STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waters of Gallatin, LLC	555 East Bledsoe Street Gallatin, TN 37066

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, facility Infection Control Program document review, observation, and interview, the facility failed to ensure the prevention and spread of infections for 1 of 1 (Resident #97) when reusable medical equipment was not properly cleaned, and failed to establish and implement an infection control program to identify, report, investigate, and control infections and communicable diseases when the facility failed to ensure the tracking and trending of infections were conducted monthly for 1 of 3 months (February 2026) reviewed. This facility's failure to ensure tracking and trending of infections were conducted had the potential to affect 86 of the 86 residents residing in the facility.The findings include: 1. Review of the facility policy titled, Nebulizer Therapy, dated 4/1/2026, revealed .It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions .Observe resident during the procedure for any change in condition .Clean after each use .Disassemble parts after every treatment .Rinse the nebulizer cup and mouthpiece with sterile or distilled water .Shake off excess water . Air dry on an absorbent towel . Review of the undated facility policy titled, Cleaning and Disinfection of Resident-Care Equipment, revealed Resident-care equipment can be a source of indirect transmission of pathogens .Reusable single-resident items are items that may be used multiple times, but for one resident only .Direct care staff are responsible for cleaning single-resident equipment . Review of the facility policy titled, Infection Surveillance and Tracking, dated 4/1/2026, revealed A system of infection surveillance serves as a core activity of the facility's infection control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.Monthly time periods will be used for capturing and reporting data.All residents and infections will be tracked.All resident and infections will be tracked . 2. Review of the medical record revealed Resident #97 was admitted to the facility 8/26/2025, with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, and Anxiety. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed Resident #97 scored a 15 on the Brief Interview for Mental Status assessment, which revealed he was cognitively intact. Review of the Physician's Order dated 1/29/2026, revealed .Ipratropium-Albuterol Inhalation Solution [a combination of bronchodilators (medications used to open the lungs for better breathing) used to treat and prevent symptoms of wheezing and shortness of breath that is caused by ongoing lung disease] 0.5-2.5 (3) MG[milligram]/3ML[milliliter] .1 vial inhale orally every 4 hours for SOB [Shortness of Breath] . Observation at Resident #97's doorway on 4/6/2026 at 2:33 PM, revealed Licensed Practical Nurse (LPN) E, with gloved hands, removed the nebulizer treatment mouthpiece from the resident's mouth and disconnected the tubing from the breathing treatment machine. LPN E used a brown paper towel to wipe off the mouthpiece and placed the mouthpiece, with the nebulizer medication cup still connected, in a plastic bag. LPN E failed to separate and rinse the mouthpiece and the nebulizer medication cup off and allow them to air dry on a barrier before placing them into the plastic bag for storage. During an interview on 4/6/2026 at 2:40 PM, the Director of Nursing (DON) was asked after a breathing treatment what should nursing staff do with mouthpiece and nebulizer medication cup that (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medication is poured into. The DON stated, The mouthpiece and casing [round plastic piece that the medication is poured into] should be separated, rinsed, and allowed to dry .turning the pieces upside down on a barrier, then in a plastic bag for storage. The DON was asked to explain the purpose of rinsing and allowing to dry. The DON stated. For infection control, to prevent buildup of bacteria from forming in the chamber. The DON was asked to explain what the chamber is. The DON stated, The chamber is the part of the mouthpiece where you pour the solution. During an interview on 4/6/2026 at 2:43 PM, LPN E was asked about what she did with the resident's mouthpiece and the nebulizer medication cup that held the resident nebulizer treatment after the resident had finished his nebulizer treatment. LPN E stated, I wiped it out with the paper towel and put it in the bag. LPN E failed to clean the resident's mouth piece and nebulizer cup in accordance with the facility policy. 