STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445135	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waters of Clinton, LLC	220 Longmire Rd Clinton, TN 37716

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to obtain consent for administration of psychotropic medications for 2 of 5 residents (Resident #10 and Resident #24) reviewed for unnecessary medications. The findings include:Review of the facility's undated policy titled, Psychotropic Drugs Usage, revealed .Any resident receiving psychotropic medication will have a signed informed consent for the use of the medication .Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Severe Dementia with Psychotic Disturbance and Delusional Disorder. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident received an antidepressant medication. Review of current Physician Orders for Resident #10 revealed Sertraline (medication used to treat Depression) 25 mg (milligram) at bedtime was ordered on 6/10/2025.Review of the Medication Administration Record (MAR) for Resident #10 dated 6/10/2025 to 6/30/2025, revealed Resident #10 received Sertraline 25 mg daily at bedtime.Review of the MAR for Resident #10 dated 7/1/2025 to 7/31/2025, revealed the resident received Sertraline 25 mg daily at bedtime.Review of the MAR for Resident #10 dated 8/1/2025 to 8/31/2025, revealed the resident received Sertraline 25 mg daily at bedtime. Review of the MAR for Resident #10 dated 9/1/2025 to 9/23/2025 revealed the resident received Sertraline 25 mg daily at bedtime.Review of the medical record for Resident #10 revealed no consent for the use of Sertraline. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Major Depressive Disorder, Mood Disorder Due to Known Psychological Condition with Depressive Features, Generalized Anxiety Disorder, Adjustment Disorder with Depressed Mood.Review of a quarterly MDS assessment dated [DATE], revealed Resident #24 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review revealed the resident received antianxiety and antidepressant medications.Review of current Physician Orders for Resident #24 revealed Alprazolam (medication used to treat anxiety) 0.25 mg two times a day was ordered on 6/16/2025. Review of current Physician Orders for Resident #24 revealed Buspirone (medication to treat anxiety) 10 mg three times a day was ordered on 6/25/2025.Review of current Physician Orders for Resident #24 revealed Sertraline 50 mg one time a day was ordered on 6/26/2025.Review of current Physician Orders for Resident #24 revealed Trazodone (medication used to treat insomnia) 100 mg, give 2 tablets (for a total of 200 mg) at bedtime was ordered on 9/9/2025.Review of the MAR for Resident #24 dated 6/16/2025 to 6/30/2025, revealed the resident received Alprazolam 0.25 mg two times daily. Further review revealed the resident received Buspirone 10 mg three times daily from 6/25/2025 through 6/30/2025, and Sertraline 50 mg one time daily from 6/26/2025-6/30/2025. Review of the MAR for Resident #24 dated 7/1/2025 to 7/31/2025, revealed the resident received Alprazolam 0.25 mg two times daily, Buspirone 10 mg three times daily, and Sertraline 50 mg one time daily. Review of the MAR for Resident #24 dated 8/1/2025 to 8/31/2025, revealed the resident received Alprazolam 0.25 mg two times daily, Buspirone 10 mg three times daily, and Sertraline 50 mg one time daily. Review of the MAR for Resident #24 dated 9/1/2025 to 9/23/2025, revealed the resident received Alprazolam 0.25 mg two times daily, Buspirone 10 mg three times daily, and Sertraline 50 mg one time daily. Further review revealed the resident received Trazodone 200 mg at bedtime from 9/9/2025 through 9/22/2025. Review of the medical record for Resident #24 revealed no consent for the use of Alprazolam, Buspirone, Sertraline, or Trazodone.During an interview on 9/23/2025 at 5:40 PM, the Director of Nursing stated the nurse who admitted the residents to the facility was responsible for obtaining psychotropic medication consents. The DON confirmed the facility failed to obtain consent forms for psychotropic medications for Resident #10 and Resident #24.