STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445281	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whites Creek Wellness and Rehabilitation Center	3425 Knight Drive Whites Creek, TN 37189

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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 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, observation, and interview, the facility failed to maintain and ensure the prevention and spread of infection during medication administration and catheter care for 4 of 7 (Resident #1, #22, #69, #88) sampled residents reviewed. The findings include: 1. Review of the undated facility policy titled, Medication Administration, revealed .Medications are administered by licensed nurses.as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Wash hands prior to administering medication. Review of the undated facility policy titled, Hand Hygiene revealed .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.The use of gloves does not replace hand hygiene.perform hand hygiene prior to donning gloves, and immediately after removing gloves.Before preparing or handling medications. Review of the facility policy titled, Infection Prevention and Control Program, dated 1/24/2025, revealed .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.All staff shall use personal protective equipment (PPE) according to the established facility policy governing the use of PPE.All reusable items and equipment requiring.disinfection.shall be cleaned in accordance with our current procedures governing the cleaning and.contaminated equipment. Review of the facility undated policy titled, Enhanced Barrier Precautions, reveal .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted Gown and gloves use during high contact resident care activities.An order for enhanced barrier precautions will be obtained for residents with any of the following.wounds, indwelling medical devices.urinary catheters [tubing in the bladder], feeding tubes [tube placed into your stomach or bowel to help you get nutrition], tracheostomy [opening that allows air into the lungs].High contact resident care activities include.dressing.transferring.changing linens.Device care or use .urinary catheters, feeding tubes, tracheostomy .wound care. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Dementia, Respiratory Failure, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was moderately cognitively impaired. Review of Resident #1's Physicians Orders revealed orders for the following oral medications: Oxcarbazepine (an anticonvulsant) 150 mg (milligrams) 1 tablet twice a day, Potassium Chloride ER (Extended Release) (a supplement) 20 mEq (milliequivalent) 1 twice a day, Metoprolol (a medication to treat high blood pressure) 12.5 mg 1 twice a day, Metformin hcl (Hydrochloride) (a medication to treat Diabetes) 850 mg twice a day, Escitalopram Oxalate (an antidepressant) 5 mg 1 daily, Levetiracetam (a medication to treat Seizures) 500 mg 1 twice a day, Escitalopram Oxalate 10 mg 1 every day, Apixaban (a blood thinner) 5 mg 1 twice a day, Bumetanide (a diuretic) 1 mg 1 every day, Famotidine (a medication to reduce stomach acid) 20 mg 1 twice a day, and Megestrol Acetate (a medication to increase appetite) 40 mg every day. During observation and interview during Medication Administration at the 200/300 (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	hall medication cart on 3/10/2026 at 9:40 AM, revealed LPN B retrieved the following medications from the medication cart to administer to Resident #1: Oxcarbazepine 150 mg, Potassium Chloride ER 20 mEq , Metoprolol 12.5 mg, Metformin hcl 850 mg, Escitalopram Oxalate 5 mg, Levetiracetam 500 mg, Escitalopram Oxalate 10 mg, Apixaban 5 mg, Bumetanide 1 mg, Famotidine 20 mg, and Megestrol Acetate 40 mg. LPN B prepared the medications without preforming hand hygiene, entered the resident's room, and administered the medications to Resident #1. LPN B failed to perform hand hygiene prior to preparing and administering Resident #1's medications. LPN B was asked if she performed hand hygiene before preparing Resident #1 medications. LPN B stated, No, I did not. LPN B was asked if she should have performed hand hygiene prior to preparing medications she stated, Yes, ma'am I should have . The Director of Nursing (DON) was asked should hand hygiene be performed prior to preparing medication for administration. The DON stated, Yes . 3. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Dementia, Osteoarthritis, Chronic Pancreatitis, and Diverticulosis. Review of Resident #22's current Physician's Orders revealed an order for Alphagan P [eye medication to treat glaucoma] Solution 0.1% [percent] Instill 1 drop in both eyes every 12 hours. Review of the quarterly MDS assessment dated [DATE], revealed Resident #22 had a BIMS score of 9, which indicated moderate cognitive impairment. Observation during medication administration in the Resident's room on 3/11/2026 at 7:58 AM, revealed LPN D entered Resident #22's room and placed a plastic bag containing Alphagan eye drops half on the barrier and half on the table. LPN D pushed a blood pressure machine into Resident #22's room and used the machine to obtain a blood pressure that was elevated, she took the blood pressure 2 more times with that blood pressure machine. LPN D left the room to get a different blood pressure machine and used the second machine to obtain a blood pressure. LPN D donned gloves and took a clean tissue and wiped Resident #22's right eye with a dry tissue and then wiped the left eye with a dry tissue, each with one swipe. Then without performing hand hygiene, LPN D administered 1 drop of eye drops in the right eye and immediately administered 1 drop into the left eye wearing the same pair of