STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445304	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndridge Health and Rehab Ctr	456 Wayne Avenue Crossville, TN 38555

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on facility policy review, facility report review, and interview, the facility failed to notify the Long-Term Care (LTC) Ombudsman of resident discharges from the facility timely for 152 residents discharged from 9/3/2025-3/25/2026.The findings include: Review of the facility's policy titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 5/2025, revealed .The facility's transfer/discharge notice will be provided to the LTC [Long Term Care] Ombudsman .The facility will maintain evidence that the notice was sent to the Ombudsman . Review of a resident discharge report from 9/3/2025-3/25/2026 revealed 152 residents had been discharged from the facility. During an interview on 3/25/2026 at 8:10 AM, the Social Worker stated she had been unable to send resident discharge notifications to the LTC Ombudsman because the new Ombudsman had not provided contact information. During a telephone interview on 3/25/2026 at 8:20 AM, the LTC Ombudsman stated she had not received notifications of resident discharges from the facility since starting the role in 11/2025. The LTC Ombudsman stated she had provided contact information to the facility and had informed the facility of the need to be notified of resident discharges. During an interview on 3/25/2026 at 11:00 AM, the Social Worker confirmed she had not notified the LTC Ombudsman of resident discharges since 9/3/2025.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, observations, and interview, the facility failed to properly store refrigerated food items, which had the potential to affect 77 out of 85 residents.The findings include:Review of the facility's undated policy titled, Food Storage Guidelines, revealed .'Open Dating' .on a food product .can .help .to know the time limit to .use the product at its best quality .'Use by' date is the last date recommended for the use of the product .The date has been determined by the manufacturer .If a product has a 'use by' date, follow that date .During an observation of the walk-in refrigerator on 3/23/2026 at 9:57AM, with the Certified Dietary Manager (CDM), revealed a turkey breast (approximately 5 pounds) with a manufacturer use by date of 3/20/2026. Further observation revealed an opened 32 fluid ounce bottle of lemon juice (approximately 3/4 full) with no manufacturer use by date or open date. During an interview on 3/23/2026 at 10:04 AM, the CDM confirmed the turkey breast was expired according to the manufacturer use by date and was available for resident use. The CDM further confirmed the 32 fluid ounce bottle of lemon juice was opened, had no manufacturer use by date, or an opened date on the bottle and was available for resident use.

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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 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, observation, and interview, the facility failed to maintain a clean, comfortable, homelike environment for 2 of 4 units observed for a clean, comfortable, homelike environment. Review of the facility's undated policy titled, Housekeeping Services, revealed thorough scrubbing will be used for all environmental surfaces that are being clean in patient care areas .due to the nature of the ventilator unit .cleaning is to be done daily on each shift from housekeeping, nursing staff, and respiratory therapy .Review of the facility's undated policy titled, Housekeeper Job Description, revealed .clean, wash, sanitize, and/or polish bathroom fixtures. Ensure that water marks are removed from fixtures .clean floors, to include sweeping, dusting, damp/wet mopping .remove dirt, dust .film from surfacesReview of the facility's undated policy titled, Housekeeping Department: Routine Cleaning of Equipment, revealed .environmental equipment is cleaned on a daily schedule and as needed such as: sinks, commodes, floors .Review of Pest Control Invoice #23745 dated 3/5/2026, revealed .sprayed kitchen + dining .room [ROOM NUMBER] .room [ROOM NUMBER] .During observations on 3/23/2026 at 12:34 PM and 3/25/2026 at 3:58 PM in room [ROOM NUMBER], revealed a significant amount of broken drywall material and drywall dust in the floor behind Bed A, adjacent to the resident's respiratory equipment. Continued observation revealed the drywall behind the bed near the baseboard was damaged with numerous visible penetrations. During observations on 3/24/2026 at 10:30 AM, 3/25/2026 at 10:41 AM, and 3/25/2026 at 3:22 PM in room [ROOM NUMBER], revealed pink, brown, and gray streaks in the bathtub, brown, black and pink stains around the bathtub drain. Further observation revealed a paper towel was present in the drain, caulking around the tub had brown, green, and gray discoloration, black debris was present at the edge of the faucet, and the faucet appeared to be leaking. Continued observation revealed, the vinyl baseboard was detached from the wall below the sink. During an observation on 