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on facility policy review and interview, the facility failed to ensure the electronic medical records of the facility were protected by using safeguards to ensure the electronic medical records were not available for direct public to view within the facility. The findings include:Review of the facility's undated policy titled, What is HIPAA, revealed .It is the health insurance portability and accountability act of 1996 (HIPAA) .A major goal of the privacy rule is to assure that individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being .Any and all health information on a resident or employee that identifies an individual. This can be in any form, such as paper records, electronic records, and even spoken communication .It shall be the policy of the facility to protect and safeguard the PHI (personal health information) created, acquired and maintained in accordance with the Privacy Regulation pursuant to the Health Insurance Portability and Accountability Act of 1996 .During an observation on 9/22/2025 at 2:20 PM, the south hall medication cart was unattended. The computer atop the medication cart was open, logged into an electronic medical record, and available for the public to view. During an observation and interview on 9/22/2025 at 2:22 PM, Charge Nurse (CN G) stated Registered Nurse (RN F) had .parked the medication cart in front of the nurses' station and went to lunch about 10 minutes ago (2:10 PM) . CN G stated RN F had used the medication cart previously for the mid-day medication administration. CN G confirmed the computer screen had been left open to an electronic medical record and was available for public view. CN G confirmed the facility failed to ensure electronic records were secured and protected.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual review, medical record review, and interviews, the facility failed to ensure MDS assessments were accurate for 1 resident (Resident #65) of 22 residents reviewed for MDS assessments. The findings include: Review of the MDS (Minimum Data Set) 3.0 RAI Manual Verson 19.1, dated 10/2024, revealed .SECTION H: BLADDER AND BOWEL .The intent of the items in this section is to gather information on the use of bowel and bladder appliances .provided with individualized treatment .Appliances .INDWELLING CATHETER A catheter that is maintained within the bladder for the purpose of continuous drainage of urine .Health-related Quality of Life .It is important to know what appliances are in use and the history .Steps for Assessment .Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances .were used in the past 7 days . Review of the medical record revealed Resident #65 admitted to the facility on [DATE] with diagnoses including Benign Prostatic Hyperplasia, Obstructive and Reflux Uropathy, and Retention of Urine. Review of a Physician's order for Resident #65 dated 11/12/2024, revealed .Remove .cath [indwelling urinary Catheter] after 48 hours .Review of an MDS Note for Resident #65 dated 3/17/2025, revealed .cath [indwelling urinary catheter] has been removed .is occasionally incontinent of bladder .Review of a Nurse Practitioner Progress note for Resident #65 dated 3/31/2025, revealed .History of urinary retention: Resident has been urinating effectively since discontinuation of .catheter .Review of a MDS Note for Resident #65 dated 6/13/2025, revealed .Resident is occasionally incontinent of bladder and bowel .Review of a quarterly MDS assessment dated [DATE], revealed Resident #65 scored a 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #65 had an indwelling catheter. During an observation on 9/21/2025 at 3:19 PM, revealed Resident #65 was sitting in his wheelchair. Further observation revealed Resident #65 had no indwelling urinary catheter in place. During an observation and interview on 9/22/2025 at 3:40 PM, revealed Resident #65 was sitting in his wheelchair. Further observation revealed Resident #65 had no indwelling urinary catheter in place. Resident #65 stated he used to have an indwelling urinary catheter. During an interview on 9/23/2025 at 10:37 AM, MDS Coordinator (MDS C) reviewed the quarterly MDS assessment dated [DATE] and the medical record for Resident #65. MDS Coordinator C confirmed Resident #65 did not have an indwelling urinary catheter during the 7-day look back period (6/7/2025 through 6/13/2025) of the quarterly MDS assessment dated [DATE]. The MDS Coordinator C further confirmed the quarterly MDS assessment for Resident #65 dated 6/13/2025 was not accurately coded. During an interview on 9/23/2025 at 10:42 AM, the Director of Nursing confirmed the facility failed to ensure the accuracy of the quarterly MDS assessment dated [DATE] for Resident #65.