gloves. Then LPN D took the eye drop bottle and placed it back in the plastic bag and returned the bag to the medication cart drawer without disinfecting the eye drop bottle or bag. LPN D failed to disinfect the eye drop bottle or bag and failed to disinfect the two blood pressure machines that she used to obtain a blood pressure on Resident #22. During an interview on 3/11/2026 at 8:11 AM, LPN D was asked, after taking the bag with the eye drops into the room, should you have cleaned the eye drop bottle, the bag, or the blood pressure machines. LPN D stated, Yes, I should have cleaned the eye drop bottle and I should have cleaned the blood pressure machines before and after using. During an interview on 3/11/2026 at 2:08 PM, the DON was asked during medication administration should the nurse have disinfected the eye drop bottle and bag that she replaced back into the medication cart drawer. The DON stated, Yes, at the least cleaned the bag. The DON was asked if the nurse should have cleaned the blood pressure machines she used on Resident #22. The DON stated, Yes, before and after use on a resident. 4. Review of the medical record revealed Resident #69 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Hypertension, and Polyneuropathy. Review of the admission MDS assessment dated [DATE], revealed Resident #69 scored a 15 on the BIMS assessment, which indicated she was cognitively intact. Review of Resident #69's current Physician's Orders revealed an order for Humalog Insulin 3 Unit subcutaneous before meals. Observation during Medication Administration at the 100 Hall Medication Cart, on 3/10/2026 at 11:29 AM, revealed LPN C put on (donned) gloves without performing hand hygiene, cleaned a glucometer machine with a disinfecting wipe, placed the glucometer machine in a plastic cup, and took off (doffed) gloves without performing hand hygiene. LPN C then placed an insulin needle, a plastic bag with an insulin pen inside, and alcohol pads into a second plastic cup. LPN C entered Resident #69's room, placed the cup with the insulin pen on the nightstand and the other plastic cup on the bedside table. LPN C donned gloves wiped Resident #69's right thumb with an alcohol pad to obtain a blood specimen. LPN C doffed gloves, without performing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene, and returned to the medication cart to obtain a blood glucose test strip. LPN C returned to Resident #69's room, donned gloves without performing hand hygiene, and obtained the blood specimen from right thumb. LPN C dropped a plastic cup on floor and the plastic bag with the insulin pen inside fell on the floor. LPN C picked the plastic bag up off the floor, placed it back into the plastic cup, doffed gloves without performing hand hygiene and returned to the medication cart. LPN C then placed the dirty bag into a clean plastic cup and returned to Resident #69's room. LPN C removed the insulin pen from the plastic bag with his right hand, then removed the cap from insulin pen, the end of insulin pen touched the dirty plastic bag while in his right hand, placed needle on insulin pen without disinfecting the end of the insulin pen and administered Lispro (Humalog) 3 units subcutaneously to Resident #69's right lower abdomen. During an interview on 3/10/2026 at 11:49 AM LPN C was asked when should hand hygiene be performed. LPN C stated, Before and after touching a resident and when my hands are soiled. LPN C was asked should he perform hand hygiene prior to preparing medication for administration. LPN C stated, Yes ma'am I should. LPN C was asked should you performed hand hygiene when donning and doffing gloves. LPN C stated, Yes. Ma'am. LPN C was asked should the end of the insulin pen be disinfected before connecting the needle. LPN C stated, I think that would be common practice to clean off the end . During an interview on 3/11/2026 at 11:01 AM, the DON was asked should staff perform hand hygiene before donning and doffing gloves. The DON stated, Yes, the staff should perform hand hygiene before donning and doffing gloves. The DON was asked should the end of the insulin pen be disinfected after touching a dirty plastic bag. The DON stated, Yes, it should have been disinfected . 5. Review of the medical record revealed Resident #88ˆwas admitted to the facility on [DATE]ˆwith diagnoses including Acute Pyelonephritis, Hypertension, and Benign ProstaticˆHyperplasia.ˆˆ ReviewˆoftheˆMDS assessment dated [DATE],ˆrevealed resident #88 scored a 5 on the BIMS assessment, whichˆindicatedˆhe was severely cognitively impaired.ˆˆThe residentˆrequiredˆsubstantial to maximalˆassistanceˆfrom staff for toileting hygieneˆand had an indwelling catheter.ˆˆ Review of the physician order dated 1/21/2026, revealed .Change [named] catheter and bedside drainage bag using 24 FRˆ[French]ˆ30mlˆ[milliliter]ˆbulb as neededˆAND at bedtime every 30 day(s) .ˆ Review of the Physician Order dated 2/11/2026, revealedˆ .Enhanced Barrier Precautions r/t [related to] [named] Catheter/Wounds every shift .ˆ Random observation in the resident room Resident #88's room on 3/11/2026 at 9:21 AM, revealed CNA A emptying Resident #88's indwelling urinary catheter bag. CNA A failed to wear a gown when she emptied the urine from the catheter bag. During an interview on 3/11/2026 at 9:30 AM, CNA A was asked what PPE she ˆshouldˆwearˆwhen a resident is on EBP. CNA A stated, wear gloves . CNA A was asked when sheˆemptied the urine from Resident #88's catheter bag was she supposed to wear a gown and gloves. CNA A stated, Iˆwill be honest. I am not for sure. During an interview on 3/11/2026 at 3:12 PM, the DON was asked if staff should wear a gown and gloves when urine is emptied from the resident's catheter bag The DON stated, Yes, that is direct patient care.