3/24/2026 at 10:33 AM in room [ROOM NUMBER], revealed an orange and brown substance splattered on tiles surrounding the bathtub faucet and in the bathtub. Further observation revealed pink and brown streaks in the bathtub and brown, green, and gray stains near the drain. Continued observation revealed four rolls of toilet paper, two wrapped in paper, and two unwrapped, situated on the outer rim of the bathtub which was stained with a light brown substance. During an observation of the 100 Hall Shower Room on 3/24/2026 at 2:51 pm, revealed numerous cracked, chipped, and broken tiles in the front left shower stall with pink and brown staining and a black spotted substance present on and around tiles near the floor. Further observation revealed the shower head in the front left shower stall appeared to be leaking. A blue, plastic razor was noted on the floor between the shower stalls.During an observation on 3/25/2026 at 10:32 AM in room [ROOM NUMBER], revealed brown staining in a ring-shaped pattern on the interior of the toilet bowl. Further observation revealed the toilet seat was damaged with broken, stained plastic on the left side of the hinge, chipped plastic at the left edge, and yellow staining to the underside of the toilet seat. Continued observation revealed a foul and pervasive odor in the bathroom and the presence of several flying insects around the toilet. During an interview on 3/25/2026 at 10:41 AM, Housekeeper I stated, .the residents' rooms are cleaned every day .During an observation and interview on 3/25/2026 at 3:17 PM, in the 100 Hall Shower Room with Certified Nursing Assistant (CNA) G, revealed numerous cracked, chipped, and broken tiles in the front left shower stall with pink and brown staining and a black spotted substance present on and around tiles near the floor. Further observation revealed the shower head in the front left shower stall appeared to be leaking. A blue, plastic razor was noted on the floor between the shower stalls and a black to brown insect was noted on the floor near the drain of the rear left shower stall. CNA G stated, .there really shouldn't be bugs in the shower room .the razor is not supposed to be in the floor .During an observation on 3/25/2026 at 3:20 PM in room [ROOM NUMBER], revealed an orange and brown (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substance splattered on tiles surrounding the bathtub faucet and in the bathtub. Further observation revealed pink and brown streaks in the bathtub and brown, green, and gray stains near the drain. Continued observation revealed two rolls of toilet paper, one wrapped in paper, and one unwrapped, situated on the outer rim of the bathtub which was stained with a light brown substance. During an observation on 3/25/2026 at 3:29 PM in room [ROOM NUMBER], revealed brown staining in a ring-shaped pattern on the interior of the toilet bowl. Further observation revealed the toilet seat was damaged with broken, stained plastic on the left side of the hinge, chipped plastic at the left edge, and yellow staining to the underside of the toilet seat. Continued observation revealed a foul and pervasive odor in the bathroom and the presence of several flying insects around the toilet. During an interview on 3/25/2026 at 3:31 PM, Licensed Practical Nurse (LPN) G stated, .the facility has had intermittent issues with insects in the secure unit the past few months .During an interview on 3/25/2026 at 3:35 PM, the Administrator viewed photos of the above observations, and confirmed the facility failed to provide a clean, comfortable, and home-like environment on the 100 Hallway. During an interview on 3/25/2026 at 4:00 PM, the Assistant Director of Nursing (ADON) confirmed the drywall damage and debris in room [ROOM NUMBER] needed to be reported to the maintenance director and corrected immediately. During an interview on 3/25/2026 at 4:05 pm, the Maintenance Director confirmed the facility failed to maintain a clean, comfortable, and homelike environment on the 400 hallway.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record reviews, observations, and interviews, the facility failed to ensure Physician's Orders were obtained for ventilator (a machine or device used to support or replace the breathing of a person who has difficulty breathing on their own) use for 1 resident (Resident #1) of 3 residents reviewed for ventilators, and for tracheostomy (a surgically created opening in the front of the neck leading into the windpipe/trachea) use for 2 residents (Residents #8 and #9)) of 3 residents reviewed for tracheostomies, the facility failed to ensure oxygen was administered according to Physician's Orders for 1 resident (Resident #65) of 23 residents reviewed for oxygen therapy, and failed to safely secure portable oxygen tanks in residents' rooms for 2 residents (Residents #88 and #69) of 23 residents reviewed for oxygen therapy. The findings include: Review of the facility's undated policy titled, Oxygen Use, General revealed Oxygen therapy is administered .upon written order of a licensed physician .must be inspected before oxygen is turned on to assure .proper working order .Oxygen Safety .Oxygen cylinders must be stored in racks .sturdy portable carts and/or approved stands .Oxygen cylinders may not be left free standing. They must be securely fastened at all times . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Epilepsy (seizure disorder), Acute on Chronic Respiratory Failure, Tracheostomy, and Dependence on Ventilator. Review of the comprehensive care plan for Resident #1 revealed a problem dated 11/25/2025, .ventilator dependent . and .has a tracheostomy . with appropriate goals and interventions. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. During observations on 3/23/2026 at 11:15 AM and 3/24/2026 at 2:00 PM, Resident #1 was observed lying in bed with a tracheostomy connected to a mechanical ventilator. Review of a Respiratory Care assessment for Resident #1 dated 3/25/2026, revealed the resident used a mechanical ventilator and the settings were documented, the resident was suctioned 4 times on 3/25/2026, and the resident had a tracheostomy with the size and type documented. Review of the Physician's Orders for Resident #1 dated 3/25/2026, revealed no orders were present for ventilator use or ventilator settings to guide care such as mode (type), rate (number of breaths delivered per minute), tidal volume (amount of air delivered in each breath), FiOˆ (Fraction of Inspired Oxygen-the percentage of oxygen delivered), or PEEP (Positive End-Expiratory Pressure-pressure kept in the lungs at the end of breathing out). Further review revealed no Physician's Orders were present for resident suctioning, or for tracheostomy use and tracheostomy care, type, and size, and there were no Physician's Orders authorizing respiratory therapy to manage ventilator settings. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Traumatic Brain Injury, Quadriplegia, Acute Respiratory Failure, and Tracheostomy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan for Resident #8 revealed a problem dated 5/13/2025, .has a tracheostomy . with appropriate goals and interventions. Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. During observations on 3/23/2026 at 11:25 AM and 3/24/2026 at 2:15 PM, Resident #8 was observed lying in bed with a tracheostomy in place. Review of a Respiratory Care assessment for Resident #8 dated 3/25/2026, revealed the resident was suctioned 6 times on 3/25/2026, and the resident had a tracheostomy with the size and type documented. Review of the Physician's Orders for Resident #8 dated 3/25/2026, revealed no orders were present for resident suctioning, or for tracheostomy use and tracheostomy care, type, and size. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure, Dependence on Ventilator, and Tracheostomy. Review of the comprehensive care plan for Resident #9 revealed a problem dated 11/21/2025, .dependent on vent [ventilator] has tracheostomy . with appropriate goals and interventions. Review of a quarterly MDS assessment dated [DATE], revealed Resident #9 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. During observations on 3/23/2026 at 11:33 AM and 3/24/2026 at 2:35 PM, Resident #9 was observed lying in bed with a tracheostomy in place connected to a mechanical ventilator. Review of a Respiratory Care assessment for Resident #9 dated 3/25/2026, revealed the resident had a tracheostomy with the size and type documented. Review of the Physician's Orders for Resident #9 dated 3/25/2026, revealed the resident's orders did not include the tracheostomy type or size. During an interview on 3/25/2026 at 2:50 PM, Registered Nurse Assistant Director of Nursing (RN/ADON) confirmed no Physician Orders were present for Resident #1's ventilator use, ventilator settings, suctioning, tracheostomy use, or tracheostomy type or size. The ADON also confirmed there were no Physician Orders for Resident #8's tracheostomy use, type, or size, and the Physician Orders for Resident #9's tracheostomy did not include the type or size. During an interview on 3/25/2026 at 3:00 PM, the Director of Nursing (DON) confirmed Physician Orders were required to direct resident care, including respiratory support with tracheostomy and ventilator use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy reviews, medical record reviews, observations, and interviews, the facility failed to ensure practices to prevent the potential spread of infection were maintained by not following Enhanced Barrier Precautions (EBP) and not adhering to appropriate hand hygiene during respiratory care for 2 residents (Residents #1 and #8) of 4 residents with a ventilator and/or tracheostomy, and during medication administration for 1 resident (Resident #22) of 4 residents observed during medication pass, failed to offer hand hygiene assistance prior to meals for 3 residents (Residents #47, #31, and #66) of 23 residents observed during dining, and failed to secure a urinary catheter bag off the floor for 1 resident (Resident #15) of 10 residents observed for urinary catheters.The findings include: Review of the facility's undated policy titled, Enhanced Barrier Precautions (EBP), revealed .EBP are implemented to reduce the transmission of Multi-Drug