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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, and interview, the facility failed to obtain a Physician's Order for isolation precautions for 1 resident (Resident #12) of 16 residents reviewed for isolation orders. The findings include: Review of the facility's policy titled, Infection Control/Isolation Guidelines, undated, revealed .to prevent unprotected exposure of residents, visitors, and staff to potentially infectious microorganisms .to decrease the spread Contact precautions used for multidrug-resistant organisms [MDRO's] [microorganisms, primarily bacteria, that have developed resistance to 3 or more antimicrobial drugs making them difficult to treat with standard antibiotics] .and order must be obtained from the physician .Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Schizophrenia, Anxiety Disorder, and Major Depressive Disorder. Review of a Laboratory Result reported to the facility on 9/16/2025, revealed Resident #12 had a urine culture which revealed the resident grew out Extended-Spectrum Beta-Lactamases (ESBL) (bacteria is resistant to a wide range of antibiotics) in her urine. Review of a Physician's Order for Resident #12 dated 9/16/2025, revealed .ertapenem sodium [medication used to treat infection] 1 gram intravenously [IV] every 24 hours for ESBL UTI [Urinary Tract Infection] for 7 days . Further review revealed no Physician's Order was obtained for isolation precautions. Review of a comprehensive care plan dated 9/17/2025 for Resident #12 revealed, .receiving IV meds R/T [related to] a UTI . with intervention, .contact precautions per facility policy .During an interview on 9/23/2025 at 1:30 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) confirmed Resident #12 was being treated currently for a UTI with ESBL, and there was no Physician's Order for isolation precautions.

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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. Based on facility policy review, observation, and interview, the facility failed to ensure medications were securely stored in 1 medication cart (North medication cart) of 4 medication carts reviewed.The findings include: Review of the facility policy titled, Medication Storage in the Facility, dated 3/2023, revealed . Medications are stored safely, securely, and properly .accessible only to licensed nursing personnel . Medication rooms, carts, and medication supplies are locked and attended by person with authorized access . During an observation on 9/21/2025 at 1:14 PM, the North medication cart was located in the North hallway against the wall, and the drawers were facing the hallway. The medication cart was unlocked and there were no employees present. During an interview on 9/21/2025 at 1:15 PM, LPN D confirmed she had been in a resident room with the door closed and the North medication cart in the hallway was unlocked, and out of LPN D's view. LPN D also confirmed medication carts are to be locked when unattended by the licensed nurse.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, observation, and interview the facility failed to maintain a clean and sanitary kitchen which had the potential to affect 90 of 90 residents of the facility.The findings include:Review of the facility's policy titled, Labeling and Dating, dated 7/30/2023, revealed .leftovers and opened foods shall be clearly labeled with date food item is to be discarded .Review of the facility's undated policy titled, Equipment Cleaning and Sanitizing revealed .Equipment is washed, rinsed, and sanitized after each use to ensure safety of food served to residents .Employees who use equipment will be responsible for washing and sanitizing removeable parts after each use. Steps include .Disassemble removable parts from equipment . wash, rinse, and sanitize all food contact surfaces and the equipment that are sanitary .During an observation and interview on 9/21/2025 at 10:30 AM, 6 sandwiches in plastic bags identified by staff as peanut butter and jelly were in the kitchen refrigerator. Continued observation revealed 5 of the 6 sandwiches were unlabeled and undated. The Dietary Manager (DM) confirmed 5 of the 6 peanut butter and jelly sandwiches were unlabeled and undated and were available for resident use.During an observation with the DM on 9/21/2025 at 10:40 AM revealed the following:a. Debris was observed in and on the commercial can opener next to the cutting blade. b. The ice machine drain extended inside the rim of the floor drain; the ice machine drain tubing had a thick black substance inside the drain matching the appearance of the substance inside the floor drain. c. 108 eggs stored on a bottom shelf in the kitchen refrigerator and were uncovered. Desserts, fruits and vegetables were stored on shelves above the eggs.d. Dirt and debris were observed on the floor behind the dry food storage room, the ice machine, and under the dishwasher.e. There was a buildup of grease with a collection of lint and hair on 3 of 3 of the fire suppression piping located directly above the stove. During an interview on 9/21/2025 at 10:40 AM, the DM confirmed the facility failed to maintain a sanitary kitchen.