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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 policy review, American Association of Post-Acute Care Nursing article review, observation, and interview, the facility failed to ensure neurological (neuro) checks were performed after falls and failed to follow the care plan for 1 of 3 (Resident #20) sampled residents reviewed for falls.The findings include: 1. Review of the facility undated policy titled, Comprehensive Care Plans, revealed .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions. Review of the facility undated policy titled, Fall Prevention Program, revealed .Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. 2. Review of the American Association of Post-Acute Care Nursing article titled, Post-Fall Assessments, dated 8/202, revealed .An assessment of neurological status, often called a neuro check, should be done when a resident hits his or her head or if it is unknown if they hit their head (unwitnessed fall) . 3. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Pancreas, Bipolar, and Hypertension. Review of a Fall Risk assessment dated [DATE], revealed Resident #20 scored a 50, indicating she was at high risk for falling. The Resident had impaired, weak gait. Review of the Care Plan dated 2/16/2026, revealed the resident was at risk for falls related to weakness and required assistance with mobility. Review of the admission Minimum Data Set assessment dated [DATE], revealed Resident #20 scored a 15 on the Brief Interview for Mental Status assessment, which indicated she had intact cognition. Resident #20 required partial to moderate assistance from staff for transfers and to walk. The resident was coded as no falls prior to admission and no falls during the assessment period. Review of an Incident Report dated 2/26/2026, revealed .Unwitnessed Fall .Resident notified nurse that she had fell while trying to get up off the toilet .Intervention: encourage resident to ask for assistance . injuries Observed at Time of Incident .No injuries observed at time of incident . Review of a Fall Risk assessment dated [DATE], revealed Resident #20 scored a 40, indicating she was at moderate risk for falling. The Resident overestimated or forgot limits. Review of the revised Care Plan for falls dated 2/26/2026, revealed the resident's call light was to be kept in the resident's reach and the staff encourage the resident to ask for assistance when needing help. The facility Incident Report dated 3/1/2026 at 6:15 AM, revealed .Witness fall . 3/1/2026 .Resident's roommate came into hallway .resident had fallen .Resident observed on the rt [right] side of the bed between the wall and the bed, face down .Injuries Observed at Time of Incident .Hematoma . Review of an Alert Note dated 3/1/2026 at 6:20 AM, revealed, .Staff entered room and observed resident [Resident #20] lying on the right side of the bed, face down. Resident's roommate stated that she [Resident #20] was coming out of the bathroom and fell onto the floor .Resident skin observed and resident did have a hematoma to the Rt [right] Side of her forehead that was growing in size .Resident sent to the hospital per family request ensure resident had not broken anything from fall . Review of a [Named Company] Weekly Skin Check, dated 3/1/2026, revealed . Resident had some redness to the Lt [Left] Knee; Hematoma to the Rt [Right] forehead; no open areas noted at this time . Review of a Fall Risk assessment dated [DATE], revealed Resident #20 scored a 95 indicating she was at high risk for falling. The resident had impaired, weak gait and overestimated or forgot limits. The facility failed to conduct neuro checks after Resident #20's fall on 3/1/2026. Review of the revised Care Plan dated 3/1/2026, revealed visual cues as an intervention for falls for Resident #20. Review of the facility incident Report dated 3/3/2026 at 12:30 AM, revealed .Witness Fall .Called to hallway outside of resident's room where resident is sitting on floor. CNA [Certified Nurse Assistant] stated she was in the room across the hall .looked up and noticed resident [Resident #20] was in the hall way .resident [Resident #20] got tangled up on her slides' and fell hitting the right side of her face and right shoulder against the the [NAME] [the door] frame .Resident [Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#20] complaint of pain to rights side of face and right shoulder .Injuries observed at Time of Incident .Injured Type .hematoma .Injury Location .4) Face . Review of a Nurses Note dated 3/3/2026 at 12:35 AM, revealed .Called to hallway outside of resident's room where resident is sitting on floor .resident got tangled up on her slides [a type of light shoe that is characterized by having a loose heel that holds on to the foot from the front.] and fell hitting the right side of her face and right shoulder against the door frame. Resident states that she was trying to get up. Resident complaint of pain to right