepare and when I turned back around, the student was giving it [Resident #77's medications] to [Resident #3 Name]. I saw the student on [Resident #3 Name] side walking towards the door. I had [Resident #3 Name] medicine in my hand and said this is for [Resident #3 Name] by the window and the student said, I already gave it to her. I immediately reported to the ADON and DON the resident received the roommate's medication. Further interview revealed the NM did not observe the student administering the medications, stating her back was facing the entry of the door the entire time of the medication administration process. During an interview on 1/22/2026 at 1:05 PM the DON and ADON stated they became aware of the medication error the morning of 11/14/2025. The ADON immediately went to Resident #3's room to assess the resident and if patient identifiers were in place prior to medication administration. She confirmed identifiers were in place. The DON immediately pulled the students from the floor and notified the TCAT Licensed Nursing instructor.During an interview on 1/22/2026 at 2:39 PM, the NP stated she became aware Resident #3 received Resident #77's medications on the morning of 11/14/2026 and ordered labs, vital sign monitoring, and held the appropriate medications. The NP confirmed there was no negative outcome from the medications Resident #3 received in error. MD was also notified.The deficient practice was cited as past non-compliance for F-684 and the facility is not required to submit a plan of correction.Non-Compliance began on 11/14/2025 and ended on 12/15/2025.The facility put corrective actions in place as follows:A plan of correction was developed from 11/14/2025-12/15/2025 to address the deficient practice identified. The corrective actions were verified on-site by the surveyor on 1/20/2026-1/22/2026 through interviews and review of facility documents. The Physician, family, and TCAT Licensed Nurse Instructor were notified of the alleged incident. The facility's Plan of Correction included the following:1. All Nursing students were removed from patient care areas pending investigation on 11/14/2025.2. The ADON conducted Eight Rights of Medication Administration and Safety in-service education to active staff and students and observing students during medication administration on 11/14/2025.3. Licensed Nurse Preceptor was in-serviced by DON (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and ADON on the Eight Rights of Medication Administration Safety and all students are supervised during medication administration on 11/14/2025.4. All Licensed Nurses were in-serviced on the eight Rights of Medication Administration Safety as part of facility training from 11/14/2025 -11/17/2025.5. Beginning 11/14/2025, 5 random Medication Administration Supervision Audit's will be performed by the DON, ADON, Quality Manager, and Nurse Supervisors with each LPN student class over the next 3 months. Results will be reported monthly to the center Quality Assurance and Performance Committee (QAPI) x 3 months. The process will be reviewed and continued as needed.6. Root Cause Analysis Performed with the following areas of potential identified: all residents have the same potential to have been affected by the same deficient practice. 7. LPN students will be oriented and trained on the Eight Rights of Medication Administration and supervision during medication administration prior to every LPN class and completed with each Licensed Nurse new hire. 5 Random audits x 3 months and findings will be reported to QAPI. Random audits started 11/14/2025.8. When current interventions are not producing the desired outcome or resolution to prior issues, the Administrator, in conjunction with the QAPI committee will provide additional recommendations and help develop alternate interventions until compliance is achieved and sustained. The facility Governing Board will be informed of any issues that may require additional oversight or guidance. A member of the Governing Body will review QAPI meeting minutes at least quarterly.Surveyor verified the following onsite:The surveyor reviewed and validated on site: Education/In-service materials provided to Licensed Nursing staff with signed in-service materials completed on 11/17/2025.The surveyor reviewed and validated on site In-service handout, What are the Eight Rights of Medication Administration Safety with student signatures and date of education completed on 12/15/2025.The surveyor reviewed Medication Administration Supervision Audit Sheets. Completion date by 2/14/2025.Multiple interviews conducted with licensed staff during the survey 1/20/2026 through 1/22/2026, verified staff had received education on medications rights, safety, and supervision of Nursing students during medication preparation, administration, and reporting medication errors. Staff were knowledgeable of the new process for future students and of the facility policies related to medication administration and preventing and detecting medication errors.During an interview on 1/22/2026 at 4:10 PM, LPN C stated she had been educated on monitoring nursing students and the 8 rights of medication administration and safety. During an interview on 1/22/2026 at 4:15 PM, LPN D stated she had been educated on monitoring nursing students and the 8 rights of medication administration and safety. During an interview on 1/22/2026 at 4:17 PM, LPN E stated she had been educated on monitoring nursing students and the 8 rights of medication administration and safety.During an interview on 1/22/2026 at 4:21 PM, LPN B stated she had been educated on monitoring nursing students and the 8 rights of medication administration and safety. During an interview on 1/22/2026 at 4:25 PM, NM stated she had been educated on monitoring nursing students and the 8 rights of medication administration and safety and confirmed education was provided to nursing students. F-684 was cited as Past Non-Compliance and the facility is not required to submit a Plan of Correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, FT Sanders	2120 Highland Ave Knoxville, TN 37916

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure that medications were secure for 1 resident (Resident #84) of 134 residents reviewed. Review of the facility policy titled, Medication Storage In The Facility, dated 2/25/2025, revealed .Medications .are stored safely securely, and properly, following manufacturer's recommendations .the medication supply is accessible only to licensed nursing personnel .stored in a medication cart or other designated area . Review of the medical record revealed Resident #84 was admitted to the facility on [DATE], with diagnoses including Diabetes and Acute Metabolic Acidosis (electrolyte disorder causing too much acid in the blood).Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #84 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of the current comprehensive care plan for Resident #84 revealed .risks related to compromised gastrointestinal status .risks related to skin integrity .TF [tube feed] ileostomy . Review of the Medication Administration Record (MAR) dated 9/1/2025-10/23/2025, revealed .Sodium Chloride 0.9% .administer 150 milliliters gastric tube every four hours .Flush before and after tube feed and meds. Flush with 15ML between meds. Start date 8/11/2025 End date 9/30/2025 .During an observation on 1/20/2026 at 3:00 PM, revealed 2 cases containing a total of 48 1000ml bags of 0.9% Sodium Chloride resting on the ledge of the windowsill with blinds partially open in Resident #84's room. During an observation on 1/21/2026 at 1:59 PM, revealed 2 cases containing a total of 48 1000ml bags of 0.9% Sodium Chloride resting on the ledge of the windowsill with blinds partially open in Resident #84's room.During an observation and interview on 1/22/2026 at 12:26 PM, revealed 2 cases containing a total of 48 1000ml bags of 0.9% Sodium Chloride resting on the ledge of the windowsill with blinds partially open in Resident #84's room. During an interview Resident #84 stated she had been on tube feeding and the bags of saline had not been removed from her room after she no longer required tube feeding. Further interview confirmed the cases of Sodium Chloride had remained in the room greater than 90 days. During an interview on 1/22/2026 at 1:43 PM, the Director of Nursing (DON) confirmed the 2 cases of Sodium Chloride had not been stored correctly and were left in Resident #84's room greater than 90 days.