STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445424	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center on Aging and Health	880 South Mohawk Drive Erwin, TN 37650

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, the facility failed to obtain consent for administration of psychotropic medications for 5 of 5 residents (Resident #21, #33, #8, #42 and #3) reviewed for unnecessary medications.The findings include: 1.Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Delusional Disorder, and Psychotic Disorder. Review of a Physician's Order for Resident #21 dated 6/14/2024, revealed .Memantine [a medication used to treat dementia] .Oral Tablet 1000 mg . Give 1 tablet by mouth two times a day . Review of a Physician's Order for Resident #21 dated 7/24/2024, revealed .Sertraline [a medication used to treat depression] .Oral Tablet 100 mg . Give 1 tablet by mouth one time a day . Review of a Physician's Order for Resident #21 dated 6/11/2025, revealed . Brexpiprazole [antipsychotic medication used to treat agitation] 0.5 milligram [mg] once daily by mouth . Review of a Physician's Order for Resident #21 dated 10/22/2025, revealed .Divalproex Sodium [medication used to treat mood disorders] Capsule .100 mg .Give 3 capsules by mouth in the morning . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #21 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the Medication Administration Record (MAR) dated 2/1/2026- 4/15/2026, revealed Resident #21 received Brexpiprazole, Divalproex Sodium, Memantine, and Sertraline as ordered. Review of the medical record revealed no documentation of an informed consent form for the use of Brexpiprazole, Divalproex Sodium, Memantine, or Sertraline for Resident #21. Review of the medical record revealed no documentation that Resident #21 or Resident #21's representative had been informed in advance of the risks and benefits, options, and alternatives to treatment of the Brexpiprazole, Divalproex Sodium, Memantine, or Sertraline. 2. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including Dementia, Cognitive Communication Deficit, and Generalized Anxiety Disorder. Review of a Physician's Order for Resident #33 dated 3/30/2023, revealed .trazodone [antidepressant medication used to treat insomnia] .oral tablet 100 mg .give 1 tablet by mouth at bedtime . Review of a Physician's Order for Resident #33 dated 10/19/2023, revealed .Sertraline [antidepressant] .50 mg .give 1 tablet by mouth one time a day . Review of a Physician's Order for Resident #33 dated 6/11/2025, revealed .Memantine [medication used to treat dementia] .Oral Capsule 14 mg .give 1 capsule by mouth one time a day . Review of a Physician's Order for Resident #33 dated 2/18/2026, revealed .Alprazolam Oral Tablet [medication used to treat anxiety] 0.25 mg .give one tablet by mouth at bedtime . Review of a quarterly MDS assessment dated [DATE], revealed Resident #33 scored a 12 on the BIMS assessment, which indicated the resident had moderate cognitive impairment. Review of the MAR for Resident #33 dated 2/1/2026 - 4/15/2026, revealed Resident #33 received Alprazolam, Memantine, Sertraline, and Trazodone as ordered. Review of the medical record for Resident #33 revealed no documentation of an informed consent form for the use of Alprazolam, Memantine, Sertraline, or Trazodone. Review of the medical record revealed no documentation that Resident #33 or Resident #33's representative was informed in advance of the risks and benefits, options, and alternatives to treatment of the Alprazolam, Memantine, Sertraline, or (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Trazodone. 3. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Dementia with Psychotic Disturbance, Psychotic Disorder with Delusions, Generalized Anxiety Disorder and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 3 on the BIMS assessment, which indicated the resident had severe cognitive impairment. Review of a Physician's Order for Resident #8 dated 8/17/2024, revealed .Alprazolam Oral Tablet 0.5 mg .Give 1 tablet by mouth in the morning . Review of a Physician's Order for Resident #8 dated 8/21/2024, revealed .Donepezil .Oral Tablet 10 mg .Give 10 mg by mouth at bedtime . and an order for .Memantine .Oral Tablet 10 mg .Give 10 mg by mouth two times a day . Review of a Physician's Order for Resident #8 dated 10/29/2025, revealed .Risperidone [medication used to treat psychosis] Tablet 1 mg .Give 1 tablet by mouth in the afternoon . Review of a Physician's Order for Resident #8 dated 1/3/2026, revealed .Trazodone .tablet 50 mg .Give 1 tablet by mouth in the afternoon . Review of a Physician's Order for Resident #8 dated 2/10/2026, revealed .Sertraline .tablet 100 mg .Give 1 tablet by mouth one time a day . Review of the MAR dated 2/1/2026 - 4/15/2026, revealed Resident #8 received Alprazolam, Donepezil, Memantine, Risperidone, Sertraline, and Trazodone as ordered. Review of the medical record for Resident #8 revealed no informed consent form for the use of Alprazolam, Donepezil, Memantine, Risperidone, Sertraline, or Trazodone prior to administration of the medications. Review of the medical record revealed no documentation that Resident #8 or Resident #8's representative was informed in advance of the risks and benefits, options, and alternatives to treatment of the Alprazolam, Donepezil, Memantine, Risperidone, Sertraline, or Trazodone. 4. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses to include Dementia, Diabetes, Depression, and Psychotic Disorders. Review of the comprehensive MDS assessment dated [DATE] revealed Resident #42 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the physician recapitulation orders dated 3/30/2026, revealed Escitalopram Oxalate (antidepressant medication) Tablet 10 MG give 1 tablet by mouth one time a day, Quetiapine Fumarate Tablet 50 MG give 1 tablet by mouth at bedtime, Xanax Oral Tablet 0.25 MG (Alprazolam) give 1 tablet by mouth every 12 hours as needed for anxiety/agitation. Review of the MAR for Resident #42 dated 4/1/2026 through 4/14/2026 revealed the resident had received the Escitalopram Oxalate, Quetiapine Fumarate daily as ordered, and received the Xanax on 4/2/2026, 4/10/2026, and 4/11/2026. Review of the medical record for Resident #42 revealed no informed consent form for the use of Escitalopram Oxalate, Quetiapine Fumarate, and Xanax prior to administration of the medications. Review of the medical record revealed no documentation that Resident #42 or Resident #42's representative was informed in advance of the risks and benefits, options, and alternatives to treatment of the Xanax, Escitalopram Oxalate, or Quetiapine Fumarate. 5. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Dementia with Agitation, Post-Traumatic Stress Disorder, and Generalized Anxiety Disorder. Review of the comprehensive MDS assessment dated [DATE], revealed Resident #3 scored a 2 on the BIMS assessment, which indicated the resident had severe cognitive impairment. Review of a Physician's Order for Resident #3 dated 3/17/2026, revealed .Depakote Sprinkles [brand name for divalproex sodium] Oral Capsule .125 mg .Give 125 mg by mouth every 8 hours . Review of a Physician's Order for Resident #3 dated 3/22/2026, revealed .diazepam [medication used to treat anxiety] Oral tablet 10 mg .Give 1 tablet by mouth two times a day . Review of a Physician's Order for Resident #3 dated 3/31/2026, revealed .Mirtazapine [medication used to treat depression] Tablet 15 mg .Give 1 tablet by mouth at bedtime . Review of the MAR dated of 3/17/2026 - 4/15/2026, revealed Resident #3 received Depakote Sprinkles, Diazepam, or Mirtazapine as ordered. Review of the medical record for Resident #3 revealed no informed consent form for the use of Depakote Sprinkles, Diazepam, or Mirtazapine prior to administration of the medications. Review of the medical record revealed no documentation that Resident #3 or Resident #3's representative was informed in advance of the risks and benefits, options, and alternatives to treatment of the Depakote Sprinkles, Diazepam, or (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Mirtazapine. During an interview on 4/15/2026 at 2:05 PM, the Administrator confirmed the facility did not have a psychotropic medication policy. During an interview on 4/15/2026 at 2:47 PM, the Administrator confirmed the facility did not have psychotropic medication consent forms for any residents.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review and observations the facility failed to ensure Protected Health Information (PHI) was safeguarded from access and public view for 19 of 19 residents visible on the screen (Residents #15, #2, #69, #9, #13, #68, #30, #29, #14, #49, #24, #7, #41, #60, #23, #1, #11, #31, and #32) on 2 of 3 medication carts observed. The findings include: Review of the facility policy titled, Corporate Compliance and Ethics Manual, dated 7/2024 revealed .Safeguarding Protected Health Information (PHI) .the company shall have in place .appropriate physical and technical safeguards to protect PHI .Staff members shall log off their workstation when leaving the work area .computer monitors shall be positioned so that unauthorized persons cannot easily view information on the screen .Review of the following medical records revealed: Resident #15 was admitted to the facility on [DATE], with diagnoses including Unspecified Fracture of T11-T12 (Thoracic Vertebrae), Muscle Weakness, and Reduced Mobility. Resident #2 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Hypertensive Heart Disease, and Cognitive Communication Deficit. Resident #69 was admitted to the facility on [DATE] with diagnoses including Muscle Wasting and Atrophy, Adult Failure to Thrive, and Chronic Obstructive Pulmonary Disease (COPD). Resident #9 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, Unspecified Convulsions, and Cognitive Communication Deficit. Resident #13 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis (Weakness/Paralysis on 1 side of the body) following Cerebral Infarction (Stroke), Muscle Weakness, and Anorexia. Resident #68 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Human Metapneumovirus, and Generalized Anxiety Disorder. Resident #30 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, COPD, and Atrial Fibrillation. Resident #29 was admitted to the facility on [DATE] with diagnoses including Myocardial Infarction (Heart Attack), Muscle Weakness, and Cardiomyopathy (enlarged heart muscle). Resident #14 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Muscle Weakness, and Reduced Mobility.Resident #49 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, Age-Related Cognitive Decline. Resident #24 was admitted to the facility on [DATE] with diagnoses including Senile Degeneration of the Brain, Constipation, and Depression. Resident #7 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Gout, and