side of face and right shoulder . Review of the [Named Company] Weekly Skin Check, dated 3/3/2026, revealed .Any bruising or redness yes .face .right side of face around Eye . Review of a Fall Risk assessment dated [DATE], revealed Resident #20 scored a 65, indicating she was at high risk for falling. The Resident had impaired, weak gait and overestimated or forgot limits. Review of the revised Care Plan dated 3/3/2026, revealed the resident is to wear nonskid socks. The facility failed to conduct neuro checks after Resident #20's fall on 3/3/2026. During observation and interview in the Resident's room on 3/10/2026 at 2:51 PM, Resident #20's call light was under Resident #20's bedframe, between the frame and the mattress. LPN C confirmed he was the nurse currently assigned to Resident #20. LPN C was asked to explain why the resident's call light was not in her reach. LPN C stated, I have not made rounds to check for call lights .she has been back in bed about 30 minutes .had no idea .hospice tech left the call light under mattress. LPN C was asked who is responsible for making sure call lights are in place. LPN C stated, The nurses and techs [nurse aide technicians] at the facility. The facility failed to ensure Resident #20's call light was in reach as an intervention for fall. During an interview on 3/11/2026 at 9:55 AM, the Director of Nursing (DON) was asked what interventions were put in place after Resident #20's 3/1/2026 fall. The DON stated, Visual cues. The DON was asked to explain visual cues. The DON stated, .Signage [signs] in the room, it should be posted [displayed] and should say call don't fall . During an observation and in the resident's room on 3/11/2026 at 10:05 AM, the DON observed the walls in the Resident #20's room. The DON stated, She has no signage in room. Let me look to see if she has one lying somewhere. The DON was not able to find any sign in the resident's room. The DON was asked should Resident #20 have should call before fall, call for help to walk signage on her wall. The DON stated, Yes. The facility failed to provide signage in Resident #20's room as an intervention for falls. During an interview on 3/11/2026 at 10:53 AM, the DON was asked for Resident #20's neuro checks after the 3/1/2026 and the 3/3/2026 fall. The DON stated, the facility does not have any neuro checks related to Resident #20's falls on those days. During an interview on 3/11/2026 at 2:56 PM, the Nurse Practitioner (NP) confirmed she was made aware of Resident #20's falls on 3/1/20206, and 3/3/20206. The NP was asked did she expect staff to have conducted neuro checks for Resident #20 after each of those falls. the NP stated, Yes. During an interview on 3/11/2026 at 3:12 PM, the DON was asked should the facility staff have conducted neuro checks for the resident on 3/1/2026, and 3/3/2026. The DON stated Yes. During an interview on 3/11/2026 3:27 PM, the DON was asked for the facility's neuro check policy. The facility was unable to provide a neuro check policy.

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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 policy review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 1 of 5 staff members (Licensed Practical Nurse (LPN) C) left medication unattended, and out of sight during Percutaneous Endoscopic Gastrostomy (PEG) medication administration.The findings include: 1. Review of the facility undated policy titled .Medication Storage, revealed .During a medication pass, medications must be under the direct observation of the person administering medications. 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Neurogenic Bladder, Gastrostomy, Tracheostomy, Seizures, and Cocaine Abuse. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #8 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was severely cognitively impaired. Review of the Physician Order dated 12/31/2025, revealed .Valproic Acid Oral Solution [medication used for seizures] 250 mg [milligrams] /[per] 5ml [milliliters] Give 5 ml via [by] G-[Gastrostomy] Tube [a feeding tube inserted directly into the stomach through the abdominal wall] four times a day for seizures. Observation in the resident's room during medication administration on 3/11/2026 at 12:10 PM, revealed LPN C entered Resident #8's room with Valproic Acid Oral Solution 5 ml in a medication cup. LPN C sat the medication on the over bed table and went to the bathroom to wash his hands. LPN C left the medication out of sight and unattended. LPN C returned to the resident's room then went back into the bathroom to obtain water in a plastic cup and left the medication unattended again. During an interview on 3/11/2026 at 12:34 PM, LPN C was asked should he have left the medication out of sight. LPN C stated, No ma'am. During an interview on 3/11/2026 at 2:08 PM, the Director of Nursing (DON) was asked should the nurse have left the medications out of sight and unattended. The DON stated, No, they should not be left unattended.