

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445404                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                           | (X3) DATE SURVEY<br>COMPLETED<br><br>07/15/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Ocoee Transitional Care Center LLC                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2320 East Lamar Alexander Pkwy<br>Maryville, TN 37804 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    |                                                 |
| F 0657<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, medical record review, and interviews, the facility failed to revise a care plan for 2 residents (Resident #7 for fall interventions and Resident #5 for diet interventions) of 16 care plans reviewed.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, revealed .person centered care plan .includes .objectives .to meet the resident's physical .functional needs .implemented for each resident .Assessments of residents are ongoing .care plans are revised as .information about the residents .conditions change .</p> <p>Review of the undated facility policy titled, Falls Incident Management Clinical Protocol, revealed .with falls .put an immediate intervention in place .place the intervention on the Falls Care Plan .date the intervention .</p> <p>Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Depression, Hypertension, and Adult Failure to Thrive.</p> <p>Review of a Facility Fall Incident report for Resident #7 dated 5/28/2026, revealed .Patient [Resident #7] was attempting to look for husband .pt [patient] lying on floor in room near recliner .New Intervention .Dycem [non-slip material to prevent sliding] to recliner .</p> <p>Review of a comprehensive care plan revised 5/29/2026, revealed Resident #7 .at risk for further falls related to .cognitive impairment .poor coordination . Continued review revealed no new intervention had been added after the fall on 5/28/2026 and did not include the Dycem to the recliner.</p> <p>Review of a significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 scored a 4 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment and had no falls since prior MDS assessment.</p> <p>During an interview on 7/15/2026 at 10:34 AM, the Quality Assurance Nurse confirmed the care plan for Resident #7 had not been revised to include the new intervention after the fall on 5/28/2026.<br/>(continued on next page)</p> |                                                                                                    |                                                 |

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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                    |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445404                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                           | (X3) DATE SURVEY<br>COMPLETED<br><br>07/15/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Ocoee Transitional Care Center LLC                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2320 East Lamar Alexander Pkwy<br>Maryville, TN 37804 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    |                                                 |
| F 0657<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>During an interview on 7/15/2026 at 10:36 AM, the Director of Nursing (DON) confirmed the care plan for Resident #7 had not been revised to include the new intervention after the fall on 5/28/2026.</p> <p>Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Left Humerus Fracture, Adult Failure to Thrive, Weakness, and Dysphagia.</p> <p>Review of an admission/5-day MDS dated [DATE], revealed Resident #5 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review revealed the resident had difficulty with swallowing and had a mechanically altered diet.</p> <p>Review of a comprehensive care plan dated 5/6/2026, revealed Resident #5 .AT RISK FOR ALTERED NUTRITION .therapeutic diet, altered texture, thicken liquids .Provide prescribed diet as ordered .</p> <p>Review of the Physician's Orders for Resident #5 dated 5/26/2026, revealed .Patient is OK for thin water ONLY between meals and after oral care has been provided by caregivers/staff in order to decrease risk of dehydration and provide oral moisture/comfort .</p> <p>During an observation on 7/13/2026 at 10:10 AM, Resident #5 was sitting up in chair in her room, water pitcher with thin water noted on the bed side table and within resident's reach.</p> <p>Review of the comprehensive care plan for Resident #5, revealed the care plan had not been revised to include thin water between meals and after oral care for Resident #5 after the physician's order was received for thin liquids dated 5/26/2026.</p> |                                                                                                    |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445404                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                           | (X3) DATE SURVEY<br>COMPLETED<br><br>07/15/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Ocoee Transitional Care Center LLC                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2320 East Lamar Alexander Pkwy<br>Maryville, TN 37804 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                    |                                                 |
| F 0658<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure accurate accountability of controlled substances for 2 residents (Resident #28 and #72) on 1 of 3 medication carts observed. The findings include: Review of the facility policy titled, Controlled Substances, dated January 2019, revealed .Accurate accountability of the inventory of all controlled drugs is maintained at all times .the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record [MAR] .Date and time of administration .Amount administered .Remaining quantity .Initials of the nurse administering the dose, completed after the medication is actually administered . Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction, Dementia Without Behavioral Disturbance, and Chronic Pain. Review of the Physician's Orders for Resident #28 dated 6/8/2026, revealed .Oxycodone [medication to treat pain] 10 mg [milligrams] .one tablet by mouth every 12 hours .chronic pain . Review of the MAR for Resident #28 dated 7/1/2026-7/31/2026, revealed the resident received Oxycodone 10 mg as ordered on 7/15/2026 on the morning medication pass. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Type II Diabetes Mellitus, Anxiety, and Polyneuropathy. Review of the Physician's Orders for Resident #72 dated, 6/25/2026, revealed .Gabapentin [medication used for nerve pain] 200 mg .two times a day .neuropathy . Review of the MAR for Resident #72 dated 7/1/2026-7/31/2026, revealed the resident received Gabapentin 200 mg as ordered on 7/15/2026 on the morning medication pass. During a medication storage observation and controlled substance count with Licensed Practice Nurse (LPN) A on 7/14/2026 at 8:05 AM, revealed the Oxycodone 10 mg for Resident #28 had not been documented as administered on the controlled substance record resulting in a discrepancy of 1 tablet. Further observation revealed the Gabapentin 200 mg for Resident #72 had not been documented as administered on the controlled substance record resulting in a discrepancy of 1 tablet. During an observation and interview on 7/14/2026 at 8:08 AM, LPN A confirmed she had administered Oxycodone 10 mg to Resident #28 and Gabapentin 200 mg to Resident #72 but failed to document the medication administration on the controlled substance record which led to the discrepancy in the controlled substance record. During an interview on 7/15/2026 at 2:40 PM, the Director of Nursing confirmed it was her expectation that all licensed nurses document on the controlled substance record when the medication is administered to the resident.</p> |                                                                                                    |                                                 |