3. Review of the facility's infection tracking and trending reports revealed the facility had no tracking and trending of infections report for 2/2026. During an interview on 4/8/2026 at 11:32 AM, the Infection Control Preventionist (ICP) was asked to see the last 3 months of tracking and trending for infections. The ICP confirmed the facility had tracking and trending for December 2025 and January 2026 but did not have tracking and trending of infections for February 2026. During an interview on 4/8/2026 at 1:52 PM. The ICP was asked should the facility have the tracking and trending for infections for February 2026. The ICP stated, Yes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to reimburse funds within 30 days to 1 of 1 (Resident #101) sampled residents reviewed for personal fund accounts. The findings include: 1. Review of the undated policy titled, Conveyance of Resident Funds Upon Death, revealed .Upon the death of a resident with a personal fund deposited with the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, in accordance with State law 2. Review of the medical record revealed Resident #101 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Depression, and Adult Failure to Thrive. Review of the medical record revealed Resident #101 was deceased on [DATE]. Review of Resident #101's Resident Trust Fund Account revealed, a returned check dated [DATE] was issued for the account balance of $1,285.81, 33 days passed the allotted 30 day time period. The facility failed to refund the remaining balance to Resident #101's estate within 30 days of death. During an interview on [DATE] at 9:18 AM, the Business Office Manager (BOM) was asked when resident trust fund balances should be refunded. The BOM stated .I did not make the 30-day timeframe.I just overlooked it. During an interview on [DATE] at 1:42 PM, the Administrator was asked when resident funds should have been sent. The Administrator stated, 30 days. The Administrator was asked if it should be completed in those 30 days. The Administrator stated, Yes, it should have.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on facility policy review, Certified Nursing Assistant (CNA) in-service review, and interview, the facility failed to ensure 4 of 11 CNA's (CNA A, B, C, and D) received at least 12 hours of required in-service training annually. The findings include: 1. Review of the facility policy titled, Nurse Aide Training Program, with a revision date of 4/1/2026 revealed . Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date, not calendar year.The Staff Development Coordinator shall maintain documentation of training in his/her office during the current training year, and shall forward to the HR [Human Resources] Director at the completion of the training year to be maintained in the employee's personnel file. 2. Review of the CNA in-service training revealed the following: CNA A was hired on 1/31/2002 and only completed 8 hours of education from 1/31/2025 to 1/31/2026. CNA B was hired on 10/7/2021 and only completed 7 hours of education from 10/7/2024 to 10/7/2025. CNA C was hired on 12/27/2024 and only completed 6 hours of education from 12/27/2024 to 12/27/2025. CNA D was hired on 6/6/2022 and only completed 7 hours of education from 6/6/2024 to 6/6/2025. During an interview on 4/8/2026 at 2:56 PM, the Director of Nursing (DON) was asked if a CNA should have 12 in-service hours during a 12-month period beginning on his/her hire date annually. The DON replied, Yes, annually. During an interview on 4/8/2026 at 2:58 PM, the Staffing Coordinator was asked if a CNA should have 12 in-service hours during a 12-month period beginning on his/her hire date annually. The Staffing Coordinator replied, Yes.