Resistant Organisms (MDRO's) in residents who require high-contact care activities .this policy applies to all staff providing direct care, including .Nursing .Therapy staff .EBP .a set of targeted infection-control practices requiring gloves and gowns during high-contact resident care activities .including .device care (catheters, feeding tubes, trachs [tracheostomies-a surgically created opening in the front of the neck leading into the windpipe/trachea], drains) .During high-contact care activities, staff must wear .gowns .gloves .procedure: .perform hand hygiene .review signage for EBP requirements .don gown and gloves prior to beginning high-contact care .avoid touching environmental surfaces unnecessarily .remove gloves and gown before leaving the resident's room or care space .perform hand hygiene immediately . Review of the facility's undated policy titled, Handwashing, revealed .may use waterless handwashing such as alcohol gels .when hands are not visibly soiled .hands should be washed after 3 times of using waterless cleaner . Review of the facility's policy titled, Handwashing Policy (Residents), dated 2/2025, revealed .Staff must offer hand hygiene before meals . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Epilepsy (seizure disorder), Acute on Chronic Respiratory Failure, Tracheostomy, and Dependence on Ventilator (a machine or device used to support or replace the breathing of a person who has difficulty breathing on their own). Review of the comprehensive care plan for Resident #1 revealed a problem dated 11/25/2025, .ventilator dependent . and .has a tracheostomy . with appropriate goals and interventions. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Traumatic Brain Injury, Quadriplegia, Acute Respiratory Failure, and Tracheostomy. Review of the comprehensive care plan for Resident #8 revealed a problem dated 5/13/2025, .has a tracheostomy . with appropriate goals and interventions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. During an observation on 3/25/2026 at 8:38 AM, Respiratory Therapist (RT) E entered Resident #1's room to provide tracheostomy care. There was a sign on Resident #1's door for EBP, including gown and gloves for high-contact activity. RT E reached into her uniform pocket for a small bottle of hand sanitizer and sanitized hands, donned gloves, but did not don a gown or mask. RT E gathered and opened a gauze package, moistened the gauze with Hydrogen Peroxide, and lay the moistened gauze on top of the package wrapping on the resident's abdomen. RT E opened the split gauze package and lay the split gauze on top of the package wrapping on the resident's abdomen. RT E removed used split gauze from under Resident #1's trach collar and lay it on the package on the resident's abdomen. RT E performed cleaning of the site under the collar, then placed the new split gauze under the trach collar. RT E then removed the tracheostomy inner canula (portion of the tracheostomy tube that fits into the outer canula tube, which is in the windpipe/trachea), and laid the inner cannula on one of the gauze packages on the resident's abdomen, where it promptly rolled off the resident's abdomen onto the linens. RT E gathered the used supplies and discarded them. RT E grabbed a box (still with the same gloves) and left the room, walked down the hall to the RT office, and laid the box down on the desk. RT E then went to the RT supply cart, discarded her gloves, and reached into her uniform pocket for a small bottle of hand sanitizer, sanitized hands, and replaced it in her pocket. Further observation revealed RT E entered Resident #8's room to perform tracheal suctioning. There was a sign on Resident #8's door for EBP, including gown and gloves for high-contact activity. RT E donned gloves but did not don a gown or mask. RT E used the in-line suction catheter to suction Resident #8 via tracheostomy several times, and Resident #8 did have reflex coughing (can be normal during suctioning). After suctioning was complete, RT E discarded gloves, pulled the hand sanitizer from her pocket, sanitized hands, and replaced it in her pocket. During an interview on 3/25/2026 at 9:05 AM, RT E confirmed supplies were not set up appropriately for tracheostomy care by laying them on the resident's abdomen, confirmed she did not discard used gloves and perform hand hygiene before leaving Resident #1's room, and did not follow EBP for high-contact resident care. RT E stated .I don't know why they .[Residents #1 and #8] .had signs on their doors for EBP .we only have to do that [EBP precautions] if the resident has an active infection . RT E confirmed she did not follow the EBP for Residents #1 and #8. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure, Quadriplegia, Tracheostomy Status, and Gastrostomy Status (tube placed through the abdomen into the stomach for nutrition and hydration). Review of the comprehensive care plan for Resident #22 revealed a problem dated 10/10/2025, .has a feeding tube for all nutrition, fluids, medications . with appropriate goals and interventions. Review of a quarterly MDS assessment dated [DATE], revealed Resident #22 had long-term and short-term memory deficits, and severely impaired cognitive skills for daily decision making. During an observation on 3/25/2026 at 8:30 AM, Registered Nurse (RN) C entered Resident #22's room to administer medications via gastrostomy (feeding) tube. RN C donned gloves but did not don a gown. RN C used the piston syringe (large syringe used to draw up and administer medications via feeding tube) to flush the tube with water, administered medications, and flushed with water again as ordered. RN C, with used gloves still on, took the piston syringe to the sink in the room, rinsed it, and set it on paper towels to dry. With the same gloves on, RN C proceeded to perform the OcuSoft eye lid (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scrub to both eyes. When completed, RN C discarded gloves and performed hand hygiene with hand sanitizer. During an interview on 3/25/2026 at 8:45 AM, RN C confirmed Resident #22 had a sign for EBP on the door. RN C confirmed she did not don a gown while performing feeding tube medication administration, and RN C confirmed she did not perform hand hygiene or change gloves between administering medications through the feeding tube and performing the eye lid scrub. During an interview on 3/25/2026 at 3:11 PM, the Infection Preventionist (IP) confirmed EBP was to be used with high-contact resident care, including tracheal care, suctioning, and feeding tube care, confirmed used gloves should be discarded before leaving a resident's room and hand hygiene should be performed every time gloves are discarded. The IP confirmed hand hygiene and changing of gloves was expected between administering medications by a different route. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including Acute and Chronic Respiratory Failure, Epilepsy, Atrial Fibrillation, and Chronic Pulmonary Edema. Review of the comprehensive care plan for Resident #47 dated 9/17/2025, revealed the resident was dependent for hygiene, dressing, mobility, and feeding assistance/supervision with meals. Review of a quarterly MDS assessment dated [DATE], revealed Resident #47 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. During an observation on 3/23/2026 at 11:55 AM, Certified Nursing Assistant (CNA) J delivered the lunch meal tray to Resident #47. CNA J assisted Resident #47 to set up the meal tray and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure, and Morbid Obesity. Review of a quarterly MDS assessment dated [DATE], revealed Resident #31 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of the comprehensive care plan for Resident #31 dated 3/17/2026, revealed .partial to moderate assistance with hygiene . During an observation on 3/23/2026 at 11:53 AM, CNA A delivered the lunch meal tray to Resident #31. CNA A set up the meal tray and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #66 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, and Generalized Muscle Weakness. Review of a quarterly MDS assessment dated [DATE], revealed Resident #66 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of the comprehensive care plan for Resident #66 dated 2/26/2026, revealed the resident required substantial to maximal assistance with ADLs and assistance when needed with meals. During an observation on 3/23/2026 at 11:48 AM, CNA J delivered the lunch meal tray to Resident #66. CNA J set up the resident's lunch tray and exited the room without offering hand hygiene assistance to the resident. During an interview on 3/23/2026 at 11:55 AM, CNA J confirmed residents were to be offered hand hygiene assistance prior to meals. CNA A confirmed she had not offered hand hygiene assistance to residents today and stated .I did not .if the resident mentions it, I will offer . During an interview on 3/25/2026 at 3:05 PM, the Infection Preventionist confirmed staff were to offer hand hygiene assistance to all residents prior to meals. Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses including Chronic Osteomyelitis, Depression, Anxiety, and Paraplegia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #15 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of the care plan for Resident #15 dated 1/16/2026 revealed the resident requires assistance with ADLs. Further review revealed . Provide care for urinary care per orders and per protocol including changing of urinary catheter, providing urinary care q shift and PRN, emptying (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445304	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyndridge Health and Rehab Ctr	456 Wayne Avenue Crossville, TN 38555

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 - Few	drainage bag q [every] shift and PRN [as needed], monitoring for complications with urine as noted above . During an interview and observation on 3/23/2026 at 12:17 PM, revealed Resident #15 lying in bed with urinary catheter bag lying beside bed on the floor. LPN B confirmed the catheter bag should be hung from the resident's bed. During an interview on 3/25/2026 at 03:05 PM the Infection Preventionist confirmed urinary catheter bags were to be suspended off the ground to prevent infection.