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure appropriate Personal Protective Equipment (PPE) was donned for 1 resident (Resident #9) of 16 residents observed on Enhanced Barrier Precautions (EBP), and the facility failed to perform hand hygiene during medication administration for 1 resident (Resident #10) of 4 residents observed during medication administration.The findings include: Review of the facility's policy titled, Guidelines for Enhanced Barrier Precautions, undated, revealed .Enhanced Barrier Precautions (EBP) is defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of multidrug-resistant organisms [MDRO's] [microorganisms, primarily bacteria, that have developed resistance to 3 or more antimicrobial drugs making them difficult to treat with standard antibiotics] .onto the hands and/or clothing of the rendering caregiver .for residents at high-risk for acquiring or spreading a MDRO . residents with an indwelling medical device including .central venous catheters .examples of high-contact activities include .transferring .providing hygiene-ADL's [activities of daily living] .when engaging in . high-contact resident care activities with a resident .who would be at high-risk .use gloves and gowns . Review of the facility's policy titled, Medication Administration Policy and Procedure, dated 8/2014, revealed . This facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub .or .soap .and water .after direct contact with residents .Before donning [applying] . gloves . After removing gloves .Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Dialysis Dependent, Diabetes, and Chronic Obstructive Lung Disease.Review of a Physician's Order for Resident #9 dated 7/16/2025, revealed . Enhanced Barrier Precautions for Dialysis Perma Cath .Review of a Physician's Order for Resident #9 dated 8/12/2025, revealed .RT [right] .Perma Cath . During an observation on 9/22/2025 at 2:25 PM, revealed a PPE bin hanging on the outside of Resident #9's room door, with a Centers for Disease Control (CDC) sign for Enhanced Barrier Precautions, .Providers and staff must .wear gloves and a gown for the following High-Contact Resident Care Activities .Dressing .Transferring .Providing Hygiene . Further observation inside the room revealed Resident #9 was lying in bed with pants part way up the legs. CNA E was at the bedside assisting the resident with the pants. The CNA was wearing gloves but did not have a gown in place. During an observation and interviews on 9/22/2025, a Physical Therapy Assistant (PTA) and a Physical Therapist (PT) entered Resident #9's room at 2:46 PM. The PTA and PT did not retrieve PPE from the bin on the resident's door. The PT and PTA exited the room at 3:12 PM. During an interview, the PT and PTA stated they were providing therapy for Resident #9 including transferring. The PT and PTA confirmed they wore PPE for EBP when providing care for the reason the resident was on EBP, for example wound care, or catheter care. Both PT and PTA confirmed they did not wear a gown when they provided therapy which included transferring for Resident #9. During an interview on 9/22/2025 at 2:52 PM, CNA E stated EBP was to be used for the reason the resident was on EBP such as catheter care or if the resident had a wound. CNA E confirmed Resident #9 was on EBP and the EBP sign on the door stated a gown and gloves were to be worn .for dressing, bathing, and personal hygiene . CNA E confirmed she did not wear a gown when she provided hygiene and dressing for Resident #9.During an interview on 9/22/2025 at 3:25 PM, the Staff Development Coordinator (SDC) confirmed Resident #9 was on EBP. The SDC stated residents with an indwelling device, wounds, catheter, and some other conditions require EBP. The SDC stated residents on EBP only required staff to don gowns for direct contact with the reason for EBP, for example indwelling device care, and open wounds. During an interview on 9/23/2025 at 1:30 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) confirmed Resident #9 was on EBP. The ADON/IP stated residents on EBP only required donning gowns for direct contact with the reason for EBP, for example indwelling device care, care for foley catheters, and care for open wounds. After ADON/IP reviewed the CDC EBP signage, and the facility's policy, ADON/IP confirmed the EBP required wearing gowns for all high-contact care including dressing, transferring, and providing hygiene to protect residents at high-risk of acquiring or spreading a MDRO.Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, and Kidney Failure.During an observation of medication administration on 9/22/2025 at 8:20 AM, revealed Licensed Practical Nurse (LPN) D applied gloves, prepared insulin medication for Resident #10, entered the resident's room, checked the resident's