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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 store medications in accordance with facility policy when medications were found unsecured and unattended at the resident's bedside and failed to ensure equipment was properly cleaned after use for 1 of 1 (Resident #97) residents. The findings include: Review of the facility policy titled, Nebulizer Therapy, dated 4/1/2026, revealed .It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions .Observe resident during the procedure for any change in condition .Clean after each use .Disassemble parts after every treatment .Rinse the nebulizer cup and mouthpiece with sterile or distilled water .Shake off excess water . Air dry on an absorbent towel . Review of the facility policy titled, Medication Storage, dated 4/1/2026, revealed .During a medication pass, medications must be under the direct observation of the person administering medications . Review of the undated facility policy titled, Cleaning and Disinfection of Resident-Care Equipment, revealed Resident-care equipment can be a source of indirect transmission of pathogens .Reusable single-resident items are items that may be used multiple times, but for one resident only .Direct care staff are responsible for cleaning single-resident equipment . 2. Review of the medical record revealed Resident #97 was admitted to the facility 8/26/2025, with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, and Anxiety. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed Resident #97 scored a 15 on the Brief Interview for Mental Status assessment, which revealed he was cognitively intact. Review of the Physician's Order dated 1/29/2026, revealed .Ipratropium-Albuterol Inhalation Solution [DuoNeb is a combination of bronchodilators (ipratropium bromide and albuterol sulfate) used to treat and prevent symptoms of wheezing and shortness of breath that is caused by ongoing lung disease] 0.5-2.5 (3) MG[milligram]/3ML[milliliter] .1 vial inhale orally every 4 hours for SOB [Shortness of Breath] . A random observation at Resident #97's doorway on 4/6/2026 at 2:12 PM, revealed Resident #97 was holding his nebulizer treatment mouthpiece in his mouth as he was getting the nebulizer treatment. There was no nurse in the room during Resident #97's nebulizer treatment. During an observation and interview at Resident #97's doorway on 4/6/2026 at 2:14 PM, the Director of Nursing (DON) was asked about Resident #97 self-administering the breathing treatment. The DON stated, The nurse should be with the resident during the breathing treatment the entire time. [Named Resident #97] has not been assessed to self-administer his medications. The DON summoned for Licensed Practical Nurse (LPN) E to come to the resident's doorway. The DON stated to LPN E, Anytime Resident #97 is getting a breathing treatment you [LPN E] should be there the entire time because he [named Resident #97] has not been assessed to self-administer medications. Observation at Resident #97's doorway on 4/6/2026 at 2:33 PM, revealed LPN E with gloved hands removed the nebulizer treatment mouthpiece from the resident's mouth and disconnected the tubing from the breathing treatment machine. LPN E used a brown paper towel to wipe off the mouthpiece and placed the mouthpiece, with the nebulizer cup still connected, in a plastic bag. LPN E failed to separate the mouthpiece from the nebulizer cup and failed to rinse them off and place them on a barrier to dry before placing them into the plastic bag for storage. During an interview on 4/6/2026 at 2:35 PM, LPN E was asked the name of medication during Resident #97's nebulizer treatment. LPN E stated DuoNeb. During an interview on 4/6/2026 at 2:40 PM, the DON was asked after a breathing treatment what should nursing staff do with mouthpiece and round plastic piece that the medication is poured into. The DON stated, The mouthpiece and casing [round plastic piece that the medication is poured into] should be separated, rinsed, and allowed to dry .turning the pieces upside down on a barrier, then in a plastic bag for (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	storage. The DON was asked to explain the purpose of rinsing and allowing to dry. The DON stated. For infection control, to prevent buildup of bacteria from forming in the chamber. The DON was asked to explain what the chamber is. The DON stated, The chamber is the part of the mouthpiece where you pour the solution. During an interview on 4/6/2026 at 2:43 PM, LPN E was asked about what she did with the resident's mouthpiece and the round plastic piece (chamber) that held the resident nebulizer treatment after the resident had finished his nebulizer treatment. LPN E stated, I wiped it out with the paper towel and put it in the bag.