Hypokalemia. Resident #41 was admitted to the facility on [DATE] with diagnoses including Sepsis, Polyneuropathy, and Vitamin D Deficiency.Resident #60 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Heart Disease, and Morbid (severe) Obesity.Resident #23 was admitted to the facility on [DATE] with diagnoses including Legal Blindness, Acute Kidney Failure, and Anxiety Disorder. Resident #1 was admitted to the facility on [DATE] with diagnoses including Sepsis, Muscle Weakness, and Dementia. During an observation on 4/13/2026 at 11:41 AM, revealed the 200 South Hall medication cart computer open with 16 resident's identifiers (Picture, name, medical number, wing, and room number) visible on the screen (Residents #1, #2, #7, #9, #13, #14, #15, #23, #24, #29, #30, #41, #49, #60, #68, and #69) in view of the public. Licensed Practical Nurse (LPN) C confirmed she walked away from the medication cart and did not safeguard the PHI. Review of the following medical records revealed:Resident #11 was admitted to the facility on [DATE] with diagnoses including Low Back Pain, End Stage Renal Disease, and Anemia. Resident #31 was admitted to the facility on [DATE] with diagnoses including Encounter for other Orthopedic Aftercare, Muscle Weakness, and Epilepsy. Resident #32 was admitted to the facility on [DATE] with diagnoses including Reduced Mobility, Dysphagia, and Hepatic Encephalopathy. During an observation on 4/14/2026 at 1:44 PM, on the East Hall medication cart computer, revealed resident information (name, medical record number, and room number) visible on the screen and in view of the public. Registered Nurse (RN) D stated she had just walked away and would have normally locked her screen. RN D confirmed she walked away from the medication cart and did not safeguard PHI.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure nail care had been provided to 1 resident (resident #42) of 3 residents reviewed for nail care. The findings include:Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, revealed .Residents will be provided with care, treatment and services as appropriate .residents who are unable to carry out activities of daily living [ADLs] independently will receive the services necessary to maintain .grooming .appropriate care and services will be provided for residents who are unable to carry out ADLs independently . Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses to include Dementia, Diabetes, Depression, and Psychotic Disorders. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment and was dependent on staff for personal hygiene and mobility. Review of the comprehensive care plan for Resident #42 revealed .assess fingers and toes for warmth .ADL deficit .evaluate resident's ability to perform ADL's . Review of the facility documents titled Skin Check for Resident #42 dated 3/15/2026 through 4/12/2026, revealed .foot evaluation completed . During an observation and interview on 4/14/2026 at 9:04 AM, revealed Resident #42 laying upright in bed. Continued observation revealed the resident's fingernails were long, untrimmed, and had a brown substance underneath the nails. The resident had bilateral heel protectors in use with toes visible. The residents' toenails were long, curled over the tips of the toes and jagged. The resident stated, .I would feel better if my nails and toes were done [trimmed and cleaned] . During an interview on 4/14/2026 at 9:10 AM, Certified Nursing Assistant (CNA) A stated she provided nail and foot care on bath days and made sure the residents' nails were cleaned. The CNA stated she did not provide foot or nail care to residents with Diabetes. During an observation and interview and on 4/14/2026 at 1:48 PM, Registered Nurse (RN) D observed Resident #42's nails and toenails and confirmed, .those [fingernails and toenails] need to be trimmed .mainly nursing and wound care take care of trimming toes and nails . The nurse was unable to provide an answer as to why Resident #42's nails and toenails had not been cleaned or trimmed. During an interview on 4/14/2026 at 2:00 PM, the Wound Care Nurse (WCN) stated, .nursing is to do weekly skin checks, and it includes feet . the WCN was unable to provide an answer as to why Resident #42's nails and toenails had not been cleaned or trimmed. During an interview on 4/14/2026 at 2:30 PM, the Director of Nursing (DON) stated the expectation was for the skin assessment to be completed and all skin should be dealt with before a weekly skin assessment becomes due. The DON stated Resident #42 is a diabetic and nail and foot care was provided by the RN or WCN. The DON confirmed nail and foot care had not been provided to Resident #42.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations and interviews, the facility failed to ensure foot and nail care had been provided for 1 resident (Resident #25) of 3 residents reviewed. The findings include: Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, revealed .Residents will be provided with care, treatment and services as appropriate .residents who are unable to carry out activities of daily living [ADLs] independently will receive the services necessary to maintain .grooming .appropriate care and services will be provided for residents who are unable to carry out ADLs independently .report any changes .in skin .skin between the toes .if nails are too hard or too thick to cut .Documentation .should be recorded in the .medical record .date and time nail care was provided .condition of the .nails .feet . Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses of Malignant Neoplasm of Brain, Palliative Care, and Melanoma of Neck and Scalp. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact and required maximum assistance to total dependence with ADLs. Review of the hospice care plan for Resident #25 dated 3/19/2026 revealed, .adjust ADLs to compensate for resident's changing abilities . Review of the weekly skin assessments for the months of 3/2026 and 4/2026 revealed the foot evaluation assessments had not been completed. During an observation and interview on 4/14/2026 at 8:20 AM, Resident #25 was resting in bed. CNA A was present in the resident's room and stated Resident #25 was .on hospice and they [hospice staff] take care of his baths and care . During an observation and interview on 4/14/2026 at 8:39 AM in Resident #25's room, revealed Licensed Practical Nurse (LPN) C pulled back the sheet and observed Resident #25's feet. The resident's right foot had a thick layer of dried yellow crusted skin over the top of the great toe and in-between all 4 digits. The nails were thick, long, and curled. The nail on the 2nd digit curled approximately 3/4 of an inch to the left and rested against the great toe. The nail on the 3rd digit curled and rested against top of the 2nd digit, and the nail on the 4th digit curled underneath covering the tip of the digit. Observation of the left foot revealed short nails and a thick layer of dried crusted skin on the top of the great toe and in-between all 4 digits. LPN C stated, .hospice does the bathing/showers and foot care .those should have been taken care of .the wound care nurse adds the residents who require foot care above what we can do here to the Podiatry list .I'm not sure if he is on the list for Podiatry . During an interview on 4/14/2026 at 8:47 AM, the Social Service Director (SSD) stated, .if there is an urgent need I send the request [podiatry service request] and the company [podiatry company] adds the resident to the list .currently, I do not have a Podiatry list .I do not have any residents scheduled for any upcoming Podiatry visits as of 4/14/2026 . During an observation and interview and on 4/14/2026 at 1:55 PM, Registered Nurse (RN) D observed Resident #25's feet and toenails and stated the condition of Resident #25's feet and toes were unacceptable (in her professional assessment) and should have been addressed during the full head to toe admission assessment. The RN confirmed foot and nail care had not been provided for the resident. During an interview on 4/14/2026 at 2:02 PM, the Wound care Nurse (WCN) stated, .nursing is to do weekly skin checks, and it includes feet .he is on the list for Podiatry services .he's supposed to be on it .I don't know why he [Resident #25] wasn't added .this is not the first time I've seen his feet like this . During an interview on 4/14/2026 at 2:11 PM, the SSD stated, .a nurse just came in and needed a gentleman added to the Podiatry list, but I can't remember his name [Resident #25] . During an interview on 4/14/2026 at 2:30 PM, the Director of Nursing (DON) stated the expectation on admission was for the skin assessment to be completed and all skin (to include feet) should be dealt with before a weekly skin assessment becomes due. The DON confirmed Resident #25 had not been provided with foot and nail care, had not been seen by the podiatrist and stated, .he should have been taken to Podiatry .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on facility policy review, observation, and interview, the facility failed to ensure 1 of 1 wound treatment carts, which contained topical medications and supplies, was locked and secured allowing unauthorized persons including residents, staff, and visitors access to the cart and the contents. The findings include: Review of the facility policy titled, Security of Medication Cart, dated 4/2007, revealed .the nurse must secure .the cart .to prevent unauthorized entry .the cart must be locked before entering a resident's room .carts must be securely locked at all times when out of the nurses view . During an observation on 4/13/2026 at 11:09 AM, in the East hallway, revealed a treatment cart unlocked and unattended against the wall. The cart doors were facing the opposite side of the hall and was accessible to unauthorized staff and visitors. During an interview on 4/13/2026 at 11:11 AM, the Wound Care Nurse (WCN) stated, .I know you just found the treatment cart unlocked. I have not been here since Friday . The WCN confirmed the cart was unlocked and was left unattended. During an observation on 4/15/2026 at 9:03 AM, the treatment cart was observed unlocked and unattended outside of the nurse's station adjacent to the North Hall. The cart doors were facing the nurse's station and was accessible to unauthorized staff and visitors. During an interview on 4/15/2026 at 9:08 AM, Licensed Practical Nurse (LPN) E approached the treatment cart and stated, .the cart is not to be unlocked. We [nursing staff] don't normally leave it open . During an interview on 4/15/2026 at 10:00 AM, the Director of Nursing stated, .the expectation is for all treatment and medication carts to be locked when unattended. The DON confirmed the treatment cart was unlocked and unattended and the contents were accessible to unauthorized staff or visitors.