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, Patient & Family Fridge Notice review, Bistro Fridge Notice review, observation, and interview, the facility failed to properly store resident food when 2 of 2 (Patient & Family and Bistro) refrigerators contained unlabeled, undated, and uncovered food items. The findings include: 1. Review of the facility policy titled, Use and Storage of Food Brought in by Family or Visitors, dated 4/1/2026, revealed .It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident.All food items that are already prepared by the family or brought in must be labeled with content and dated.The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator.The prepared food must be consumed by the resident within 3 days.If not consumed within 3 days, food will be thrown away by facility staff. Review of the undated facility policy titled Food Safety Requirements, revealed .It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will so be stored, prepared, distributed and served in accordance with professional standards for food service safety.Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon deliver/receipt and ensure timely and proper storage.Practices to maintain safe refrigerated storage include.Labeling, dating, and monitoring refrigerated food.Keeping foods covered or in tight containers. 2. Review of the undated Patient & Family Fridge Notice, revealed .This refrigerator is available for food items provided by patients and their families. To ensure food safety and compliance with Tennessee health code guidelines, please follow the expectations below.All items must be clearly labeled with the patient's name and date.Items may be stored for a maximum of 3 days only.Unlabeled or expired items will be removed during routine checks. 3. Review of the undated Bistro Fridge Notice, revealed .This refrigerator is designated for snacks provided by the Dietary Department for patients only. To ensure food safety and compliance with Tennessee health code guidelines, please follow the expectations below.All items placed in this fridge must be properly labeled with a date. 4. During an observation of the Patient & Family Fridge in the nourishment room on 4/8/2026 at 10:36 AM, revealed the following items: a. One (1) 12 ounce (oz) opened can of lemonade undated, unlabeled, and uncovered with a straw inside the can opening b. Two (2) 8 oz bottles of nutritional supplement with a use by date of 1/19/2026 c. 1 undated small Styrofoam container of salad d. 2 undated to go containers full of unknown food items e. 1 clear plastic container containing a chicken salad sandwich and potato salad with sell by date of 3/23/2026 f. 1 small undated box of pizza g. A 32 oz tub full of Greek vanilla yogurt with a use by date of 3/26/2026 h. A 32 oz tub full of Greek strawberry yogurt with a use by date of 3/29/2026 i. 1 unlabeled and undated paper plate with hotdogs and baked beans loosely covered with foil j. 1 unlabeled and undated cheeseburger loosely wrapped in foil k. 1undated large to go bowl full of chili l. 1 undated small to go bowl full of an unknown food item m. 1 undated large cup with opening in lid full of chocolate ice cream 5. During an observation of the Bistro Fridge in the nourishment room on 4/8/2026 at 10:50AM, revealed 5 undated roast beef and cheese sandwiches wrapped in plastic. During an interview on 4/8/2026 at 10:53 AM, LPN F was asked should unlabeled, undated, expired, or uncovered food items be in the Patient & Family or Bistro refrigerators. LPN F stated, No. During an interview on 4/8/2026 at 1:43 PM, the Certified Dietary Manager (CDM) was asked if items in the Patient & Family refrigerator should be dated. The CDM stated, It should be labeled with resident name and dated. The CDM was asked if expired items should be in the Patient & Family refrigerator. The CDM stated, No. The CDM was asked if opened and uncovered items should be in the Patient & Family refrigerator. The CDM stated, No. The CDM was asked if sandwiches should be in the Bistro refrigerator without a date. The CDM stated, No. ˆ

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on facility policy review, Certified Nursing Assistant (CNA) in-service review, and interview, the facility failed to ensure 4 of 11 CNA's (CNA A, B, C, and D) received at least 12 hours of required in-service training annually. The findings include: 1. Review of the facility policy titled, Nurse Aide Training Program, with a revision date of 4/1/2026 revealed . Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date, not calendar year.The Staff Development Coordinator shall maintain documentation of training in his/her office during the current training year, and shall forward to the HR [Human Resources] Director at the completion of the training year to be maintained in the employee's personnel file. 2. Review of the CNA in-service training revealed the following: a. CNA A was hired on 1/31/2002 and only completed 8 hours of education from 1/31/2025 to 1/31/2026. b. CNA B was hired on 10/7/2021 and only completed 7 hours of education from 10/7/2024 to 10/7/2025. c.CNA C was hired on 12/27/2024 and only completed 6 hours of education from 12/27/2024 to 12/27/2025. d. CNA D was hired on 6/6/2022 and only completed 7 hours of education from 6/6/2024 to 6/6/2025. During an interview on 4/8/2026 at 2:56 PM, the Director of Nursing (DON) was asked if a CNA should have 12 in-service hours during a 12-month period beginning on his/her hire date annually. The DON replied, Yes, annually. During an interview on 4/8/2026 at 2:58 PM, the Staffing Coordinator was asked if a CNA should have 12 in-service hours during a 12-month period beginning on his/her hire date annually. The Staffing Coordinator replied, Yes.